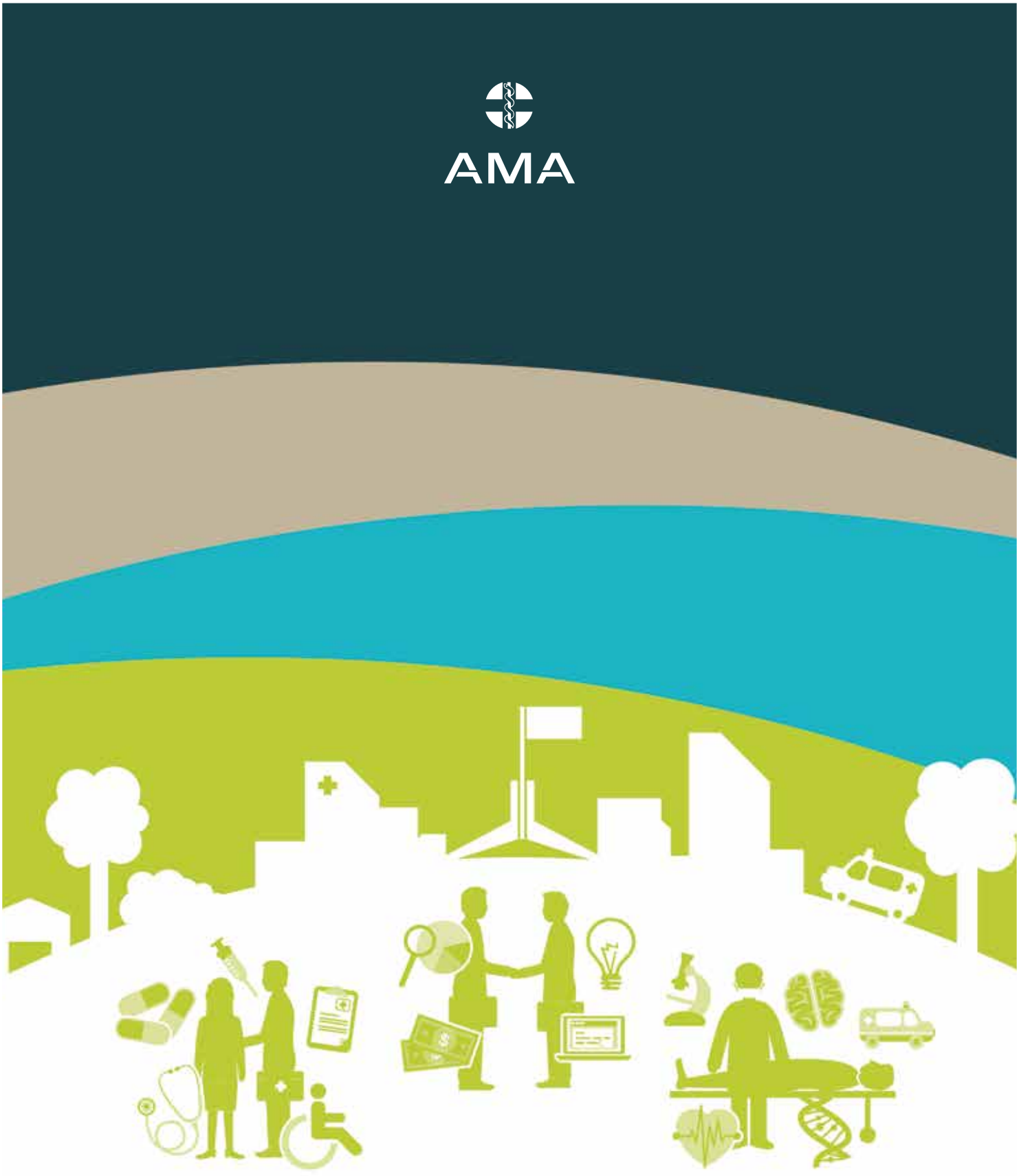
AMA



AUSTRALIAN MEDICAL ASSOCIATION

ANNUAL REPORT 2015

AMA

Australian Medical Association Limited

Strategic Plan 2015-2017

Mission

Leading Australia's Doctors - Promoting Australia's Health

Strategic Objectives

- Leading on advocacy
- Growing and valuing membership
- Ensuring financial security and flexibility
- Organisational capability

Contents

Editor
John Flannery, Federal AMA

Sub Editor:
Adrian Rollins, Federal AMA
Maria Hawthorne, Federal AMA

Production Coordinator:
Kirsty Waterford, Federal AMA

Graphic Design:
Streamline Creative, Canberra

President's Report

Defending, promoting, and enhancing the best interests of doctors and patients

This year was another period of high-level and high-speed activity, advocacy, achievement, and advancement for the AMA – on many fronts.

The year began very much in the same vein as 2014 ended, with health policy and politics centred on the Government's controversial and contentious co-payment policies, which in 2015 entailed a $5 cut to the Medicare patient rebate (a co-payment by stealth), a freeze to the Medicare rebate, and changes to Level A and B GP consultations.

The year also began with a change of Health Minister, with Sussan Ley taking over from Peter Dutton, who moved to Immigration. The AMA's relationship with Minister Ley started on good terms and, even throughout occasional tumultuous times, a strong transparent relationship remained in place at year's end.

It was Minister Ley's job to take the heat out of the co-payment debate – to consult and to keep things calm. It worked. It was not long before the Government's co-payment plans were gone – dead, buried, cremated.

Having worked tirelessly for this outcome, the AMA then called on the Government to shift its health priorities to chronic disease management, public hospital funding, Commonwealth/State relations, prevention, and medical training.

We stressed to the Government and the community that there was no health funding crisis facing Australia, as claimed by some in the Government and some commentators.

The foundations of the health system were sound. Health spending was not out of control. Our health system was, and is, the envy of the world.

It is not perfect, but the foundations – the balance between public and private, the defined roles for the Commonwealth and the States, high life expectancy, and good health outcomes – continue to underpin a healthy nation.

The problem for the Government throughout 2015 was that the damage from the 2014 Budget would not go away. The quest for significant savings in the health budget had come to a sudden halt with the demise of the co-payment.

A change of strategy came in the 2015 Budget with the announcement of the Review of the Medicare Benefits Schedule (MBS) and the Primary Health Care Review.

While welcoming the reviews and offering willing AMA participation, we let it be known from the beginning that the AMA would not support a process that was primarily about cost cutting and Budget savings.

Despite assurances from the Minister, all the rhetoric around the reviews was about removing items, not introducing new items as well, as had been agreed at the outset.

There was unanimity around building a modern MBS that reflects modern medical practice. That unanimity was frayed by the end of the year, as we waited for preliminary reports from both reviews.

In October, the Minister announced a review of the private health insurance sector. This came after months of inappropriate behaviour by some funds in their negotiations with private hospitals, and questions being raised about the value of many private health policies. The emergence of 'junk policies', where patients discovered they were not covered for care in a private hospital, added further impetus for the review.

Meanwhile, the private health funds continued pushing for a greater role in primary care

Then, in November, the Government released its long-delayed response to the mental health review. This virtually amounted to the Government allocating funding packages to Primary Health Networks to be distributed to various care providers and services at the local level.

There is still scant detail, and only a small number of PHNs operating at an efficient level, so question marks remain over this strategy, especially given the lack of commitment to a key role for GPs.

But the AMA advocacy and policy profile was much broader throughout the year.

We launched the AMA *Pharmacist in General Practice Incentive Program (PGPIP)*, our plan to have non-dispensing pharmacists part of the GP team.

We released the *Community Residency Program for Junior Medical Officers (JMOs)*, the AMA *Guide to 10 Minimum Standards for Medical Forms*, we co-launched the report, *Climate Change challenges to health: Risks and Opportunities*, with the Australian Academy of Science, and we co-launched the *Avoid the crash, Avoid the trauma* road safety campaign.

We launched new or updated AMA Position Statements on Palliative Care, Residential Aged Care, Methamphetamine, Combat Sports, Climate Change and Human Health, Aboriginal and Torres Strait Islander Health, Sexual Harassment in the Medical Workplace, Workplace Bullying and Harassment, Medical Graduates, Primary Health Networks (PHNs), the Medical Home, Tobacco Smoking and E-cigarettes, and the Health Care of Asylum Seekers.

The AMA Indigenous Health Report Card was warmly received by all stakeholders, and was broadly publicised in the media.

Our Public Hospital Report Card set the political agenda on hospital funding.

AMA advocacy brought an end to proposed Government changes to the Medicare Safety Net.

Our leaders and grassroots members spoke out in support of proper health care and compassion for asylum seekers, especially children in detention.

Importantly, the AMA played a leading role in the medical profession's examination of bullying and harassment in the profession and in medical workplaces, and this work is ongoing.

There have also been changes with AMA governance arrangements, which are detailed in the Secretary General's report.

As I approach my final months as AMA President, I thank my Vice President, Federal Council, Board, and Secretariat staff for working as a team to keep the AMA at the forefront of medico-political advocacy in Australia.

And I thank all AMA members for your feedback, your ideas, your energy, and your dedication to your patients, your peers, and the profession. You make us strong.

There will be a Federal Election in 2016. The AMA will be watching things very closely, and we will be standing up for what is best for doctors, their patients, and the community.

Professor Brian Owler
President

Secretary General's Report

The year started with a storm over the Government's proposed changes to Medicare billing, which had been announced late in 2014, and followed rapidly by the appointment of a new Minister, Sussan Ley, to calm the rising tide of anger among doctors and their patients. This set the theme for the year, with multiple reviews announced by the new Minister for Health but no overarching vision for health policy.

At the end of the year, the AMA was watching with caution the review into MBS services, the outcomes of the review of primary health care, the responses to the review of mental health, and the review of private health insurance. Underlying tensions remain within the health portfolio with the Government looking to modernise aspects of health policy, but also seeking to identify and deliver savings. These will play out as the nation heads toward the 2016 Federal Election.

Public health issues have continued to be of considerable interest to members during 2015, with members always willing to share their views with the AMA. During the year, member input was sought when the AMA reviewed its Position Statement on the impacts of climate change on human health. This was a good example where direct member consultation on a controversial but critical issue improved the final product.

In 2015, for the first time a National Conference was held without an AMA leadership election. The consensus of participants was that the absence of an election added to the collegiality of the event. The secretariat received many suggestions on approaches that might be taken to National Conference in the alternate, non-election year.

Federal Council has embraced the changed organisational structure with governance matters now managed by the Board, leaving Federal Council to focus on policy matters. The Chair of Federal Council, Dr Beverley Rowbotham, has encouraged broader contribution by members of Federal Council by including two policy-focused discussions at each meeting of the Council. These have ranged across the Federal Government's review agenda, the value of private health insurance, the challenges for the medical workforce, and more.

While the standing Councils and Committees of Federal Council continue to provide a solid foundation for the development of position statements for the AMA, more working groups have been used during the year to formulate rapid responses to current issues. These have included working groups to respond to the Federal Government's strategy on methamphetamines, the review of the climate change position statement, and formulation of policies on end of life care.

During the year, the Federal Council established a working group to review member representation on the Council and as delegates to National Conference. Federal Council accepted the recommendations of the working group, which were subsequently endorsed by the Board. The result is that Practice Groups replace Special Interest Groups, with two new groups added in 2015 – Rural Doctors and Private Specialist Practice. From 2017, the Practice Groups will nominate representatives to National Conference in addition to nominees of the State and Territory AMAs. Some minor amendments to the Constitution will be required at the 2016 Annual General Meeting.

A development in 2015 of considerable importance to the medical profession was the establishment of an AMA subsidiary, Doctors Health Services Pty Limited. With funding from the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, the company will coordinate the consistent delivery of health services to doctors and medical students across the country.

Another important development during 2015 was the formalisation of a Memorandum of Understanding with the Australian Medical Students' Association under which the AMA provides ongoing operational support, including appointment of an Executive Officer based within the AMA Secretariat. The medical students of today will be the AMA members of the future and the relationship supports early familiarity with the AMA.

At an operational level, 2015 has been a year of laying the foundations for future growth. A more efficient structure has been put in place for shared services functions within the AMA Group – shared information technology systems and staff, a shared finance team, and a Group human resources function. The restructure of the finance team has been supported by the transition to a new finance system, to be followed in 2016 with a new HR management system across the Group.

A high point in 2015 was the launch of the AMA's CPD tracker, which is freely available to members, and which supports reporting against the CPD requirements of every College. Online learning will be available through the doctorportal platform, with an emphasis on building learning content in 2016.

Following the re-launch of the AMA website in late 2014, several State AMAs now also have a home as subsidiary sites on the main site.

In 2016, there will be a major upgrade to the national member register. As the upgrade rolls out, the AMA will be refining the information it collects from members to support more streamlined member communications.

Staff changes during 2015 have introduced new skills and experience into the Secretariat, strengthening the AMA's capacity to undertake advocacy on behalf of members, and provide members with resources and information to support their practices.

I would like to thank the President and Vice President and the members of the Board and Federal Council, in particular the Chairs of each – Dr Elizabeth Feeney and Dr Beverley Rowbotham – for their commitment and support during 2015. I also thank the staff of the AMA Secretariat for their energy and passion for their work in supporting our members.

Anne Trimmer
Secretary General

AMA Board

The AMA has had a successful year in pursuing the strategic objectives adopted by the Board in late 2014. These continue to serve the company well with a mission of *Leading Australia's Doctors – Promoting Australia's Health*. The strategic objectives focus on four areas of activity – leading on advocacy, growing and valuing membership, ensuring financial security and flexibility, and organisational capability.

While the objective of leading on advocacy is rightly the domain of the President, Vice President and Federal Council, the Board has concentrated its efforts on the remaining three pillars. In supporting member value, the Board approved investment in the CPD tracker, which was launched at the 2015 National Conference, and ongoing contributions to the doctorportal platform, managed by the AMA subsidiary, AMPCo (Australasian Medical Publishing Company Pty Limited).

The Board views digital products as a major area of investment by the Federal AMA to complement and supplement the services provided by the State and Territory AMAs. The Board remains cognisant of the need to appropriately harness members' subscriptions for maximum benefit.

In working to ensure financial security and flexibility the Board took a major step in 2015 with the establishment of an Investment Committee. The Committee is chaired by Dr Gary Speck with Professor Geoff Dobb and myself as the other members. An external financial adviser has been appointed to work with the Committee to guide the management of the AMA's assets. These were added to during the year with the sale of AMPCo House in Sydney, following the relocation of the AMPCo business to more suitable premises.

In promoting organisational capability, the Board has focused on consolidating the foundational activities of its first year under the new constitutional structure. The Board supported the introduction of a Group shared services function across information technology, financial services, and human resources. These changes make better use of the investment in the corporate services areas, and leverage human resources across two sites.

The year has been a challenging one for AMPCo following the decision of its Board to outsource production of the *Medical Journal of Australia* to better manage the production costs of the Journal. As the year drew to a close, the Board of AMPCo was delighted to announce the appointment of Laureate Professor Nicholas Talley as the new Editor in Chief of the Journal, bringing to the role a rich research and editorial background.

A new subsidiary company was established during the year – Doctors Health Services Pty Limited (DrHS) – to provide nationally consistent health services to doctors and medical students. The initiative is funded by the Medical Board of Australia and Australian Health Practitioner Regulation Agency and is one that the Board embraced as an exemplar of the contribution that the AMA can make to the welfare of medical practitioners and medical students. The Board of DrHS is independent of the AMA and chaired by Dr Janette Randall. The other Board members are Dr Jennifer Alexander, Dr Michael Bonning, Dr Roger Sexton, and Dr Peter Sharley OAM (representing the parent company).

The Board of DrHS is informed by the input of an Expert Advisory Council and supported by staff within the AMA Secretariat. Considerable work has been undertaken to put in place appropriate governance arrangements, followed by an expression of interest process to identify suitable providers of health services in each State and Territory.

In May, the first changes were made to the Board membership, with Dr Kathryn Austin and Dr Tony Bartone stepping down, replaced by Dr Bav Manoharan and Dr Gary Speck. I would like to acknowledge the contributions of Dr Austin and Dr Bartone as two of the founding directors of the Board.

I would like to thank my fellow Directors and the AMA Secretariat for their contributions to a successful year for the company.

Dr Elizabeth Feeney
Chair

AMA Federal Council

AMA President
Professor Brian Owler

AMA Vice President
Dr Stephen Parnis

Chair of Federal Council
and Pathologist Nominee
Dr Beverley Rowbotham

ACT Nominee
Dr Elizabeth Gallagher

NSW Nominee
Dr Saxon Smith

VIC Nominee
Dr Anthony Bartone

QLD Nominee
Dr Chris Zappala

WA Nominee
Dr Michael Gannon

SA Nominee
Dr Janice Fletcher

NT Nominee
A/Prof Robert Parker

TAS Nominee
A/Prof Tim Greenaway

NSW-ACT Area Nominee
A/Prof John Gullotta AM

QLD Area Nominee
Dr Richard Kidd

SA-NT Area Nominee
Dr Chris Moy

TAS Area Nominee
Dr Helen McArdle

VIC Area Nominee
A/Prof Robyn Langham

WA Area Nominee
Dr Richard Choong

Anaesthetist Nominee
Dr Andrew Mulcahy

Dermatologist Nominee
Dr Andrew Miller

Emergency Physician Nominee
A/Prof David Mountain

GP Nominee
Dr Brian Morton AM

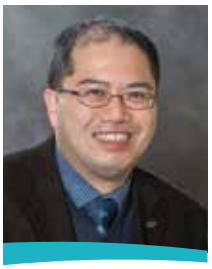
Obstetrician and
Gynaecologist Nominee
Dr Gino Pecoraro

Ophthalmologist Nominee
Dr Bradley Horsburgh

Orthopaedic Surgeon Nominee
Dr Omar Khorshid

Paediatrician Nominee
Prof Gary Geelhoed

Physician Nominee
Dr Richard Whiting



Psychiatrist Nominee
A/Prof Jeffrey Looi

Radiologist Nominee
Professor Mark Khangure

Surgeon Nominee
A/Prof Sue Neuhaus

Rural Doctor Nominee
Dr David Rivett OAM

Salaried Doctor Nominee
Dr Roderick McRae

Doctors in Training Nominee
Dr Danika Thiemt

Australian Medical Students'
Association Nominee
Mr James Lawler

Health Snapshot of Australia 2015

GP Care

84% of patient services bulk billed

93% of Australians have a usual general practice

33,275 GPs in Australia

Hospital Care

17.2 public hospital beds available per 1000 population aged 65 and over

68% triage category 3 patients seen within recommended time

73% emergency department visits completed in four hours or less

35 day wait for elective surgery

1,359 in 2013–14, there were 1,359 hospitals in Australia—747 public hospitals, accounting for 65% of hospital beds (58,600), and 612 private hospitals accounting for 35% of beds (31,000)

Health Spending

$423m in the 2015-16 Budget, the Commonwealth reduced public hospital funding by $423 million for the three years to 2017-18

$154.6b was spent on health goods and services in total in 2013–14

$6,639 was spent per person on average on health in 2013–14

Public Health

1 in 5 Australians affected by multiple chronic diseases

1.3m or 7% of Australians have used methamphetamine

1 in 8 Australians smoke

2 in 3 almost 2 in 3 adults are overweight or obese, 1 in 4 children are overweight or obese

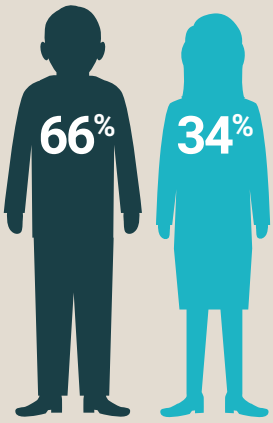
9.7 litres of pure alcohol was consumed per capita

Sources:

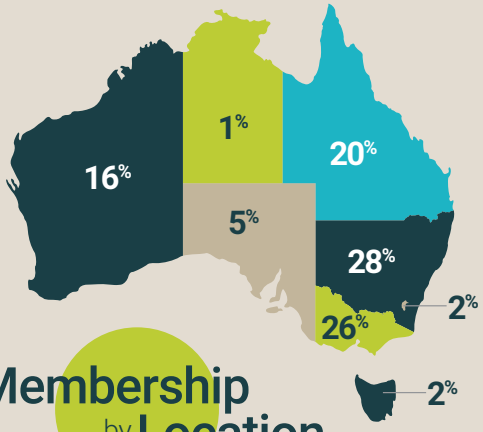
GP Care	Menzies Centre for Health Policy (2012). The Menzies-Nous Australian Health Survey 2012
Hospital Care	Australian Institute of Health and Welfare (2015). Australia's hospitals 2013–14: at a glance; Australian Bureau of Statistics (2015). Australian Demographic Statistics, Sep 2015; Australian Institute of Health and Welfare (2015). Emergency department care 2014–15: Australian hospital statistics; Australian Institute of Health and Welfare (2015). Elective surgery waiting times 2014–15: Australian hospital statistics.
Govt Spending	Commonwealth Budget and MYEFO papers; Australian Institute of Health and Welfare (2015). Commonwealth funding for public hospitals: Health expenditure Australia 2013-14
Public Health	Australian Institute of Health and Welfare (2014). 2013 National Drug Strategy Household findings: key findings; Australian Institute of Health and Welfare (2015). Australian Burden of Disease Study: fatal burden of disease; Australian Institute of Health and Welfare (2014). Australia's Health 2014

By the numbers

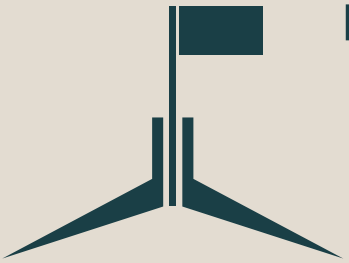
AMA Membership and Advocacy 2015



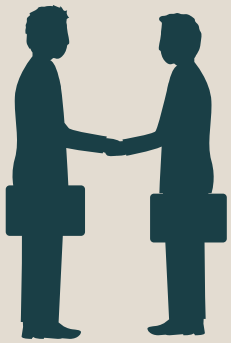
Membership by Gender



Membership by Location



73 The AMA made **submissions** to Parliamentary Inquiries



The AMA President attended around **90 key health meetings** representing the AMA

Source: AMA Membership and Marketing

Year in Review

January

AMA President Professor Brian Owler with Health Minister Sussan Ley

As the holiday season hit its peak, AMA President Professor Brian Owler warned Australian families that too many lives were being needlessly lost on our roads, and advised drivers to adhere to speed limits, don't drink and drive, and do not drive when fatigued. Meanwhile, the AMA's fight against the Government's proposed GP co-payments continued, with the President writing to Prime Minister Abbott urging him to personally intervene to stop the changes. AMA Vice President Dr Stephen Parnis said that the capacity crisis strangling the UK health system would be replicated in Australia if the Government continued its attacks on general practice and primary care. The AMA released internal research that graphically illustrated the potential impact of co-payments on Australian household incomes, with a $20 cut in Medicare patient rebates for standard GP consultations, and a total of $1.3 billion being ripped out of general practice. Strong leadership and lobbying from the AMA resulted in the Government abandoning its planned changes to Level A and Level B Medicare patient rebates for GP visits. Professor Owler congratulated new Health Minister Sussan Ley on the Government's decision, but advised that the AMA still strongly opposed plans to cut the Medicare patient rebate by $5, freeze Medicare rebate indexation, and introduce co-payments.

February

GP Forum in Sydney to discuss Government's Medicare reforms

A new report from the Productivity Commission confirmed that general practice was the most efficient and cost-effective part of the Australian health system. Professor Owler said that the report was further evidence that the Government's attacks on general practice were unwarranted, ill-directed, and politically unwise. The AMA presented to the Senate Committee on Health, and outlined the devastating effects that the Government's co-payment and freeze policies would have on patients, especially the poor and disadvantaged. The AMA conducted a series of doctor forums across the country to discuss the Government's destructive Medicare reforms. As PM Tony Abbott survived a leadership spill vote, the AMA called on the PM to

urgently intervene and dump his Government's bad health policies, most notably the co-payment, rebate cut, and freeze. The latest Close the Gap Campaign Report showed that targets for life expectancy, reduced mortality rates, and other key performance indicators for Indigenous health were not being met. Professor Owler said greater effort and funding was needed to address the social determinants of health, and that primary health care was an important part of the close the gap strategy. In response to the damning Human Rights Commission report on the health and treatment of refugees and asylum seekers, the AMA again called for an independent panel to monitor health services, and for children to be removed from detention. The AMA Specialist Trainee Survey revealed a high level of satisfaction with trainees' work and training experiences. Following representations from the AMA, the WMA, and other national medical associations, the Turkish Government dropped charges against doctors who assisted people who were injured in protests.

March

Professor Owler speaks to media after the Government scrapped the GP co-payment

The Government dumped its latest co-payment proposals, with Prime Minister Tony Abbott declaring that all co-payment plans were "dead, buried, and cremated". At a Parliament House media conference, Professor Owler welcomed the Government's decision to back away from its decision to cut the Medicare patient rebate by $5 – the so-called optional co-payment – but called for the Government to go further and lift the freeze on Medicare rebate indexation. Against a backdrop of revelations of incidents of bullying and harassment in medical workplaces, the AMA used International Women's Day to condemn harassment, acknowledge the magnificent achievements of women in medicine, and applaud the profession for its hallmarks of fairness and gender equality. A review conducted by the Australian National Audit Office (ANAO) found that the Medical Specialist Training Program was delivering on its targeted specialist training goals, including boosting specialist medical services in regional and rural Australia. A report from the National Health Performance Authority (NHPA) showed that general practice was the most efficient and most cost-effective part of the health system but, as the AMA had been telling the Government, greater investment was needed to allow general practice to continue providing high quality services to the community. On Close the Gap Day, Professor Owler said that coordinated action from all governments and the whole health sector was needed to really make a difference on long-term health outcomes for Indigenous Australians. The new AMA *Position Statement on Palliative Approach in Residential Aged Care Facilities* recommended that acute medical care settings should prioritise preserving and, where possible, extending life. The revised AMA *Position Statement on Restraint in the Care of People in Residential Aged Care Facilities* recognised the need for balance between a patient's right to self-determination and protection from harm, including harm to other residents and staff. The AMA released its *Guide to 10 Minimum Standards for Medical Forms* to help organisations design better forms for extracting medical information. Professor Owler addressed the BMA Symposium on the Australian perspective of the social determinants of health. Dr Parnis delivered a keynote address on physical activity at a Heart Foundation Policy Launch at Parliament House.

April

Professor Owler and Vice President Dr Stephen Parnis launching the AMA Public Hospital Report Card

The AMA released its Community Residency Program for Junior Medical Officers (JMOs), a plan to encourage more young doctors to choose a career in general practice. Professor Owler conducted a round of media interviews to support the Government's '*no jab, no pay*' vaccination policy. Warning of a 'perfect storm' in Australia's public hospitals, the 2015 AMA Public Hospital Report Card was launched with a call on governments to restore funding, build capacity, and stop the blame game. The Report Card was covered extensively in the national media, and brought an almost instant response of a Government pledge to put hospital funding at the top of the COAG agenda. The AMA welcomed the Government's announcement of a Review of the Medicare Benefits Schedule (MBS) and the establishment of the Primary Health Care Advisory Group, but warned about both initiatives being solely about finding Budget savings. Professor Owler visited Gallipoli to officiate at a special ceremony to pay tribute to doctors and other health workers who cared for the injured and dying from all sides at the Gallipoli landing in 1915. The AMA joined with the Australian Academy of Science to launch *Climate Change challenges to health: Risks and opportunities*, a report outlining how to respond to the impacts of climate change on human health. The AMA backed the NPS Medicine Wise program, *Choosing Wisely*, to minimise waste in the health system. Dr Parnis led the AMA's call on the Government to rule out cuts to public hospital tax concessions for public hospital staff.

May

Professor Owler with Leadership Development Dinner guest speaker, former Australian Prime Minister Julia Gillard

The AMA and the Medical Board of Australia (MBA) signed a contract for the national delivery of health services to medical practitioners and medical students. The AMA welcomed the election of Senator Richard Di Natale – a general practitioner – as Leader of The Greens, noting his experience as a doctor would give him valuable insight on health policy. Professor Owler declared the 2015 Federal Budget a huge disappointment, with little on offer to make up for the massive cuts delivered to the health sector in the 2014 Budget. The only major initiative was the previously announced MBS Review. Professor Owler delivered a strong speech to the smaller private health funds, calling for greater transparency around private health insurance products. The AMA strongly criticised the Federal Government's decision to fund a new medical school at Curtin University in WA, citing a need for new training places, not new medical schools. Dr Parnis welcomed the After Hours Review Report, which recommended returning after hours funding

to the Practice Incentives Program (PIP). Dr Parnis raised the AMA's concerns that the Sixth Community Pharmacy Agreement was increasing funding to pharmacy at a time when the Medicare rebate freeze was cutting funding for medical services. The AMA joined with Palliative Care Australia in National Palliative Care Week to encourage broader community debate about death and dying, including end of life care. An Independent Expert Panel advised the Government to re-introduce a program to provide junior doctors with a rural general practice experience – a move supported and championed by the AMA. The AMA launched its *Pharmacist in General Practice Incentive Program* (PGPIP), a plan to make non-dispensing pharmacists a key part of the future general practice health care team. The AMA National Conference took place in Brisbane.

June

Professor Owler being interviewed for ABC *Lateline*

The AMA and the Law Council of Australia joined forces to raise awareness of the victims of domestic violence, and the important role played by medical practitioners in identifying and assisting victims. Professor Owler acknowledged the outstanding contribution of the many doctors – GPs, other specialists, researchers, and educators – who were awarded Queen's Birthday Honours. In Men's Health Week, the AMA urged Australian men to get serious about looking after their own health, with Dr Parnis telling the media that two-thirds of men over 18 were either overweight or obese. The AMA and AMSA reiterated their opposition to the new Curtin medical school, citing a COAG report confirming there were sufficient medical graduates under existing arrangements. *The Lancet* report – *Health and Climate Change: policy responses to protect public health* – set out policy responses to the impacts of climate change on human health, consistent with the AMA Position Statement.

July

Professor Owler addresses the National Press Club

Professor Owler used 1 July to remind Australians that Medicare rebates had been frozen for three years, pushing up the costs of medical services and private health insurance premiums. He also welcomed the commencement of 31 new Primary Health Networks (PHNs) across the country, replacing the former Government's failed Medicare Locals. AMA Family Doctor Week kicked off with a renewed call for the Federal Government to support the PGPIP – a proposal that Deloitte Access Economics estimated would deliver $1.56 in savings for every dollar invested in it. Professor Owler used his National Press Club

Address to acknowledge the outstanding contributions of grassroots GPs in successfully opposing the Government's bad policies, including the GP co-payment, the changes to level A and B rebates, and the $5 cuts to Medicare rebates. He also defended the right of doctors and other healthcare workers working with refugees and asylum seekers to speak out about concerns for their patients' welfare, and called for a legislated exemption from prosecution. Responding to an options paper released by the COAG Health Council's Review of Medical Intern Training, the AMA warned against sweeping changes and instead called for the Review to follow the United Kingdom's lead and undertake a national survey of medical training. Professor Owler took to the airwaves to warn that an increase in the GST would not necessarily lead to more funding for public hospitals. He urged the Federal Government to live up to its responsibilities and provide proper funding to the States and Territories. The AMA made an extensive submission to the Expert Advisory Group (EAG) on Discrimination, Bullying and Harassment established by the Royal Australasian College of Surgeons (RACS) to deal with concerns of unacceptable behaviour in the health sector. Professor Owler said the medical profession was leading the way in tackling problems that were prevalent across society as a whole.

August

Professor Owler with Senator Nova Peris during NT visit

The AMA welcomed the Primary Health Care Advisory Group's Discussion Paper, *Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care*, but warned important reforms could not succeed without significant new investment in general practice and genuine Government support for GPs. Ahead of the return of Federal Parliament following the winter recess, the AMA called for a National Alcohol Strategy to tackle alcohol misuse. Professor Owler said the Federal Government had shown what was possible with the establishment of the National Ice Task Force, and similar decisive action was needed on alcohol. The AMA joined forces with the Australasian New Car Assessment Program (ANCAP) on a new campaign urging politicians to make new technology - starting with Autonomous Emergency Braking - standard features in all new cars sold in Australia. The *Avoid the crash, Avoid the trauma* campaign was launched at Parliament House. The AMA kept up the pressure on Medibank Private over its aggressive contract negotiations with private hospitals, hosting a summit of more than 60 leaders from across all medical specialties to discuss the insurer's behaviour. There was intense media interest in the event, with Professor Owler appearing on the ABC's *AM* program and on talkback radio.

September

Professor Owler met with Professor Patrick McGorry to discuss mental health issues

Three updated AMA Position Statements were released – on *Methamphetamine, Combat Sport,* and *Climate Change and Human Health*. The AMA also released its submission to the Federal Government's *Primary Health Care Review*, warning against radical change for change's sake, and calling for the urgent lifting of the freeze on Medicare rebates. The RACS Expert Advisory Group adopted several AMA recommendations in its draft report on discrimination, bullying, and harassment, including the critical need to provide complainants with a safe place to come forward, free of the fear of retribution or stigma. The AMA congratulated Malcolm Turnbull on his election as Prime Minister on 15 September. But the goodwill was gone by 27 September when Ms Ley launched a political attack on Medicare and the integrity of doctors. Laureate Professor Nicholas Talley was announced as the new Editor-in-Chief of the *Medical Journal of Australia*.

October

Professor Owler adressed the Australasian Road Safety Conference

The AMA welcomed the Government's decision to return responsibility for aged care to the Health portfolio under Ms Ley, giving it the public and political focus it deserved. After months of pressure, the Government shelved its controversial university deregulation legislation. Professor Owler welcomed the decision but called on the Government to provide certainty for students that education would not be priced out of their reach after the next election. The AMA backed the stance taken by Royal Children's Hospital (RCH) doctors in raising concerns about the physical and mental health of children in immigration detention centres, and called on the Prime Minister to intervene. In separate submissions to the Department of Health, the AMA called for a significant expansion of the Specialist Training Program (STP), and rejected a plan to link Practice Incentive Program (PIP) e-Health Incentive Payments to the adoption of the MyHealth Record by GPs. Another AMA Position Statement was released, on *Aboriginal and Torres Strait Islander Health*. The AMA called on the Federal Government to hold the South Australian Government to account after the State reneged on a deal to commit to providing enough medical internships to meet the growing number of graduates from SA medical schools. Professor Owler wrote to Ms Ley urging her to make

medical training a priority agenda item at the November meeting of State and Territory Health Ministers. The Federal Government introduced legislation for changes to Medicare Safety Net arrangements. The AMA called for the changes to be voted down as they would wind back financial assistance to patients for out-of-hospital health care costs. The AMA lodged its submission in response to the MBS Review Taskforce Consultation Paper, recommending a fast review and rapid implementation of its findings.

November

Dr Parnis, Professor Tom Calma, and Professor Owler launching the AMA Indigenous Health Report Card

Applications opened for the 2016 AMA Indigenous Peoples' Medical Scholarship. A new Bettering the Evaluation and Care of Health (BEACH) report confirmed that Australia's GPs were delivering efficient, high-quality primary care, putting the lie to the Government's regular criticisms of GPs in its efforts to sell its cost-cutting MBS review model. Professor Owler called on the Prime Minister to immediately rule out extending the GST to cover health, saying such a move would penalise the poorest and sickest in the community. New figures showed a 10 per cent growth in organ donations from deceased donors between January and September 2015. The AMA welcomed the rise but warned that the donor rate was still low by international standards. Professor Owler urged people to seek advice from their GP and share their decision with their family. The AMA called on Immigration Minister Peter Dutton to show compassion and immediately fly a pregnant diabetic Kurdish woman to Australia for urgent medical care, instead of sending a neonatal specialist to the Nauru Regional Processing Centre. The COAG Health Council released the recommendations of its Medical Intern Review and adopted many of the AMA recommendations, including a National Training Survey. However, the AMA said it was yet to be convinced of the need for the Review's option of a pilot program in which the transition to practice is split between university in the first year and the workplace in the second. Professor Owler and Rural Health Minister Fiona Nash joined forces to launch the AMA *Indigenous Health Report Card 2015*, highlighting the devastating effects of imprisonment on the lifelong health of Aboriginal and Torres Strait Islander people. With the school year coming to an end, the AMA warned Year 12 students to ensure their Schoolies Week celebrations were memorable for the right reasons, not visits to hospital emergency departments or embarrassing images being circulated via mobile phones. The AMA ended the month by joining with international medical associations to call on world leaders to make the health effects of climate change a priority in discussions at the United Nations Conference on Climate Change in Paris.

December

Dr Parnis on ABC News Breakfast discussing the Government's MBS Review

The Federal Government bowed to pressure from the AMA and the community and withdrew its proposed changes to the Medicare Safety Net. The AMA had raised its objections in a submission to the Senate Committee and in meetings with the Health Minister, the Opposition, and the Greens. The AMA wrote to Ms Ley offering solutions to address the shortfall in doctors in rural Australia, including lifting the targeted intake of medical students from a rural background from one-quarter to one-third of all new enrolments. The AMA released its new *Position Statement on Sexual Harassment in the Medical Workplace 2015* and its updated *Position Statement on Workplace Bullying and Harassment*, outlining the AMA's commitment to working with the whole of the medical profession to stamp these problems out. It also released Position Statements on *International Medical Graduates, Primary Health Networks (PHNs), the Medical Home, Tobacco Smoking and E-Cigarettes, and the Health Care of Asylum Seekers*. The Federal Treasurer released the Mid-Year Economic and Fiscal Outlook (MYEFO), with more cuts to health funding and cost-shifting to patients. Professor Owler said the axing of bulk billing incentives for pathology and diagnostic imaging services would increase the health cost burden for families. In its submission to the Government's Private Health Insurance (PHI) Review, the AMA called for greater transparency so people knew exactly what they were covered for under their policies. As the holiday season approached, the AMA urged all Australians to drive safely, to eat responsibly, to be careful in and around the water, to protect themselves from harmful UV exposure, and to use the time with their families to have the important but difficult conversations about end of life care. The AMA ended the year by encouraging smokers to make quitting the deadly habit their New Year resolution.

John Flannery/Maria Hawthorne

Financial Report

AUSTRALIAN MEDICAL ASSOCIATION LIMITED
ABN 37 008 426 793
AND CONTROLLED ENTITIES

31 DECEMBER 2015

CONTENTS

Directors' report

Australian Medical Association Limited (the Company) and its controlled entities for the year ended 31 December 2015, and the auditor's report thereon.

DIRECTORS

The Directors of the Company at any time during or since the end of the financial year are:

Name and Qualifications	Experience and Special Responsibilities
Dr Kathryn Austin B.Pharm B.Med GAICD, MRANZCOG	Director, Australian Medical Association Limited, 31 July 2014 - 31 May 2015. AMANSW Charitable Foundation Director, July 2013 -. Fellow in Maternal Foetal Medicine Subspecialty Obstetrics and Gynaecology. Graduate Australian Institute of Company Directors, 2014. Australian Medical Association (NSW) Limited, Treasurer and Director, Board of Directors, July 2011 - 31 July 2014. Australian Medical Association (NSW) Limited Audit and Risk Committee Chairman, June 2013 - July 2014. State Representative, AMA Council of Doctors in Training, 2009 - 2012. AMA Doctors in Training Representative, May 2010 – May 2011. NSW AMA Doctors in Training Committee Vice Chair 2009 and Chairperson, 2010 - 2012.
Dr Anthony Bartone MBBS, FRACGP, MBA	Director, Australian Medical Association Limited, 27 May 2012 - 25 May 2014 and 31 July 2014 - 31 May 2015. Director, Australian Medical Association (Victoria) Limited, May 2010 -. President, Australian Medical Association (Victoria) Limited, May 2014 -. General Practitioner.
Prof Geoffrey Dobb BSc (Hons), MBBS, FRCP, FRCA, FANZCA, FCICM, FAMA	Director, Australian Medical Association Limited, 23 October 2002 - 25 May 2014 and 31 July 2014 -. Past President, Australian Medical Association (WA) Incorporated. Chair, Australian Organ and Tissue Authority Advisory Council. Board Member, Australian Council on Healthcare Standards. Intensive Care Physician.
Dr Iain Dunlop MBBS (Hons), FRANZCO, FRACS	Director, Australian Medical Association Limited, 30 May 2010 -. Chairman of Council, Australian Medical Association Limited, 24 May 2013 – 25 May 2014. Executive Councillor, Australian Medical Association Limited, 29 May 2011 – 24 May 2013. Immediate Past President, Australian Medical Association (ACT) Limited. Director, Vision 2020 Australia, 2004 -. Director, Sight For Life Foundation, 2009 -. Past Chairman, MSC, Sydney and Sydney Eye Hospital. Past President, Royal Australian and New Zealand College of Ophthalmologists. Chairman, Department of Health Ophthalmic Prostheses Clinical Advisory Group, 2009 -. Ophthalmologist.
Dr Elizabeth Feeney MBBS, MHL, FANZCA, FAICD, FAMA	Director, Australian Medical Association Limited, 6 November 2010 -. Chairman, Board, Australian Medical Association Limited, 25 May 2014 -. Director, Australasian Medical Publishing Company Proprietary Limited, 4 June 2013 -. Director, Australian Medical Association (NSW) Limited, 2003–2011. Anaesthetist.

Directors' report

Name and Qualifications	Experience and Special Responsibilities
Dr Leonie Katekar MBBS, BSc(Med), MBioethics, FRACMA, GAICD	Director, Australian Medical Association Limited, 31 July 2014 - 31 January 2016. Councillor, Australian Medical Association Northern Territory Incorporated, 2011 -. Inaugural Board Director, HealthDirect Australia (formerly National Health Call Centre Network), 2007 - 2011. Chief Executive Officer and Medical Advisor, Top End Division of General Practice, 2001 - 2008. Medical Administrator and Health Informatics.
Dr Richard Kidd BHB, MBChB, Dip Obs, FAMA, Specialist VR General Practitioner	Director, Australian Medical Association Limited, 17 June 2011 -. Director, Board Member, The Queensland Branch of Australian Medical Association, 2007 - June 2014, December 2014 -. Chair, The Queensland Branch of Australian Medical Association, Council of General Practice, June 2009 -. Director, PeachTree Perinatal Wellness, 2012 -. Co-Founder, Doctors for Refugees. General Practitioner with special interests in Aged Care, Mental Health, Palliative Care and Medical Education.
Dr Michael Levick MBBS (Hons)	Director, Australian Medical Association Limited, 31 May 2015 – 25 June 2015. Director and Practice Principal of Moreland General Practice, 2012 -. Board Member, Australian Medical Association (Victoria) Limited, 2013 - 2015. General Practitioner.
Dr Bavahuna Manoharan BSc (BioMed), MBBS	Director, Australian Medical Association Limited, 31 May 2015 -. Treasurer & Director, Board of Directors, The Queensland Branch of Australian Medical Association, June 2014 -. The Queensland Branch of Australian Medical Association Finance, Risk & Audit Committee member, June 2014 -. The Queensland Branch of Australian Medical Association Governance Committee member, April 2015 -. The Queensland Branch of Australian Medical Association Councillor and Branch Council, June 2010 -. The Queensland Branch of Australian Medical Association Council of Doctors in Training, Executive member, January 2011-, Deputy Chair, 2014, & General Committee member, 2010. Queensland Representative to the Federal AMA Council of Doctors in Training, June 2013 - 2015). Convenor of AMA Queensland Junior Doctor Conference, annually June 2014 - 2016. Member, Queensland Health Medical Workforce Plan Steering Committee, November 2015 -. Accredited Registrar in General Surgery, Royal Australasian College of Surgeons, February 2015 -.
Dr Helen McArdle BMedSc, MBBS, MPH, FAFOEM, FRACMA, FAICD	Director, Australian Medical Association Limited, 20 March 2013 - 25 May 2014 and 31 July 2014 -. Director, AMA Tasmania. Deputy Chairman, Southern Cross Care (TAS) Inc. Chairman, Post Graduate Medical Council of Tasmania. Specialist Medical Administrator and Occupational Physician.

Directors' report

Name and Qualifications	Experience and Special Responsibilities
Prof Brian Owler MBBS, PhD, FRACS, GAICD	President, Australian Medical Association Limited, 25 May 2014 -. Director, Australian Medical Association Limited, 29 May 2011 -. Director, AMA Commercial Pty Ltd, 25 May 2014 -. Director, AMA Pty Limited, 25 May 2014 -. Director, AMA NT Pty Ltd, 25 May 2014 -. Director, Actraint No. 110 Pty Limited, 25 May 2014 -. President, Australian Medical Association (NSW) Limited, June 2012 - 13 May 2014. Neurosurgeon.
Dr Stephen Parnis MBBS, DipSurgAnat, FACEM, GAICD	Vice President, Australian Medical Association Limited, 25 May 2014 -. Director, Australian Medical Association Limited, 29 May 2011 -. Director, AMA Pty Limited, 25 May 2014 -. Director, Actraint No. 110 Pty Limited, 25 May 2014 -. President, Australian Medical Association (Victoria) Limited, May 2012 - May 2014. Vice President, Australian Medical Association (Victoria) Limited, 2006 - May 2012. Director, Australian Medical Association (Victoria) Limited, 2006 - 2014. Emergency Physician, John Fawkner Private Hospital and St Vincent's Hospital Melbourne.
Dr Peter Sharley OAM MBBS, Dip RACOG, Dip Av Med, Dip Bus Mgt, GAICD, FANZCA, FCICM	Director, Australian Medical Association Limited, 26 May 2012 - 25 May 2014 and 31 July 2014 -. Director, Doctors Health Services Pty Ltd. Board Member, Australian Medical Association (South Australia) Incorporated. Chairman of the Board, SA Post Graduate Medical Association. Intensive Care Specialist.
Dr Gary Speck AM MBBS, BMed SC (Hons), FRACS, FAOrthA, FAMA, GAICD	Director, SPT Ltd. Director MIPS Ltd. Director, Australian Society of Orthopaedic Surgeons. Chairman, Council of Procedural Specialists. Orthopaedic Surgeon.

Directors' report

PRINCIPAL ACTIVITIES

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

The principal activities during the reporting year, as set out in the Constitution, were to:

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

The AMA undertakes advocacy on behalf of its members, provides services and communications to its members and through a subsidiary, publishes and circulates the *Medical Journal of Australia*. The Australian Medical Association and Controlled Entities (the Group) owns property and investment assets to support revenue earned from membership subscriptions.

STRATEGIC DIRECTION

The strategic objectives for the AMA were adopted by the Board in late 2014 for the period 2015-2017. They are reviewed annually by the Board and were confirmed for the 2015 year.

The strategic objectives have four pillars – leading on advocacy; growing and valuing membership; ensuring financial security and flexibility; and organisational capability. These support the AMA's mission of *Leading Australia's Doctors – Promoting Australia's Health.*

Individual strategic objectives under the advocacy pillar include strengthening the AMA's role as the leader of Australia's doctors; developing the next generation of Australia's medical leaders; providing for individual member engagement in the medico-political process; and driving public health policies for a healthier and safer Australia.

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

REVIEW AND RESULT OF OPERATIONS

The consolidated profit after income tax was $350,007 (2014: $3,288,598).

The 2014 after tax profit includes the gain on sale of AMPCo House of $3,569,392.

The operations of the Group during the financial year included: promoting the interests of the medical profession in the medico-political arena and more widely; advocating for patient health and the health of the community; servicing members through the provision of a range of membership services and benefits; publishing, among other things, the highly recognised and peer reviewed general medical journal, the *Medical Journal of Australia*; the management and rental of commercial properties and maintenance and operation of a comprehensive data base containing both member and non-member information.

DIVIDENDS

The Constitution of the AMA does not permit the distribution of dividends to members.

STATE OF AFFAIRS

There were no significant changes in the state of affairs of the Group during the financial year under review which are not disclosed in the financial statements.

EVENTS SUBSEQUENT TO BALANCE DATE

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 Group, the results of those operations or the state of affairs of the Group in subsequent financial years.

Directors' report

LIKELY DEVELOPMENTS

The AMA has invested significantly in IT infrastructure and solutions over the past year. This is likely to continue with new products and services for members. During 2015 the AMA entered into an agreement with the Medical Board of Australia and AHPRA for the national delivery of a health service for medical practitioners and medical students. This will continue to evolve during 2016 with the initiation of face to face and online services delivered by State-based providers.

The Board established an Investment Committee in 2015 to work with the company's external investment adviser to maximise the investment returns to the company.

Following a review of subsidiary companies, AMA Commercial Pty Limited will be wound up in 2016 as it is surplus to needs.

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 67.

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 AMA has paid premiums on behalf of the entities in the Group in respect of Directors' and Officers' Liabilities and Professional Indemnity for the year ended 31 December 2015. Such insurance premiums insure against certain liability (subject to specific exclusions) of persons who are or have been Directors or Executive Officers of the AMA and its subsidiaries.

During the financial year the AMA has paid premiums to insure the above Directors, together with Officers of the Group, against liabilities for costs and expenses incurred by them in defending any legal proceedings arising out of their conduct whilst acting in the capacity of Directors and Officers of the Group, other than conduct involving a wilful breach of duty in relation to the Group.

INFORMATION ON DIRECTORS

2015 was the first full year of operation of the Board that was established following the major constitutional changes in 2014. The Constitution set out the process for replacement of the initial directors with half to stand down in 2015 and half in 2016. Those standing down were eligible for reappointment.

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 Elizabeth Feeney was the inaugural Chair and was reappointed in 2015 for a further term of 12 months.

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

Director's interests

Since the end of the previous financial year no Director has received or become entitled to receive a benefit, other than:

(a) a benefit included in the aggregate amount of emoluments received or due and receivable by Directors shown in the financial statements (Note 23);

(b) the fixed salary of an employee of the Company or an entity in the Group;

by reason of a contract made by the AMA or a related corporation with the Director, or with a firm of which he/she is a member, or with a company in which he/she has a substantial financial interest.

Directors' report

DIRECTORS' MEETING ATTENDANCE

Directors' meetings held during 2015 reflected the changes in the Constitution adopted by the Members at the AGM held on 24 May 2014.

During the period 1 January 2015 to 31 December 2015 the Board met on 13 occasions, 7 were face to face meetings and 6 were via teleconference/video conference.

The Audit and Risk Committee met four times during 2015, with an expanded Charter from 31 July 2014, and as a Committee of the new Board. Two members of the Committee are Directors and one is an independent appointment. An Investment Committee was established in October 2015, with all three members of the Committee being Directors.

The following tables summarise the meeting attendance of the Directors and Committee Members during 2015.

The number of meetings each Director/Committee Member was eligible to attend and actually attended is noted in the following tables:

Board Meetings		
	Eligible to Attend	Attended
Prof Brian Owler	13	10
Dr Stephen Parnis	13	13
Prof Geoffrey Dobb	13	12
Dr Elizabeth Feeney	13	13
Dr Iain Dunlop	13	9
Dr Kathryn Austin	6	6
Dr Anthony Bartone	6	6
Dr Leonie Katekar	13	13
Dr Richard Kidd	13	12
Dr Michael Levick	1	0
Dr Bavahuna Manoharan	7	7
Dr Helen McArdle	13	13
Dr Peter Sharley	13	11
Dr Gary Speck	6	6

Audit and Risk Committee		
	Eligible to Attend	Attended
Dr Iain Dunlop	4	4
Dr Leonie Katekar	3	2
Dr Helen McArdle	1	1
Mr Ed Killesteyn	4	4

Investment Committee		
	Eligible to Attend	Attended
Dr Gary Speck	2	2
Dr Elizabeth Feeney	2	2
Prof Geoffrey Dobb	2	2

Directors' report

Australian Medical Association Limited (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 to the adjustment of rights of contributories amongst themselves, of an amount not exceeding two dollars.

Signed in accordance with a resolution of the Directors.

Prof Brian Owler
Director
Australian Medical Association Limited

Dr Elizabeth Feeney
Director
Australian Medical Association Limited

Dated this 21st day of April 2016.

Statement of comprehensive income

For the year ended 31 December 2015

	Note	CONSOLIDATED 2015 $	CONSOLIDATED 2014 $
Revenue		20,249,023	20,323,111
Other income		444,973	3,821,999
	2	20,693,996	24,145,110
Expenditure			
Employee benefits expense		(11,972,944)	(11,563,136)
Depreciation and amortisation expense	22	(727,219)	(732,314)
Cost of goods sold		(37,999)	(32,759)
Bad debt expense	22	(10,879)	-
Finance costs		(88,724)	(81,243)
Production costs - *Medical Journal of Australia*		(1,104,473)	(1,182,825)
Financial assistance - States and Territories		(53,039)	(42,113)
Federal Council and committees		(585,956)	(587,550)
Travel and accommodation		(405,468)	(446,876)
Production and publications		(375,131)	(149,635)
National Conference		(437,200)	(393,686)
Outside bodies and overseas affiliations		(175,604)	(230,257)
Campaigns and projects		(172,333)	(158,219)
Cost of collection contribution		(212,768)	(201,360)
Insurance		(167,991)	(186,376)
Consultants		(527,314)	(533,855)
Communication costs		(211,981)	(210,338)
Office and administration costs		(362,021)	(449,203)
Sponsorship and commission		(13,621)	(15,007)
Other expenses	2	(3,459,618)	(2,825,973)
		(21,102,283)	(20,022,725)
(Loss)/Profit before income tax		(408,287)	4,122,385
Income tax expense	4	758,294	(833,787)
(Loss)/Profit for the year	22	350,007	3,288,598
Total comprehensive income for the year		350,007	3,288,598

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

Statement of financial position

For the year ended 31 December 2015

	Note	CONSOLIDATED 2015 $	2014 $
Assets			
Current assets			
Cash and cash equivalents	5	8,786,891	4,345,905
Trade and other receivables	6	2,009,587	9,884,189
Inventories	7	33,930	42,928
Prepayments	8	474,577	571,112
Income tax receivable		924,174	-
TOTAL CURRENT ASSETS		12,229,157	14,844,134
Non-current assets			
Other investments	9	1	1
Intangible assets	10	55,800	50,218
Investment properties	11	710,569	823,962
Property, plant and equipment	12	11,002,394	9,915,030
Deferred tax assets	13	561,069	134,201
TOTAL NON-CURRENT ASSETS		12,329,833	10,923,412
TOTAL ASSETS		24,558,990	25,767,546
Liabilities			
Current Liabilities			
Trade and other payables	14	3,433,499	3,474,057
Interest bearing loans and borrowings	15	-	1,013,000
Employee benefits	16	1,140,570	1,358,209
Income tax payable	17	-	246,745
TOTAL CURRENT LIABILITIES		4,574,068	6,092,011
Non-currrent liabilities			
Employee benefits	16	63,264	103,884
Total non-current liabilities		63,264	103,884
TOTAL LIABILTIES		4,637,332	6,195,895
Net assets		19,921,658	19,571,651
Equity			
Asset revaluation reserves		-	4,794,167
Retained earnings		19,921,658	14,777,484
TOTAL EQUITY		19,921,658	19,571,651

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

Statement of changes in equity

For the year ended 31 December 2015

CONSOLIDATED	Attributed to equity holders of the parent		
	Retained Earnings $	Asset Revaluation Reserves $	Total Equity $
At 1 January 2014	11,488,886	4,794,167	16,283,053
Profit/(loss) for the year	3,288,598	-	3,288,598
Other comprehensive income	-	-	-
At 31 December 2014	14,777,484	4,794,167	19,571,651
Profit/(loss) for the year	350,007	-	350,007
Changes due to reclassification	4,794,167	4,794,167	-
Other comprehensive income	-	-	-
At 31 December 2015	19,921,658	-	19,921,658

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

Statement of cash flows

For the year ended 31 December 2015

	Note	CONSOLIDATED 2015 $	2014 $
Cash flow from operating activities			
Membership subscriptions received		13,108,247	12,649,304
Commisssions received		1,160,953	1,155,248
Other receipts, including sales and subscriptions		9,830,047	8,331,945
Interest received		87,751	152,717
Interest paid		(88,724)	(81,243)
Income tax (paid)/received		(837,493)	72,651
Payment to suppliers and employees		(23,718,409)	(20,347,387)
Net cash (outflow)/inflow from operating activities	22	(457,628)	1,933,235
Cash flow from investing activities			
Payments for intangible assets	10	(20,500)	(20,523)
Payments for property, plant and equipment	12	(1,717,016)	(2,337,330)
Proceeds from property, plant and equipment		7,625,000	13,947
Proceeds from other investments	22	24,000	24,000
Dividends received	2, 22	129	173
Net cash inflow/(outflow) from investing activities		5,911,613	(2,319,733)
Cash flow from financing activities			
Repayment of bank borrowings		(1,013,000)	(293,000)
Net cash (outflows)/inflows from financing activities		(1,013,000)	(293,000)
Net increase/(decrease) in cash held		4,440,985	(679,498)
Cash and cash equivalents at the beginning of the year		4,345,905	5,025,403
Cash and cash equivalents at the end of the year		8,786,891	4,345,905

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

NOTE 1 STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

The consolidated financial statements and notes represent those of the AMA and its controlled entities.

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

Basis of preparation

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

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

The financial statements have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities.

The financial statements were approved by the Board on 21st April 2016.

(a) Principles of consolidation

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

Where controlled entities have entered or left the Group during the year, the financial performance of those entities is included only for the period of the year that they were controlled. A list of controlled entities is contained in Note 21 to the financial statements.

In preparing the consolidated financial statements, all inter-group balances and transactions between entities in the consolidated group have been eliminated in full on consolidation.

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

NOTE 1 STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

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

(d) Revenue recognition

Goods sold

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.

Commissions

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.

Membership subscriptions and other services

Revenue from the membership subscriptions and other services rendered are 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.

Rental income

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

NOTE 1 STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

(e) Finance income and expenses

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/(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) Non-derivative financial instruments

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

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

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

Loans and receivables

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

Available for sale financial assets

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

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.

NOTE 1 STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

(i) Cash and cash equivalents

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

(j) Trade and other receivables

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

(k) Trade and other payables

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

(l) Borrowing costs

Borrowing costs directly attributable to the acquisition, construction or production of assets that necessarily take a substantial period of time to prepare for their intended use or sale, are added to the cost of those assets, until such time as the assets are substantially ready for their intended use or sale.

All other borrowing costs are recognised in profit or loss in the period in which they are incurred.

(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.

The revaluation reserve disclosed in prior year accounts consist mainly of a revaluation of AMA House and the leasehold land it stands on, performed in 1995. This revaluation was booked prior to the change in accounting standards that require a revaluation policy be made with sufficient regularity to ensure that the carrying amount does not differ materially from that which would be determined using fair value at the end of the reporting period. The cost base of AMA House is taken to include this valuation. In the 2015 financial year, asset revaluation reserves have been re-classified to retained earnings.

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:

	2015	2014
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%
Computer Software	25%	25%
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:

	2015	2014
Membership Database	20%	20%
IT Project Development Costs	20% – 33.33%	20% – 33.33%
Website	20% – 33.33%	20% – 33.33%

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

(p) Investment properties

Investment property is 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:

	2015	2014
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

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

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

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

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

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

NOTE 1 STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

(r) Impairment (continued)

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

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

(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.

Notes to and forming part of the financial statements

For the year ended 31 December 2015

NOTE 1 STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

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

Reference	Title	Summary	Application date (financial years beginning)	Expected Impact
AASB 2015-3	*Amendments to Australian Accounting Standards arising from the Withdrawal of AASB 1031 Materiality*	The Standard completes the AASB's project to remove Australian guidance on materiality from Australian Accounting Standards.	1 July 2015	No expected impact
AASB 2014-9	*Amendments to Australian Accounting Standards – Equity Method in Separate Financial Statements*	This amending standard allows entities to use the equity method of accounting for investments in subsidiaries, joint ventures and associates in their separate financial statements.	1 January 2016	Minimal Impact
AASB 9	*Financial Instruments*	This Standard supersedes both AASB 9 (December 2010) and AASB 9 (December 2009) when applied. It introduces a "fair value through other comprehensive income" category for debt instruments, contains requirements for impairment of financial assets, etc.	1 January 2018	Minimal impact expected
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)*	Consequential amendments arising from the issuance of AASB 9.	1 January 2018	Minimal impact expected

Notes to and forming part of the financial statements

For the year ended 31 December 2015

		CONSOLIDATED	
		2015 $	2014 $
NOTE 2	**REVENUE AND EXPENSES**		
	Revenue		
	Subscription income	12,435,894	12,065,838
	Sales revenue	5,108,041	5,492,765
	Commission	1,096,502	1,144,530
	Service fee	59,091	50,000
	Rent	1,115,175	1,108,515
	Advertising - *Australian Medicine*	55,655	94,036
	Sponsorship	220,872	145,779
	Interest	87,751	152,717
	Medical fees list revenue	66,813	66,058
	AMA House conference facility	3,100	2,700
	Dividend income (Note 22)	129	173
	Other income		
	Gain on disposal of property	-	3,569,392
	Other revenue including recoveries	444,973	252,607
		20,693,996	24,145,110
	Expenses		
	Contributions to employee superannuation plans	916,275	883,550
	Rental expense on operating leases	-	19,131
	Other expenses		
	Direct operating expenses of investment properties (Note 11)	67,869	116,235
	Repairs and maintenance	485,632	538,933
	Merchant fees	171,522	188,935
	Licences and fees	141,769	129,965
	Legal fees	75,586	60,222
	Other	2,517,239	1,791,683
		3,459,618	2,825,973
NOTE 3	**AUDITORS' REMUNERATION**		
	Audit services		
	Auditors of the Group		
	RSM Australia Partners		
	- Audit of financial report	59,695	57,910
	Other services		
	Auditors of the Group		
	RSM Australia Pty Ltd		
	- Taxation services	61,430	29,996
	- Consulting services	38,375	48,120
		159,500	136,026

		CONSOLIDATED	
		2015 $	2014 $
NOTE 4	**INCOME TAX**		
	Current tax expense		
	Current year provision for income tax	-	(786,914)
	Franking credits	-	*187*
	Prior year adjustments	331,426	-
		331,426	(786,727)
	Deferred tax expense		
	Origination and reversal of temporary difference	353,405	130,595
	Adjustments for prior years	73,463	(177,655)
		426,868	(47,060)
	Total income tax expense in income statement	758,294	(833,787)
	Loss/(Profit) before income tax	408,287	(4,122,385)
	Income tax using the domestic corporation tax rate of 30% (2014: 30%)	122,486	(1,236,716)
	Increase in income tax expense due to:		
	Mutual expenditure	(4,048,272)	(3,678,274)
	Non-deductible expenses	(7,736)	(22,145)
	Sundry	(44,710)	(38,435)
		(4,100,718)	(3,738,854)
	Decrease in income tax expense due to:		
	Mutual income	4,286,265	4,231,523
	Fully franked dividends	-	187
	Intercompany transactions	(1,020)	1,020
	Profit on sale of property - non assessable	-	86,672
	Sundry	46,392	36
		4,331,637	4,319,438
		353,405	(656,132)
	Over/(under) provision for prior year - current tax expense	331,426	-
	Over/(under) provision for prior year - deferred tax expense	73,463	(177,655)
	Income tax expense	758,294	(833,787)
	Attributable to:		
	Continuing operations	758,294	(833,787)

		CONSOLIDATED	
		2015 $	2014 $
NOTE 5 CASH AND CASH EQUIVALENTS	**Note**		
Cash at bank	18	8,784,884	4,344,145
Cash on hand		2,007	1,760
Total Cash and cash equivalents		8,786,891	4,345,905

Included in the cash and cash equivalents for 2014 is $534,003 which the AMA, as one of multiple stakeholders, managed on behalf of the stakeholders of the Private Mental Health Alliance, Centralised Data Management Service, Private Mental Health Consumer Carer Network (Australia) and Private Mental Health Alliance Quality Improvement Project. In 2015, new adminstrative arrangements have been implemented for these 3 activities.

Whilst the AMA still manages the cash and cash equivalents of these 3 activities, cash held no longer forms part of the AMA's cash assets. Under these new administrative arrangements consolidation and separate disclosure of these cash assets is no longer required.

Accordingly the AMA's cash and cash equivalents no longer include cash held by the PMHA, CDMS or the Network.

NOTE 6 TRADE AND OTHER RECEIVABLES		
Current		
Trade receivables	1,349,615	555,349
Impairment losses	(10,879)	-
	1,338,736	555,349
Sale - AMPCo House	-	8,387,500
Other receivables	670,851	941,340
Total Trade and other receivables	2,009,587	9,884,189

The movement in allowance for impairment losses during the year was:

Balance at 1 January	-	72,433
Impairment loss recognised	(10,879)	(72,433)
Balance at 31 December	(10,879)	-

NOTE 7 INVENTORIES		
Finished goods	33,930	42,928
Total inventories	33,930	42,928

		CONSOLIDATED	
		2015 $	2014 $
NOTE 8	**PREPAYMENTS**		
	Prepayments	474,577	571,112
	Total Prepayments	474,577	571,112
NOTE 9	**OTHER INVESTMENTS**		
	Available for sale financial assets		
	Shares in AMA Member Services Pty Ltd	1	1
	Total Other investments	1	1

The changes in the fair value of the available for sale financial asset has not been accounted for as it is insignificant to the Group.

NOTE 10	**INTANGIBLE ASSETS**		
	Membership database - at cost	733,325	733,325
	Less accumulated amortisation	(728,935)	(720,083)
		4,390	13,242
	Website - at cost	55,943	55,943
	Less accumulated amortisation	(45,556)	(39,490)
		10,387	16,453
	IT Project development - at cost	41,023	20,523
	Less accumulated amortisation	-	-
		41,023	20,523
	Total Intangible assets	55,800	50,218

	CONSOLIDATED	
	2015 $	2014 $

NOTE 10 INTANGIBLE ASSETS (continued)

Movement in carrying amounts:

Consolidated	Membership database	Website	IT Projects	Total
31 December 2014	$	$	$	$
Opening written down value	30,245	16,968	4,991	52,204
Additions	-	-	20,523	20,523
Disposals	-	-	(4,991)	(4,991)
Amortisation	(17,003)	(515)	-	(17,518)
Closing written down value	13,242	16,453	20,523	50,218
31 December 2015				
Opening written down value	13,242	16,453	20,523	50,218
Additions	-	-	20,500	20,500
Disposals	-	-	-	-
Amortisation	(8,852)	(6,066)	-	(14,918)
Closing written down value	4,390	10,387	41,023	55,800

NOTE 11 INVESTMENT PROPERTIES	Note	CONSOLIDATED 2015 $	CONSOLIDATED 2014 $
Units 1 and 2 Tourism House – at cost		2,610,408	2,610,408
Add: Net capitalised lease costs		6,732	15,708
Less: Accumulated depreciation		(1,906,571)	(1,802,154)
Total investment property		710,569	823,962

Movement in carrying amounts:

Consolidated	Note	Units 1 and 2 Tourism House	Total
31 December 2014		$	$
Opening written down value		937,353	937,353
Additions: Capital leased costs		-	-
Expensing of capitalised leased costs	22	(8,976)	(8,976)
Depreciation		(104,415)	(104,415)
Closing written down value		823,962	823,962
31 December 2015			
Opening written down value		823,962	823,962
Additions: Capital leased costs		-	-
Expensing of capitalised leased costs	22	(8,976)	(8,976)
Depreciation		(104,417)	(104,417)
Closing written down value		710,569	710,569

A valuation of units 1 and 2 of Tourism House was performed during February 2015. The valuation was prepared by Ms Sandra Howells AAPI, Certified Practising Valuer, of Egan National Valuers (ACT). As at 10 February 2015, Units 1 and 2 of Tourism House were valued at $3,640,000 ($4,935,000 at 13 January 2012). As this value is in excess of the written down values disclosed above, no adjustment is necessary nor has been made within the financial statements.

		CONSOLIDATED	
		2015 $	2014 $
NOTE 12	PROPERTY, PLANT AND EQUIPMENT		
	Leasehold land, AMA House - at cost	1,600,000	1,600,000
	Buildings, AMA House - at cost	9,449,482	9,449,482
	Add: Net capitalised lease expenditure	123,274	-
	Less: Accumulated depreciation	(4,724,741)	(4,488,504)
		4,848,015	4,960,978
	Property, Parap Rd, Parap - at cost	381,397	381,397
	Less: Accumulated depreciation	(44,216)	(35,221)
		337,181	346,176
	Office furniture - at cost	2,872,910	2,667,478
	Less: Accumulated depreciation	(2,631,144)	(2,572,551)
		241,766	94,927
	Office equipment - at cost	266,142	229,165
	Less: Accumulated depreciation	(179,960)	(153,618)
		86,182	75,547
	Fixtures and fittings - at cost	6,422,607	6,182,543
	Less: Accumulated depreciation	(2,681,980)	(3,499,371)
		3,740,627	2,683,172
	Motor vehicles - at cost	-	-
	Less: Accumulated depreciation	-	-
		-	-
	Computer hardware - at cost	358,057	305,764
	Less: Accumulated depreciation	(258,770)	(215,468)
		99,287	90,296
	Computer software - at cost	205,334	194,532
	Less: Accumulated depreciation	(159,840)	(140,654)
		45,494	53,878

	CONSOLIDATED	
	2015 $	2014 $
NOTE 12 PROPERTY, PLANT AND EQUIPMENT (continued)		
Assets less than $300 - at cost	67,759	68,032
Less: Accumulated depreciation	(67,759)	(68,032)
	-	-
Personal computer network - at cost	119,687	119,688
Less: Accumulated depreciation	(115,845)	(109,632)
	3,842	10,056
Total Property, plant and equipment	11,002,394	9,915,030

A valuation of AMA House and the leasehold land on which it stands was performed during February 2016. The valuation was prepared by Ms Sandra Howells AAPI, Certified Practising Valuer, of Egan National Valuers (ACT). As at 10 February 2015 AMA House and the leasehold land on which it stands were valued at $13,500,000 ($17,885,000 at 6 February 2012). Because these values are in excess of the written down values disclosed in the financial statements, no adjustment is necessary nor has been made within the financial statements.

On the 13 November 2014, AMPCo exchanged contracts for the sale of its property, AMPCo House. The property was sold for $7,625,000 (excluding GST). Settlement occurred on 8 December 2015. AMPCo paid its bank loan in full with the proceeds from this sale.

An independent valuation of 2/25 Parap Road, Northern Territory was performed in February 2015 and valued at $420,000. Mr John Falvey, AAPI, Certified Practising Valuer, of Herron Todd White, prepared the valuation. As the valuation was in excess of the written down value disclosed in the financial statements, no adjustment is necessary nor has been made within the financial statements.

NOTE 12 PROPERTY, PLANT AND EQUIPMENT (continued)

Movement in carrying amounts:

Consolidated	Opening written down value	Additions	Disposals	Depreciation	Capitalised lease costs	(Note 22) Capitalised lease costs expensed	Work in Progress	Closing witten down value
31 December 2014	$	$	$	$	$	$	$	$
Property, Clarence St Sydney	4,056,943	-	(3,920,018)	(136,925)		-		-
Leasehold land, AMA House	1,600,000	-	-	-		-		1,600,000
Buildings, AMA House	5,202,786	-	-	(236,237)		(5,571)		4,960,978
Property, Parap Rd Parap	355,173	-	-	(8,996)		-		346,177
Office furniture	146,113	26,208	-	(77,397)		-		94,924
Office equipment	72,624	55,252	(34,661)	(17,667)		-		75,548
Fixture and fittings	597,039	2,156,967	-	(70,834)		-		2,683,172
Motor vehicles	14,913	-	(13,784)	(1,129)		-		-
Computer hardware	62,814	53,507	(368)	(25,655)		-		90,298
Computer software	35,354	30,794	-	(12,270)		-		53,878
Assets < $300	-	14,056	-	(14,056)		-		-
Personal computer network	19,599	546	(875)	(9,215)		-		10,055
	12,163,358	2,337,330	3,969,706	610,381		5,571		9,915,030
31 December 2015								
Leasehold land, AMA House	1,600,000	-	-	-	-	-	-	1,600,000
Buildings, AMA House	4,960,978	-	-	(236,237)	142,919	(19,645)	-	4,848,015
Property, Parap Rd Parap	346,177	-	-	(8,996)	-	-	-	337,181
Office furniture	94,924	205,433	-	(58,592)	-	-	-	241,765
Office equipment	75,548	36,977	-	(26,343)	-	-	-	86,182
Fixture and fittings	2,683,172	1,288,236	(451,223)	(209,014)	-	-	429,455	3,740,627
Motor vehicles	-	-	-	-	-	-	-	-
Computer hardware	90,298	52,293	-	(43,304)	-	-	-	99,287
Computer software	53,878	10,802	-	(19,186)	-	-	-	45,494
Assets < $300	-	-	-	-	-	-	-	-
Personal computer network	10,055	-	-	(6,213)	-	-	-	3,842
	9,915,030	1,593,741	(451,223)	(607,884)	142,919	(19,645)	429,455	11,002,394

NOTE 13 DEFERRED TAX ASSETS AND LIABILITIES

	Deferred Tax Assets		Deferred Tax Liabilities		Total	
Consolidated	2015	2014	2015	2014	2015	2014
	$	$	$	$	$	$
Property, plant and equipment	171,804	(61,713)	-	-	171,804	(61,713)
Accruals	90,599	41,551	-	-	90,599	41,551
Employee benefits	121,430	154,613	-	-	121,430	154,613
Impairment losses on receivables	3,571	-	-	-	3,571	-
Other	(250)	(250)	-	-	(250)	(250)
Carried forward losses	173,915	-	-	-	173,915	-
Total Deferred tax assets/(liabilities)	561,069	134,201	-	-	561,069	134,201

Movement in temporary differences:

Consolidated	Property, plant and equipment	Accruals	Employee benefits	Ipairment losses on receivables	Other	Carried forward losses	Total
	$	$	$	$	$	$	$
31 December 2014							
Opening written down value	(6,300)	14,329	151,592	21,730	(90)	-	181,261
Recognised in income statement	(55,413)	27,222	3,021	(21,730)	(160)	-	(47,060)
Recognised in equity	-	-	-	-	-	-	-
Closing written down value	(61,713)	41,551	154,613	-	(250)	-	134,201
31 December 2015							
Opening written down value	(61,713)	41,551	154,613	-	(250)	-	134,201
Recognised in income statement	233,517	49,048	(33,183)		3,571	173,915	426,868
Closing written down value	171,804	90,599	121,430	-	3,321	173,915	561,069

			CONSOLIDATED	
			2015 $	2014 $
NOTE 14	**TRADE AND OTHER PAYABLES**	**Note**		
	Trade creditors		477,584	592,390
	Other creditors and accruals		2,442,494	2,321,976
	Income in advance		513,421	559,691
	Total Trade and other payables	18	3,433,499	3,474,057

NOTE 15	**INTEREST BEARING LOANS AND BORROWINGS**			
	Current			
	Bill facility - secured (Note 17)		-	1,013,000
	Total Interest bearing loans and borrowings	18	-	1,013,000

The loans and borrowings were secured by registered first mortgage over land and buildings located at 277 Clarence Street, Sydney NSW 2000 and a registered equitable mortgage over the whole of its assets and undertakings including uncalled capital. The mortgages were discharged and paid out upon settlement of the contract for sale of the property.

NOTE 16	**EMPLOYEE BENEFITS**			
	Current			
	Liability for long service leave		671,118	632,624
	Liability for annual leave		469,452	725,585
			1,140,570	1,358,209
	Non-current			
	Liability for long service leave		63,264	103,884
	Total employee benefits		1,203,834	1,462,093

NOTE 17	**INCOME TAX PAYABLE**			
	Income tax payable		-	246,745
	Total Income tax payable		-	246,745

The income tax payable for the Group represents the amount of income taxes payable in respect of current and prior periods.

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.

	Note	CONSOLIDATED 2015 $	CONSOLIDATED 2014 $
Cash and cash equivalents	5	8,786,891	4,345,905
Trade and other receivables	6	2,009,587	9,884,189
Available for sale financial assets	9	1	1
		10,796,479	14,230,095

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, as disclosed in Note 6, represents the Group's maximum exposure to credit risk.

(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.

NOTE 18 FINANCIAL INSTRUMENTS AND RISK MANAGEMENT (continued)

(b) Market risk (continued)

(i) Interest risk

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

	Note	CONSOLIDATED CARRYING AMOUNT 2015 $	2014 $
Fixed rate instruments			
Financial liabilities			
Interest bearing loans and borrowings	15	-	(1,013,000)
		-	(1,013,000)
Variable rate instruments			
Financial assets			
Cash at bank		8,784,884	4,344,145
	5	8,784,884	4,344,145

Fair value sensitivity analysis for fixed rate instruments

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

A change of 100 basis points in interest rates would have increased or decreased the Group's equity by $0 (2014: $10,130).

Cash flow sensitivity analysis for variable rate instruments

A change of 100 basis points in interest rates would have increased or decreased the Group's equity by $87,849 (2014: $43,441). This analysis assumes that all other variables remain constant. The analysis was performed on the same basis for 2014.

(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)

(c) Liquidity risk

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

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

Consolidated	Note	Carrying amount $	Contractual cash flows $	6 months or less $	6-12 months $	1-2 years $	2-5 years $	More than 5 years $
Non-derivative financial liabilities								
31 December 2014								
Trade and other payables	14	3,474,057	(3,474,057)	(3,474,057)	-	-	-	-
Bill facility - secured, fixed at 7.25%	15	1,013,000	(1,021,026)	(185,887)	(185,277)	(372,025)	(277,837)	-
		4,487,057	(4,495,083)	(3,659,944)	(185,277)	(372,025)	(277,837)	-
31 December 2015								
Trade and other payables	14	3,433,499	3,433,499	3,433,499	-	-	-	-
Bill facility - secured, fixed at 7.25%	15	-	-	-	-	-	-	-
		3,433,499	3,433,499	3,433,499	-	-	-	-

(d) Fair values versus carrying amount

Except as disclosed below, the fair values of financial assets and liabilities, are not significantly different from the carrying amounts shown in the Statement of Financial Position:

		31 December 2015		31 December 2014	
Consolidated	Note	Carrying Amount $	Fair Value $	Carrying Amount $	Fair Value $
Liabilities carried at amortised cost					
Bill facility - secured, fixed at 7.25%	14	-	-	(1,013,000)	(1,029,473)
		-	-	(1,013,000)	(1,029,473)

(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

	CONSOLIDATED 2015 $	CONSOLIDATED 2014 $
Leases as lessee: Non-cancellable operating lease rentals are payable as follows:		
Not later than 1 year	-	19,131
Later than 1 year but not later than 5 years	-	-
	-	19,131
Leases as lessor: The Group leases out its investment property under operating leases (see Note 11). The future minimum rent receivable under non-cancellable leases are as follows:		
Investment property:		
Not later than 1 year	381,316	498,458
Later than 1 year but not later than 5 years	-	373,268
	381,316	871,726
Other Property:		
Not later than 1 year	509,642	498,458
Later than 1 year but not later than 5 years	1,987,773	373,268
	2,497,415	871,726
Total:		
Not later than 1 year	890,958	905,683
Later than 1 year but not later than 5 years	1,987,773	1,023,197
	2,878,731	1,928,880

The Group has entered into commercial property leases on its investment property and other property. Tourism House is classified as an investment property because no member of the group occupies any floor area of that property. The lease for that property is under a term of 5 years and nine months, commencing 1 January 2011 and ending 30 September 2016.

Lease payments escalate each year by CPI. The future minimum rent receivable has been calculated on the assumption that CPI will average 2.25% each year. This estimate is based on CPI increases from December 2012 to December 2014 and those anticipated for the remainder of the lease contract. The lease does not contain any contingent rentals.

AMA House is classified as other property. It is not classified as an investment property because the parent entity occupies the 4th floor. Several leases, for different terms, exist over tenancies within AMA House. Some tenancies were vacant for the full year ended 31 December 2015. Where there is no certainty that a lease commitment exists or will exist at a point in the future, no rent receivable has been disclosed. Some leases have fixed percentage annual escalations and some escalations are linked to CPI.

NOTE 19 OPERATING LEASES (continued)

The future minimum rent receivable has been calculated on the assumption that where applicable, CPI will average 2.25%. Fixed percentage escalations apply in accordance with existing lease contracts. CPI of 2.25% is based on CPI increases from December 2012 to December 2014 and those anticipated for the remainder of the lease contract.

During the year ended 31 December 2015, $1,115,175 was recognised as rental income in the Statement of Comprehensive Income (2014: $1,108,515). Direct operating expenses recognised in the Statement of Comprehensive Income relating to property was $1,229,231 (2014: $1,193,434).

	CONSOLIDATED	
	2015 $	2014 $
NOTE 20 COMMITMENTS		
Expenditure commitment:		
Not later than 1 year	678,098	23,270
Later than 1 year but not later than 5 years	2,697,364	12,725
	3,375,462	35,995
Commitments receivable		
Not later than 1 year	34,472	-
Later than 1 year but not later than 5 years	69,699	-
	104,171	-

NOTE 21 CONTROLLED ENTITIES

Parent entity		
Australian Medical Association Limited	n/a	n/a
Controlled entities		
Australasian Medical Publishing Company Proprietary Limited	1	1
AMA Pty Limited	2	2
AMA Commercial Pty Ltd	2	2
AMA NT Pty Ltd	1	1
Actraint No. 110 Pty Limited	2	2
Doctors Health Services Pty Ltd	1	-
	9	8

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

AMA 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	CONSOLIDATED 2015 $	2014 $
NOTE 22 RECONCILIATION OF CASH FLOWS FROM OPERATING ACTIVITIES			
(Loss)/Profit for the year		(408,287)	3,288,598
Less items classified as investing activities:			
Dividends received	2	(129)	(173)
Receipts from investment		(24,000)	(24,000)
Add/(less) non-cash items:			
Depreciation and amortisation		727,219	732,314
Bad debt expense		10,879	-
Net profit on sale of non-current assets		-	3,664,250
Expensed of capitalised leased costs	11, 12	28,621	14,547
Net movement in provision for employee entitlements		(258,259)	111,384
		76,044	7,786,920
Changes in operating assets and liabilities:			
Decrease/(Increase) - Trade and other receivables		335,260	(8,186,920)
Decrease/(Increase) - Inventories		8,998	(7,843)
(Decrease)/Increase - Trade and other payables		(296,696)	1,434,640
(Decrease)/Increase - Provision for tax liabilities		(1,339,528)	906,438
Net cash flow from operating activities		(457,628)	1,933,235

NOTE 23 DIRECTOR 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.

In addition to remuneration paid to the President and Vice President, the Group also provides remuneration in the form of Directors' fees to Directors.

Key Management Personnel are remunerated in the form of salaries or under contract.

	CONSOLIDATED	
	2015 $	2014 $
NOTE 23 DIRECTOR AND EXECUTIVE DISCLOSURE (continued)		

The Directors and Key Management Personnel compensations are as follows:

Short-term employee benefits	2,501,051	3,498,179
Termination benefits	-	65,233
	2,501,051	3,563,412

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

NOTE 24 TRUST FUNDS

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

	2015 $	2014 $
The Mervyn Archdall Medical Monograph Fund	23,194	28,387
The Federal Medical War Relief Fund	7,822	13,373
The Federal Independence Fund	4,776	4,658
	35,792	46,418

AMA Pty Limited acts as trustee for The Indigenous Peoples' Medical Scholarship Trust Fund. The net value of the assets of the Trust at 31 December 2015 is $157,647 (2014: $172,976).

NOTE 25 SUBSEQUENT EVENTS

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

NOTE 26 COMPANY DETAILS

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

- Australasian Medical Publishing Company Proprietary Limited;
- AMA Pty Limited;
- AMA Commercial Pty Ltd;
- AMA NT Pty Ltd;
- Actraint No.110 Pty Limited; and
- Doctors Health Services 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 AMA is 4th Floor, 42 Macquarie Street, Barton ACT 2600. The AMA 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 Street, Sydney NSW 2000. This company publishes the highly recognised and peer reviewed general medical journal, *Medical Journal of Australia* and maintains and operates a comprehensive database containing both member and non-member information.

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

Doctors Health Service 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 national delivery of a health service for medical practitioners and medical students.

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.

NOTE 27 PARENT ENTITY

As at, and throughout the financial year ended 31 December 2015, 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.

	2015 $	2014 $
(a) Financial information		
Profit for the year	3,584,509	19,751
Total comprehensive income	3,584,509	19,751

The 2015 profit for the year includes a dividend of $3,920,016 from the Australasian Medical Publishing Company Proprietary Limited.

Statement of financial position		
Assets		
Current assets	6,668,357	2,239,363
Non-current assets	10,511,675	9,918,759
Total assets	17,180,032	12,158,122
Liabilities		
Current liabilities	1,950,430	1,035,502
Non-current liabilities	14,976	21,710
Total liabilities	1,965,406	1,057,212
Equity		
Retained earnings	15,214,626	11,100,910
Total equity	15,214,626	11,100,910

(b) Guarantees

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

(c) Other commitments

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

(d) Contingent liabilities

There are no contingent liabilities at the reporting date.

NOTE 28 RELATED PARTY TRANSACTIONS

Parent entities

The wholly owned group consists of Australian Medical Association Limited and its controlled entities. These entities are Australasian Medical Publishing Company Proprietary Limited, AMA Pty Limited, AMA Commercial Pty Ltd, AMA NT Pty Limited, Actraint No 110 Pty Limited and Doctors Health Services Pty Ltd.

The following transactions occurred with related parties:

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	2015	2014
		%	%
Australasian Medical Publishing Company Proprietary Limited	Ordinary	100	100
AMA Pty Limited	Ordinary	100	100
AMA Commercial Pty Ltd	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	-

Directors' Declaration

In the Directors' opinion:

1) the financial statements and notes, set out on pages 31 to 64 are in accordance with the *Corporations Act 2001*, and

   i) comply with Australian Accounting Standards; and

   ii) give a true and fair view of the financial position as at 31 December 2015 and of the performance for the year ended on that date, of the AMA and consolidated Group.

2) there are reasonable grounds to believe that the AMA 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 21st day of April 2016.

Prof Brian Owler
Director
Australian Medical Association Limited

Dr Elizabeth Feeney
Director
Australian Medical Association Limited

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

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 2015, I declare that, to the best of my knowledge and belief, there have been no contraventions of:

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

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

RSM Australia Partners

RSM Australia Partners

Canberra, Australian National Territory
Dated: 27th April 2016

R MILLER
Partner

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

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF

AUSTRALIAN MEDICAL ASSOCIATION LIMITED

We have audited the accompanying financial report of the Australian Medical Association Limited ("the Company") which comprises the consolidated statement of financial position as at 31 December 2015, and the consolidated statement of comprehensive income, consolidated statement of changes in equity and consolidated cash flow statement for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the directors' declaration of the consolidated entity comprising the company and the entities it controlled at the year's end or from time to time during the financial year.

Directors' Responsibility 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 is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

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

Independence

In conducting our audit, we have complied with the independence requirements of the *Corporations Act 2001*. We confirm that the independence declaration required by the *Corporations Act 2001*, which has been given to the directors of Australian Medical Association Limited, would be in the same terms if given to the directors as at the time of this auditor's report.

Opinion

In our opinion the financial report of Australian Medical Association Limited is in accordance with the *Corporations Act 2001*, including:

(i) giving a true and fair view of the consolidated entity's financial position as at 31 December 2015 and of its performance for the year ended on that date; and

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

RSM Australia Partners

RSM Australia Partners

Canberra, Australian National Territory
Dated: 27th April 2016

R MILLER
Partner

Committee Lists

AUDIT AND RISK COMMITTEE

The Audit and Risk Committee's core objectives are to provide a link between the Board and its external auditors, and to review the integrity of financial information and the effectiveness of the company's internal controls, including the company's internal audit function.

The Audit and Risk Committee was re-shaped during 2014 following the adoption of a new Constitution, the establishment of a smaller governance Board, and the appointment of Mr Ed Killesteyn PSM as an independent member of the Committee.

The Audit and Risk Committee met on four occasions during 2015.

The Committee's activities throughout the year focused on several key activities:

- risk management;
- financial performance; and
- work health and safety.

Risk management was a significant component of each meeting during 2015. The Committee conducted a comprehensive assessment of the Association's internal controls, regularly reviewed the AMA Risk Register, established a risk assurance plan, and then distributed requests for proposals from several external service providers for Internal Audit Services and for Risk Management Services.

The Committee also considered ongoing progress addressing the recommendations of the WHS Workplace Inspection Report and the WHS Management System Audit completed in February 2015 by an independent WHS consultant.

The outcome of the 2014 audit of the financial reports of the Australian Medical Association Limited and its controlled entities and for Australasian Medical Publishing Company Proprietary Limited for 31 December 2014 and the recommendations made by the auditors on accounting procedures and internal financial reporting processes were considered at the April 2015 meeting. Unqualified Audit reports were issued for both financial reports.

The December 2015 meeting focused particularly on the 2015 audit, including:

- the auditor's annual arrangement letter for the 2015 audit;
- the auditor's Audit Strategy for the year ending 31 December 2015; and
- proposed fraud risk assessment.

Dr Iain Dunlop
Chair

AUDIT AND RISK COMMITTEE

Dr Iain Dunlop	Chair – Board Member
Dr Leonie Katekar	Board Member (until December)
Dr Ed Killensteyn PSM	Independent Member
Dr Helen McArdle	Board Member (from December)

TESTIMONIAL

"One of the reasons the AMA mattered to me personally was when my particular craft group was under threat from government changes, government fee changes, which would have compromised the quality of services we could have provided for patients ... the AMA was the body that had the entree to talk to the Minister and argue on our behalf. There was nobody else who could have done what the AMA did, and what it always does, advocating for better public policy on health and its other activities."

Dr Beverley Rowbotham
Haematologist, Queensland

AMA COUNCIL OF DOCTORS IN TRAINING

In February 2015, AMACDT released the results of the 2014 AMA Specialist Trainee Survey. The survey revealed responsiveness to instances of bullying and harassment, feedback, appeals and remediation processes, and that training costs are ongoing issues for trainees. This informed AMA advocacy on vocational training throughout the year.

The AMA brought together medical leaders from across the profession at a Roundtable to address workplace bullying and harassment. Following this, the AMA decided to develop specific policy on sexual harassment and review existing policy on bullying and harassment. AMACDT agreed to lead this work, which culminated in new and updated policy on sexual harassment, workplace bullying and harassment, flexible work arrangements, and safe work environments.

AMACDT was delighted to have the former Prime Minister, Julia Gillard, speak at its Leadership Development Dinner at AMA National Conference in May. The AMACDT policy session on the future of GP training at National Conference led to the development of a vision statement for general practice training that emphasises the value of general practice training.

AMACDT has continued to advocate for more prevocational and vocational training places to ensure medical graduates can progress to full specialist qualification, and receive a high quality relevant medical training experience. In particular, the Medical Intern Review accepted many of the AMA's recommendations to adopt an incremental approach to reform of the internship year. Towards the end of 2015, the Federal Government also announced funding for additional specialist training places, as well as for 240 rural GP rotations for interns.

The Council has continued to provide representatives to more than 30 different committees and working groups that focus on medical education and training. Council members have also presented at a number of conferences. The AMACDT would like to thank the many doctors in training who have contributed to the Council's work during 2015.

Dr Danika Thiemt
Chair

AMA COUNCIL OF DOCTORS IN TRAINING

Dr Danika Thiemt	Chair – Federal Council
Dr Julian Grabek	Deputy Chair (until April)
Dr John Zorbas	Western Australia* (until December)
Dr Chris Wilson	Western Australia*
Dr Nushin Ahmed	Australian Capital Territory
Dr Thomas Crowhurst	South Australia (until December)
Dr Robert Marshall	Northern Territory* (until September)
Dr Andrew Webster	Northern Territory* (from October)
Dr Gabrielle Diplock	Northern Territory*
Dr Chris Mulligan	New South Wales (until September)
Dr Kate Kearney	New South Wales (from October)
Dr Alistair Park	Tasmania
Dr Bavahuna Manoharan	Queensland (until June)
Dr Malcolm Forbes	Queensland (from July until December)
Dr Bernadette Wilks	Victoria (until June)
Dr Enis Kocak	Victoria (from July)
Mr James Lawler	Australian Medical Students' Association Representative (until December)

*Co-chairs/Alternating members

ETHICS AND MEDICO-LEGAL COMMITTEE

In 2015, the Ethics and Medico-Legal Committee (EMLC) updated medico-legal guidelines on disclosing medical records to third parties conducting independent medical assessments, and addressed potential conflicts of interest in owning a pharmacy.

The AMA's *Position Statement on Medical Professionalism* was revised, setting out the values and skills the profession and society expects of doctors.

The EMLC launched the review of AMA policy on euthanasia and physician assisted suicide in November by providing members with an opportunity to express their views. A comprehensive member engagement strategy was developed to accompany the ongoing review into 2016.

To support members working in end of life care, the AMA passed a resolution advocating nationally consistent legislation protecting doctors from civil or criminal liability when, in accordance with good medical practice, they:

- administer or prescribe medical treatment at the end of life with the intention of relieving pain or distress that may have an incidental effect of hastening death; and
- withhold and/or withdraw life sustaining measures which are of no medical benefit to the patient.

Following on from a very successful 2015 AMA National Conference policy session on stewardship of health care resources, the EMLC has been developing a guide for individual doctors on how to practise and promote effective stewardship in the workplace.

Media and advocacy focussed on a broad range of ethics issues including palliative care, advance care planning, organ donation, protecting the medical neutrality of health care workers in conflict zones, stewardship of health care resources, assisted reproductive technologies and the AMA's opposition to capital punishment.

On the corporate front, policies were developed to guide the AMA in making ethical investment decisions and when undertaking commercial and funding relationships relevant to doctorportal.

Dr Michael Gannon
Chair

ETHICS AND MEDICO-LEGAL COMMITTEE	
Dr Michael Gannon	Chair – Federal Council
Dr Helen McArdle	Federal Council
Dr Alexandra Markwell	Queensland
Dr Chris Moy	Federal Council
Ms Danielle Pannacio	Australian Medical Students' Association Representative (until April)
Mr Matthew Rubic	Australian Medical Students' Association Representative (from May)
Mr Andrew Took	AMA New South Wales policy advisor
Dr Bernadette Wilks	Council of Doctors in Training Representative (until May)
Dr Choong-Siew Yong	New South Wales

AMA COUNCIL OF GENERAL PRACTICE

During 2015, the AMA Council of General Practice (AMACGP) continued to work hard in the interests of GPs and their patients by providing leadership, advice and guidance on key policy issues affecting general practice and primary health care.

The year began with the AMA continuing its strong campaign against the Government's proposed introduction of a 10 minute threshold for Level B MBS consultations, a $5 cut to patient rebates for GP consultations, the Government's flawed co-payment model and the extension of the Medicare rebate freeze until 2018. This pressure ultimately saw the Government abandon most of these measures. However, the rebate freeze remains and the AMA continues to prosecute the case for indexation to be restored.

The AMACGP developed and revised a number of position statements during the year, including: *Fundholding; Ten Minimum Standards for Medical Forms; the Medical Home; General Practice Nurses;* and *Primary Health Networks*. In addition, the AMACGP contributed to a range of key AMA submissions.

Other key areas of work for the AMACGP included:

- providing strong input into the Primary Health Care Review by calling for further investment in general practice;
- finalising a model for integrating pharmacists into general practice in collaboration with the Pharmaceutical Society of Australia;
- providing input into a number of consultative processes on prevention and management of chronic disease;
- exploring potential areas for greater private health insurance involvement in primary care;
- providing input into the Government's GP training reforms, advocating for retention of the apprenticeship model for GP training and strong professional control; and
- coordinating Family Doctor Week 2015, which strongly promoted the central role of GPs in the health system.

The AMACGP, having provided significant input to the After Hours Review and the Medicare Locals Review in previous years, also welcomed the return of after hours funding to the Practice Incentive Program and the replacement of Medicare Locals with Primary Health Networks from 1 July 2015.

Dr Brian Morton AM
Chair

AMA COUNCIL OF GENERAL PRACTICE

Dr Brian Morton AM	Chair – Federal Council
Dr Richard Kidd	Queensland (until May), Federal Council (from June) and Deputy Chair
Dr Bernard Pearn-Rowe	Western Australia and Convenor
Dr Tony Bartone	Federal Council
Dr Peter Beaumont	Northern Territory
Dr Richard Choong	Federal Council
Dr Chris Clohesy	South Australia (until January)
Dr Suzanne Davey	Australian Capital Territory
Dr Dilip Dhupelia	Queensland (from September)
Mr Brian Fernandes	Observer – Australian Medical Students' Association Representative
Associate Professor John Gullotta AM	Federal Council
Dr Cathy Hutton	Victoria
Dr Michael Levick	Victoria (until June)
Dr Kean-Seng Lim	New South Wales
Dr Danielle McMullen	Council of Doctors in Training Representative
Dr Patricia Montanaro	Federal Council (until May), South Australia (from June)
Dr Annette Newson	South Australia (from June)
Dr David Rivett OAM	New South Wales and Observer - Council of Rural Doctors
Dr Shaun Rudd	Queensland
Dr Anne Wilson	Tasmania
Dr Stephen Wilson	Western Australia

AMA HEALTH FINANCE AND ECONOMICS COMMITTEE

The Health Finance and Economics (HFE) Committee has carriage of AMA policy on the economic and clinical impact of health care financing and funding arrangements in Australia, including public hospital funding; private health insurance; the Medicare Benefits Schedule; and the Pharmaceutical Benefits Scheme.

In February, HFE developed policy opposing any cuts to MBS fees or rebates and opposing the Government's freeze on the indexation of rebates. HFE also defined policy on patient co-payments, making clear that the AMA is not opposed to a patient contribution to the cost of their medical care, but opposes the introduction of co-payments for Medicare services without regard to individual patient's circumstances.

HFE developed policy against the Government's decision to restrict its future funding for public hospitals to CPI indexation and population growth only. The Committee agreed that activity based funding systems should continue to be used to monitor activity of the public hospital sector on a nationally consistent basis, complemented with measures of quality, outcome and performance of public hospital services.

Other activities included discussion of the health financing and clinical implications of the Reform of the Federation process and associated possible broad health reform options. How to measure health outcomes and possible issues involved for clinicians was also a focus for HFE.

HFE developed new policy for the AMA Fees List by not including clinical indications that have not been identified by a formal assessment process but are used to limit access to MBS rebates for other reasons.

HFE received presentations from the College of Radiologists on the Quality Framework for Diagnostic Imaging, and from the Australian Commission on Safety and Quality in Health Care on the release of the first Australian Atlas of Healthcare Variation.

HFE discussed the need for improved accountability of private health insurance arrangements and agreed that an AMA private health insurance report card should include information on all health insurance providers and their hospital cover products, with a table showing 'no gap' benefits for a sample of common medical procedures.

Professor Brian Owler
Chair

AMA HEALTH FINANCE AND ECONOMICS COMMITTEE

Professor Brian Owler	Chair - Federal Council
Dr Stephen Parnis	Deputy Chair – Federal Council
Dr Richard Choong	Federal Council
Dr Janice Fletcher	Federal Council (from June)
Dr Brad Horsburgh	Federal Council
Associate Professor Jeff Looi	Federal Council
Dr Andrew Miller	Federal Council
Dr Brian Morton AM	Federal Council
Associate Professor David Mountain	Federal Council
Associate Professor Sue Neuhaus	Federal Council
Associate Professor Robert Parker	Federal Council
Dr Beverley Rowbotham	Federal Council
Dr Shaun Rudd	Federal Council (until June)

TESTIMONIAL

"The AMA is a powerful voice for general practice by virtue of the things that they do for the community, especially for doctors and patients and lobbying governments. The AMA is highly skilled in dealing with the media. Sometimes it is appearing on TV or the radio or being quoted in the newspaper. Other times it is backgrounding and explaining to journalists what the issues are and making sure they report correctly on the issues."

Dr Brian Morton AM
GP, New South Wales

AMA MEDICAL PRACTICE COMMITTEE

The Medical Practice Committee develops AMA policy and strategies on issues that impact on medical practice including: medicines/devices and their regulation; private health insurance; e-health; pathology and diagnostic imaging; practitioner regulation and non-medical scopes of practice; safety and quality; medical services fees; medical indemnity; and medical care for the elderly and people with disabilities.

The Committee met four times via videoconference and face-to-face on 9 February, 11 April, 9 July, and 10 October, as well as progressing work via email.

Early in the year, the focus was on aged care issues, finalising a new Position Statement on palliative care and revising the existing Position Statement on the use of restraint in the care of older people. An AMA survey of members working with patients in residential aged care facilities informed the strategic priorities.

Throughout the year, the Committee provided critical guidance to the AMA on private health insurance issues such as advice on insurer gap arrangement conditions, plastic and reconstructive surgery definitions, and hospital contracts with non-payment for 'avoidable events' clauses. The AMA's submission to the ACCC on private health insurance anti-competitive practices provided detailed, real-life examples of insurer activities adversely affecting on doctors' practices and their patients. The submission was based on members' responses to a survey conducted in January. The Committee also provided advice on the content and focus of an annual AMA report card on private health insurance to begin in 2016, prompted by ongoing negative member experiences and increasingly aggressive insurer activities.

Committee members represented the AMA on numerous external groups covering topics such as e-health, aged care, antimicrobial resistance, and non-medical practitioner prescribing.

Associate Professor Robyn Langham
Chair

AMA MEDICAL PRACTICE COMMITTEE

Associate Professor Robyn Langham	Chair – Federal Council
Dr Michael Gannon	Federal Council
Dr Julian Grabek	Council of Doctors in Training Representative (until July)
Associate Professor Tim Greenaway	Federal Council
Associate Professor John Gullotta	Federal Council
Professor Mark Khangure	Federal Council
Dr Richard Kidd	Federal Council
Dr Patricia Montanaro	Federal Council (until June)
Dr Chris Moy	Federal Council
Dr Gino Pecoraro	Federal Council
Dr Richard Whiting	Federal Council
Dr John Zorbas	Council of Doctors in Training Representative (from August)

TESTIMONIAL

"I got involved with the AMA because of advocacy and the ability to work with key stakeholders at the State level, like our health department in making sure that our RMO recruitment campaign runs relatively seamlessly, that all the training issues that come up at the State level can get addressed appropriately, and also making sure that when we go to negotiate our work contracts and awards that the junior doctor voice is very loudly heard and continues to be loudly heard."

Dr Bavahuna Manoharan
Surgical Trainee, Queensland

AMA MEDICAL WORKFORCE COMMITTEE

The AMA Medical Workforce Committee (MWC) was formed in late 2014 and is responsible for developing new and revising existing AMA policies on:

- medical training and education;
- medical workforce planning;
- recruiting and retaining medical practitioners; and
- the corporatisation of medical practice and its implications for the medical workforce.

In April, the AMA released the Community Residency Program for Junior Medical Officers. This is the AMA's proposal to the Commonwealth Government to establish and fund a program for high-quality prevocational placements in general practice for junior doctors. The model was developed by the MWC to replace the valuable Prevocational General Practice Placements Program abolished by the Government in 2014.

During the year we revised the *Position Statement on International Medical Graduates* to reflect the changes over the past decade to how they are recruited, assessed and trained, as well as the growth in local graduate numbers. We also worked with the AMA Council of Doctors in Training to revise the *Position Statement on Medical Training in Expanded Settings.*

Other important areas of work undertaken by the Committee during the year were:

- preparing the AMA's submission to the Department of Health on potential reforms to the Specialist Training Program, the important workforce program that gives specialist trainees the opportunity to train in settings outside traditional metropolitan teaching hospitals;
- pushing for the National Medical Training Advisory Network to make greater progress in workforce modelling for each specialty; and
- leading the AMA's advocacy for changes to medical school selection criteria and the structure of courses to address rural workforce shortages as an alternative to opening new medical schools.

Dr Stephen Parnis
Chair

AMA MEDICAL WORKFORCE COMMITTEE

Dr Stephen Parnis	Chair – Federal Council
Dr Tony Bartone	Federal Council
Dr Elizabeth Gallagher	Federal Council
Professor Gary Geelhoed	Federal Council
Dr Bradley Horsburgh	Federal Council
Dr Omar Khorshid	Federal Council
Mr James Lawler	Australian Medical Students' Association Representative
Dr Helen McArdle	Federal Council
Dr Andrew Mulcahy	Federal Council
Dr Saxon Smith	Federal Council
Dr Danika Thiemt	Council of Doctors in Training Representative
Dr Chris Zappala	Federal Council

AMA COUNCIL OF RURAL DOCTORS

Recognising the importance of rural health care, and the special needs of doctors working in these areas, the AMA established a Special Interest Group for rural doctors, together with a Council of Rural Doctors (AMACRD), in 2015. The AMA Rural Medical Committee (AMARMC) was elevated to become the AMA Council of Rural Doctors.

The change means that there is now an AMA Federal Councillor with full voting rights. Rural doctors can also elect to be part of the newly formed special interest group.

This year has been a period of transition for the Council, with the Chair and members of the previous AMARMC being appointed to the AMACRD until the 2016 National Conference and Annual General Meeting.

A key issue in 2015 was the Government's introduction of a new rural classification system, the Modified Monash (MM) model. The MM replaced the flawed Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) rural classification.

The AMA had lobbied hard for this change, which means that rural incentives will now be better targeted. The AMACRD provided advice on the application of the MM model to the redesigned General Practice Rural Incentives Programme (GPRIP) that came into effect from 1 July 2015, the first program to use the new classification system.

Other key areas of work in 2015 included:

- continuing to advocate for policies to encourage doctors to work in rural and remote Australia;
- ongoing review of the AMA/Rural Doctors Association of Australia Rural Workforce Rescue Package;
- providing input into the Primary Health Care Review on rural health specific issues;
- supporting the development of policy and advocacy including AMA proposals for a Community Residency Program, regional training networks, and rural generalist training pathways;
- providing input into AMA policy on the establishment of Primary Health Networks and GP training reforms; and
- keeping a watch on the Government's Rural and Regional Teaching Infrastructure Grants program implementation.

Dr David Rivett OAM
Chair

AMA COUNCIL OF RURAL DOCTORS

Dr David Rivett OAM	Chair – New South Wales
Ms Sophie Alpen	Australian Medical Students' Association Representative
Dr Leonie Katekar	Northern Territory
Associate Professor Peter Maguire	Western Australia
Dr Gerard McGushin	Tasmania (until April)
Dr Rachael Purcell	Council of Doctors in Training Representative
Dr Shaun Rudd	Queensland
Dr Nigel Stewart	South Australia
Dr Joseph Tam	Victoria
Dr Geoff White OAM	New South Wales

TESTIMONIAL

"Being a part of the AMA, even as a student, makes me feel as if my voice matters. Through the AMA, I have been offered invaluable experiences to network and meet, not only doctors who are making great change, but also those that inspire and motivate me to be the best I can be. By being a student member of the AMA, I have access to irreplaceable careers and training advice."

Rebecca Nathan
Medical Student, New South Wales

AMA COUNCIL OF SALARIED DOCTORS

The AMA Council of Salaried Doctors (AMACSD) represents salaried doctors working in a variety of settings, particularly the public hospital sector. The AMACSD receives input from State and Territory AMAs, as well as the Australian Salaried Medical Officers Federation (ASMOF).

In 2015, the AMACSD reviewed Rights of Private Practice (RoPP) across Australia, and developed resources and information for members. The Committee also recognised the need to address growing concerns about the safety of doctors, and undertook a review of the Position Statement on the *Personal Safety and Privacy for Doctors*. These will be finalised in early 2016.

The Committee reviewed the *Position Statement on Hospitalists 2008*. This Statement focuses on support for hospital doctors, and the need to grow postgraduate training positions, while not undermining the role of the general physician.

The AMACSD recognised the work of the AMA and ASMOF in industrial entitlements, particularly regarding Senior Medical Officer (SMO) contracts in Queensland. The Committee welcomed news that the collective bargaining rights of Queensland SMOs were restored in 2015 by the Queensland Government.

The AMACSD supported work addressing bullying and harassment in the medical workforce. This is a vital issue in the context of salaried doctors and the hospital environment. We have also been heavily involved in developing the AMA *Position Statement on Sexual Harassment in the Medical Workplace*. This provides all medical practitioners with a framework for appropriate behaviour and responses to harassment.

After many years of uncertainty over its future, the Government announced in the 2015-16 Budget that it would introduce a cap of $5000 on Fringe Benefits Tax concessions for salary sacrificed meal entertainment and entertainment facility hiring expenses from 1 April 2016. The AMA had successfully argued against the withdrawal of this entitlement in many previous reviews and was heavily critical of the decision when it became public.

Other key items discussed by AMACSD, in concert with ASMOF entities, included a range of industrial issues and negotiations at State, Territory, and Commonwealth levels, and the Reform of the Federation White Paper.

Dr Roderick McRae
Chair

AMA COUNCIL OF SALARIED DOCTORS

Dr Roderick McRae	Chair - Federal Council
Dr Tobias Angstmann	Australian Capital Territory
Dr Barbara Bauert	Northern Territory
Dr Stuart Day	Tasmania
Dr Sue Ieraci	New South Wales
Dr John Murray	Queensland
Dr Stephen Parnis	Federal Council
Dr Andrew Russell	South Australia
Dr Tony Ryan	Western Australia
Dr Tony Sara	Australian Salaried Medical Officers Federation (ASMOF)
Dr Danika Thiemt	Council of Doctors in Training Representative

AMA TASKFORCE ON INDIGENOUS HEALTH

In 2015, the Taskforce on Indigenous Health revised the AMA *Position Statement on Aboriginal and Torres Strait Islander Health*, which was last revisited in 2005. The updated Position Statement emphasised the social determinants of health and their importance in reducing health inequalities between Aboriginal and Torres Strait Islander people and other Australians.

The Taskforce made a significant contribution to the 2015 AMA *Indigenous Health Report Card*, which was launched in November by the Federal Minister for Rural Health, Senator Fiona Nash. The Report Card focused on the impacts of incarceration on the health of Aboriginal and Torres Strait Islander people and called on the Federal Government to set a national target for closing the gap in the rates of imprisonment between Indigenous and non-Indigenous people.

Each year, the Taskforce oversees the awarding of the AMA Indigenous Peoples' Medical Scholarship to an Indigenous student studying medicine at an Australian university. The Scholarship aims to increase the number of Aboriginal and Torres Strait Islander doctors in Australia by supporting Indigenous students to complete a medical degree. The 2015 Scholarship was awarded to Ms India Latimore from the University of Newcastle.

Applications for the 2016 Indigenous Peoples' Medical Scholarship opened on 1 November 2015. To ensure that the Scholarship can continue to support Indigenous medical students, the AMA is exploring new avenues of donation from private sector and philanthropic organisations.

The AMA continued its support for the Close the Gap campaign in 2015, and remains a committed and active member of the Close the Gap Steering Committee.

A new member was also welcomed to the Taskforce, with Dr Kali Hayward joining as the new adviser from the Australian Indigenous Doctors' Association.

Professor Brian Owler
Chair

AMA TASKFORCE ON INDIGENOUS HEALTH

Professor Brian Owler	Chair – Federal Council
Dr Paul Bauert	Northern Territory
Ms Lisa Briggs	Proxy - National Aboriginal Community Controlled Health Organisation (from November)
Mr Matthew Cooke	Adviser – National Aboriginal Community Controlled Health Organisation (from November)
Mr Brian Fernandes	Australian Medical Students' Association Representative
Dr Elizabeth Gallagher	Federal Council
Dr Noel Hayman	Queensland
Dr Kali Hayward	Adviser – Australian Indigenous Doctors' Association (from September)
Dr Tammy Kimpton	Adviser – Australian Indigenous Doctors' Association (until September)
Associate Professor Robyn Langham	Federal Council
Dr Robert Marshall	Council of Doctors in Training Representative
Associate Professor Brad Murphy	Adviser – Royal Australian College of General Practitioners
Associate Professor Robert Parker	Federal Council
Professor Ian Ring	New South Wales
Dr David Scrimgeour	South Australia
Ms Kate Thomann	Proxy – Australian Indigenous Doctors' Association
Associate Professor Mark Wenitong	Adviser – National Aboriginal Community Controlled Health Organisation (until November)
Dr Lara Wieland	Queensland

AMA WORKING GROUP ON HEALTH CARE OF ASYLUM SEEKERS AND REFUGEES

AMA Federal Council convened a Working Group for the revision of the *Position Statement on the Health Care of Asylum Seekers and Refugees*. In the four years since the AMA released its first Position Statement, the health care and wellbeing of those seeking asylum in Australia had changed significantly.

AMA delegates passed an urgency motion at the 2015 AMA National Conference requesting Federal Council review its policy as a priority.

The Working Group agreed that the revised Position Statement should:

- be framed around health and the health impacts;
- make the position current to legislation since the position was written;
- include a section specific to mothers and babies;
- include asylum seekers and refugees with disabilities; and
- include a background section to strengthen the AMA position and provide evidence.

The AMA position has been adjusted to reflect legislation and reports that have been released on the topic, with the new position building on the previous one. The revised policy includes a number of new statements, and expansion on a few of the existing statements. The Position Statement now includes a background paper outlining Australia's international obligations to provide appropriate health care.

The AMA position is based on a fundamental ethical principle: that all people seeking health care, including asylum seekers and refugees in Australia, or under the protection of the Australian Government, should be able to access appropriate services and be treated with compassion, respect, and dignity.

Additionally, the AMA held a Round Table on 3 September, to discuss the health issues of asylum seekers and refugees, and to further develop AMA advocacy.

AMA Federal Council approved the revised Position Statement on 21 November, and it was launched on 23 December.

Associate Professor Robert Parker
Chair

AMA WORKING GROUP ON HEALTH CARE OF ASYLUM SEEKERS AND REFUGEES

Associate Professor Robert Parker	Chair – Federal Council
Professor Elizabeth Elliot	New South Wales
Dr Kate Kearney	Council of Doctors in Training Representative
Dr Richard Kidd	Federal Council
Mr James Lawler	Federal Council
Associate Professor Susan Neuhaus	Federal Council
Dr Stephen Parnis	Federal Council
Associate Professor Karen Zwi	New South Wales

AMA WORKING GROUP ON CLIMATE CHANGE AND HUMAN HEALTH

AMA Federal Council convened a Working Group for the revision of the *Position Statement on Climate Change and Human Health*. The scientific evidence surrounding climate change and its relationship with health had advanced since the 2008 statement, requiring major revisions drawing on this new evidence.

The Working Group had its first teleconference in June, and agreed that the Position Statement should draw on current evidence, be framed around health and the health impacts, build on the expertise of the medical profession, and be mindful of AMA member views on this topic.

The Working Group agreed to survey the membership for their opinions regarding some difficult aspects of the Position Statement and formulated the questions for the survey. The survey was sent out to members on 12 June.

Greater weight was given to the health benefits of climate mitigation and adaptation policies and addressing climate change through international process, given the purpose of the review.

Three new points were included in the Position Statement regarding promotion and planning of mitigation and adaptation strategies, advocating for disinvestment from fossil fuels and advocating for the Government to proactively develop specialised programs to help workers displaced by decarbonisation of the global economy.

AMA Federal Council approved the revised Position Statement on 22 August, and it was launched on 28 August.

The AMA used the updated Position Statement to call on the Australian Government to take strong leadership at the United Nations Climate Change Conference in Paris in November.

Dr Stephen Parnis
Chair

AMA WORKING GROUP ON CLIMATE CHANGE AND HUMAN HEALTH	
Dr Stephen Parnis	Chair – Federal Council
Professor Kingsley Faulkner	Chair of Doctors for the Environment Australia
Professor Gary Geelhoed	Federal Council
Dr Rachael Purcell	Council of Doctors in Training Representative
Dr Saxon Smith	Federal Council

AMA WORKING GROUP ON END OF LIFE

The AMA End of Life Working Group was formed to develop core areas for AMA advocacy in end of life care. The Working Group focused its activities on:

- improving access to palliative care across the health spectrum from within the community through to the hospital sector by recognising its multi-disciplinary nature, increasing palliative care in medical education, vocational training and CME and ensuring appropriate resourcing;
- increasing the use of advance care directives (ACDs) and advance care plans (ACPs) through promoting better community acceptance of death and dying, discussing ACDs and ACPs earlier in life, improving their access in emergency situations and harmonising relevant laws; and
- promoting a cultural change within the medical profession where doctors accept that death is not a failure of medicine. This also involves improving the profession's understanding of disease trajectories, including when treatment is futile as well as supporting doctors in having good quality end of life care discussions with patients and their families.

Throughout the year, AMA representatives held ongoing discussions with Palliative Care Australia (PCA) to highlight these core areas and identify opportunities for collaboration; for example, supporting PCA's National Palliative Care Week in May, and promoting the theme 'Talking About Dying Won't Kill You' in Family Doctor Week media.

The AMA continued to promote the message that everyone, old and young, sick or healthy, should talk about death and dying and make plans for their end of life care, through *Australian Medicine* articles and general media releases throughout the year.

These issues were raised, along with broader end of life care issues, during a range of face-to-face meetings with various Parliamentarians, and through a presentation to the 13th Australian Palliative Care Conference.

Dr Stephen Parnis
Chair

AMA WORKING GROUP ON END OF LIFE	
Dr Stephen Parnis	Chair – Federal Council
Professor Geoffrey Dobb	Western Australia
Dr Sonia Fullerton	Victoria
Dr Richard Kidd	Federal Council
Dr Chris Moy	Federal Council

AMA WORKING GROUP ON METHAMPHETAMINE

In 2015, Federal Council noted increasing concern about the impact crystal methamphetamine was having on individuals and hospitals. Federal Council convened a small Working Group on Methamphetamine for the purposes of updating the AMA's *Position Statement on Methamphetamine – 2008.*

Increasing public concern about methamphetamine, including the increasing popularity of crystal methamphetamine, saw the issue become very topical in 2015. As a result, there was a Joint Parliamentary Inquiry into Crystal Methamphetamine as well as a dedicated National Ice Taskforce. The Committee attended and represented the AMA at the hearing for Joint Parliamentary Inquiry into Crystal Methamphetamine.

From the outset, Working Group members agreed that the updated Position Statement should incorporate a distinct focus on the health impacts of methamphetamine use, as well as the major impacts on hospitals and health workers, particularly relating to violence, security, and staff safety. The health care sector was highlighted as an integral part of any solution, and excessive focus on law enforcement was viewed as unhelpful. Both improved access to treatment, and reducing drug demand were emphasised as needing to be more heavily funded and promoted.

Much of the activity undertaken by the Working Group was via email. However, the Working Group also convened three teleconferences to canvass and discuss significant matters for the Position Statement, including the expanded reference to treatment and rehabilitation. Given its highly topical nature, Working Group members were also invited to provide feedback on relevant submissions and AMA media commentary on methamphetamine.

Federal Council considered and approved the updated *Position Statement on Methamphetamine – 2015* at its meeting in August. The Position Statement was publicly launched on 3 September, and was well received.

Associate Professor David Mountain
Chair

AMA WORKING GROUP ON METHAMPHETAMINE	
Associate Professor David Mountain	Chair – Federal Council
Dr Tony Bartone	Federal Council
Professor Gary Geelhoed	Federal Council
Associate Professor Rob Parker	Federal Council
Dr Ionana Vlad	Western Australia
Dr John Zorbas	Council of Doctors in Training Representative

AMA WORKING GROUP ON TOBACCO AND E-CIGARETTES

A brief public statement was developed on e-cigarettes in 2014. This activity was overseen by a small Working Group, chaired by Dr Stephen Parnis. This statement was revisited and slightly amended in April 2015 to acknowledge material issued by the National Health and Medical Research Council around the evidence relating to e-cigarettes.

At its meeting in May, Federal Council established a Working Group to oversee a review of the AMA *Position Statement on Tobacco Smoking – 2005*. It was also agreed by Federal Council that the updated statement would incorporate policy statements relating to e-cigarettes.

The Working Group held one face-to-face meeting and two teleconferences. Members of the Working Group agreed that the updated Position Statement should incorporate increased reference to smoking and social disadvantage, including smoking and pregnancy. The Working Group also agreed to refine the AMA's position around smoking on television and film. Amendments were made to the statement to reflect contemporary tobacco control issues, as well as acknowledging the progress that has been made, including implementation of plain tobacco packaging. The format of the Position Statement was changed, with a view to making it easier for AMA spokespeople to use.

The Working Group provided the updated *Position Statement on Tobacco Smoking and E-Cigarettes - 2015* to Federal Council for consideration during their meeting in November. The Position Statement was approved and it was publicly launched in December. Despite a lack of strong supporting evidence, the role of e-cigarettes in smoking cessation remains contested. As this is an area of emerging research, the Working Group has agreed to revisit the Position Statement should the evidence warrant it.

Dr Saxon Smith
Chair

AMA WORKING GROUP ON E-CIGARETTES (2/12/2014 – 28/5/2015)	
Dr Stephen Parnis	Chair – Federal Council
Associate Professor John Gulotta	Federal Council
Associate Professor David Mountain	Federal Council
Dr Helen McArdle	Federal Council
Dr Saxon Smith	Federal Council

AMA WORKING GROUP ON TOBACCO AND E-CIGARETTES	
Dr Saxon Smith	Chair – Federal Council
Dr Kate Kearney	Council of Doctors in Training Representative
Dr Richard Kidd	Federal Council
Mr Matthew Lennon	Australian Medical Students' Association Representative
Dr Chris Moy	Federal Council

Public Health Report

During 2015, the Public Health section and the Secretariat worked to continue the AMA's advocacy work. The Secretariat convened working groups to oversee the updating of a number of *Position Statements* to ensure the AMA's public health positions reflect contemporary policies and practices.

POSITION STATEMENTS

Obesity

In September, a Working Group was established to revise the *Position Statement on Obesity*. Its members are Dr Richard Kidd (Chair), Dr Tony Bartone, Dr Christopher Zappala, and Dr Danika Thiemt.

Obesity is a leading risk factor for poor health, and combating it requires the participation of governments, non-government organisations, the health and food industries, the media, employers, schools, and community organisations. The revised Position Statement will emphasise the importance of increased nutritional literacy, particularly among parents.

Domestic and Family Violence

In November, Federal Council formed a Working Group to oversee the *Position Statement on Domestic and Family Violence*. The members are Professor Brian Owler (Chair), A/Prof Robyn Langham, Dr Chris Moy, Dr Gino Pecoraro, and Dr Danika Thiemt.

The revised Position Statement will focus on the health of people, particularly women and children, experiencing domestic violence, and the role of medical practitioners in addressing and assisting them. It will include issues such as mandatory reporting, referral pathways for medical practitioners, and organisations that can assist patients experiencing domestic violence.

Alcohol and FASD

The Secretariat is producing a supplementary *Position Statement on Foetal Alcohol Spectrum Disorder (FASD)*. The adverse effects of FASD are far-reaching – affecting families, the health care system, the social service system, the criminal justice system, and the education and employment systems. Australia lags behind other countries in its response to FASD, and the AMA believes that any attempt to tackle it must occur within a comprehensive approach to reduce harmful drinking across the population.

Public Health is engaging with the Foundation for Alcohol Research and Education (FARE) on alcohol and pregnancy, FASD and the on-going promotion of the *Women Want to Know* campaign, which encourages health professionals to routinely discuss alcohol and pregnancy with women, and to provide advice consistent with the NHMRC's *Australian Guidelines to Reduce Health Risks from Drinking Alcohol.*

Concussion in Sport

The AMA and the Australian Institute of Sport (AIS) partnered on a joint *Position Statement on Concussion in Sport* and website, following growing concern in Australia and internationally about the incidence of sport-related concussion and potential health ramifications for athletes, from the part-time recreational athlete to the full-time professional.

The Position Statement summarises the most contemporary evidence-based information, presenting it in a useable format for a broad range of stakeholders. It ensures that athlete safety and welfare remains the point of focus for all organisations and individuals dealing with concussion in sport.

Combat Sport

In August, the AMA released a revised *Position Statement on Combat Sport.* Combat sport includes any sport, martial art or activity in which the primary objective of participants is to strike, kick, hit, grapple with, throw or punch one or more participants. These sports are a public demonstration of interpersonal violence which is unique among sporting activities.

The AMA opposes all forms of combat sport. The Position Statement recommended banning boxing from the Olympic and Commonwealth Games, and that media coverage of combat sport be subject to control codes similar to those applying to television screening of violence. At the November Federal Council meeting, a clarification was added, noting that some sports that may be deemed 'combat' do not involve 'winning' through blows to the head or inflicting injuries on an opponent.

Blood Borne Viruses (BBV)

In December, the Federal Government announced a funding package of $1 billion over five years to subsidise a range of breakthrough medicines to treat hepatitis C, replacing the previous PBS subsidised treatments. General practitioners will be able to prescribe these antiviral medications in, or following, consultation with a specialist physician, who can also prescribe these medicines.

The Commonwealth has recognised that people in custodial facilities are a priority population for treatment of hepatitis C, and has agreed to fund the cost of these medicines for prisoners through the PBS. State and Territory health and justice departments will put in place processes to ensure prisoners are prescribed and provided with these medicines. The revised *Position Statement on Blood Borne Viruses (BBV)* will reflect these significant medical innovations and the way BBVs can be prevented, managed and treated.

Indigenous Health

The Taskforce on Indigenous Health revised the *Position Statement on Aboriginal and Torres Strait Islander Health.* The revision of this Position Statement was timely ahead of the 10th anniversary of the Close the Gap campaign in 2016.

The *2015 Report Card on Indigenous Health* called on the Government to set a national target for closing the health and imprisonment gaps between Indigenous and non-Indigenous people. It was launched on November 25 by Professor Owler and Federal Rural Health Minister Fiona Nash.

On September 10, Professor Owler and other AMA representatives met with the Law Council of Australia (LCA) to discuss opportunities for joint advocacy to address Indigenous incarceration rates. As part of this joint advocacy, Professor Owler participated in a panel discussion at the LCA's Indigenous Incarceration symposium on November 26.

The AMA Indigenous Peoples' Medical Scholarship 2015 was awarded to Ms India Latimore from the University of Newcastle. The AMA is exploring new avenues of donation from private sector and philanthropic organisations to ensure the Scholarship can continue to support Indigenous medical students in the future.

Throughout 2015, the AMA continued its support for the Close the Gap campaign and remains a committed and active member of the Close the Gap Steering Committee.

ADVOCACY

Autism

Throughout the year, AMA representatives met Autism Spectrum Disorder (ASD) advocacy bodies to discuss the role of medical practitioners, and GPs in particular, in supporting families affected by ASD. There were also preliminary discussions around addressing the delays many families encounter when seeking a formal diagnosis of ASD. In 2016, the AMA will host a meeting of relevant medical stakeholders to look at possible improvements to the process.

E-cigarettes

Federal Council convened a Working Group, chaired by Dr Parnis, to develop a brief AMA statement on e-cigarettes that could be easily updated in light of new evidence. In March, the CEO of the National Health and Medical Research Council (NHMRC) issued a statement that comprehensively covered the evidence on e-cigarettes.

Professor Owler also wrote to the Health Minister, the Treasurer and the Assistant Minister for Health, calling for the introduction of laws prohibiting the advertising of e-cigarettes, enforcement of laws prohibiting the advertising of e-cigarettes as a therapeutic good, and banning the marketing of e-cigarettes to people aged under 18 years of age.

Physical Activity

The AMA worked with peak organisations in the health and physical activity sector, including the Heart Foundation, the Confederation of Australian Sport, and Cycling Promotion Australia, to identify priorities for action and opportunities for collaboration.

Dr Parnis was a keynote speaker at the *Move More, Sit Less!* National Physical Activity Consensus Forum at Parliament House in September, and an opinion piece he wrote was published in *The Canberra Times* in October. Both were well received.

Building on this, Dr Parnis wrote to the Health Minister inviting her to partner with the AMA in writing to the 565 local councils in Australia, asking them to highlight the low-and no-cost physical activities available in their own jurisdictions. This letter highlighted the need to improve health outcomes for Australians who do not live in capital cities and who may not have access to the same range of opportunities for physical activity as city dwellers.

Road Safety

Professor Owler's advocacy for the *Don't Rush* campaign has allowed the Public Health section to build closer ties with the automotive industry and road safety stakeholders. As well as campaigning on driver behaviour – speeding and fatigue – the AMA has been collaborating with the Australasian New Car Assessment Program (ANCAP) and the Australasian College of Road Safety (ACRS) to inform and advocate for measures which save lives and prevent road trauma.

On August 12, Professor Owler launched the *Avoid the crash, Avoid the trauma* campaign at Parliament House. The campaign called on politicians, the car industry, and all road users to join the push for adoption of new technologies such as Autonomous Emergency Braking (AEB) to make cars safer and save lives.

The AMA also met with the Australian Automobile Association and the Federal Chamber of Automotive Industries to pursue further opportunities to work together. Professor Owler delivered a keynote speech to the Australasian Road Safety Conference at the Gold Coast on October 16. ACRS described the speech as a "powerful presentation", and it garnered national media coverage. At this Conference, the AMA became a signatory to the Declaration for Trauma Free Roads.

The AMA has also updated its website to include a webpage on road safety, linking to the Fitness to Drive standards and a whiplash toolkit.

WMA General Assembly 2015

The AMA provided input into past President Dr Steve Hambleton's presentation to the World Medical Association (WMA) conference in Moscow in October. Dr Hambleton subsequently provided a report on the WMA conference and the Public Health section will follow up on some of the areas. The AMA also undertook the initial revision of the WMA Council Resolution on implementation of the WHO Framework Convention on tobacco control.

Energy Drinks

Dr Hambleton made contact with the Public Health section regarding consultations being undertaken by the Toronto Health Board in relation to banning the sale of energy drinks to those aged 19 years and younger. The AMA wrote to the Toronto Health Board, confirming the health concerns associated with energy drink consumption among children and young people and noted the AMA's position that sales should be restricted to those aged under 18 years.

SUBMISSIONS AND CONSULTATION

Plain Tobacco Packaging Submission

In March, the AMA made a submission to the Commonwealth Department of Health's *Post Implementation Review of Tobacco Plain Packaging*. It reiterated the AMA's continued support for plain packaging, particularly as emerging evidence suggests that it reduces the appeal of cigarette packs to young people, it emphasises the graphic health warnings, and it also encourages smokers to consider quitting.

Joint Parliamentary Committee on Law Enforcement – Inquiry into Crystal Methamphetamine

In June, the AMA lodged a submission to the Parliamentary Inquiry into Methamphetamine Use. While the Inquiry was broadly focused on law and order responses, the AMA's submission described the health impacts of methamphetamine use and the resulting impacts on health care provision. It argued that the response to crystal methamphetamine must be balanced - ie. law and order strategies with health strategies. A/Prof David Mountain appeared via teleconference before the Inquiry.

A/Prof Robyn Langham also represented the AMA at targeted consultations undertaken by the National Ice Taskforce as part of the development of the National Ice Action Strategy.

AMA consultation on the *National Alcohol Strategy* 2016-2021

Health Outcomes International (HOI) was commissioned by the Commonwealth Department of Health to conduct stakeholder consultations to inform development of the *National Alcohol Strategy (NAS)* 2016-2021.

Dr Parnis was interviewed as the AMA's representative by HOI in October. He provided an overview of the AMA's concerns about alcohol and reiterated the position contained in the *Position Statement* and *Alcohol Summit Communique*. The AMA also provided a written submission to HOI.

AMA submission on the *National Drug Strategy 2016-2025*

The AMA's submission on the draft *National Drug Strategy 2016-2025* noted Australia was falling further behind in reducing the harm from alcohol, tobacco and other drug use, and that the policy and regulatory responses to these challenges needed to be strengthened and well-coordinated. The submission noted the increasing demand for drug and alcohol treatment and rehabilitation services, and reiterated the AMA's view that addiction to drugs or alcohol was primarily a health issue. The AMA's submission recommended the addition of targets and goals as a way to measure progress.

The AMA attended the Intergovernmental Committee on Drugs (IGCD) Stakeholder forum in November which provided an opportunity to work collaboratively with other stakeholders in identifying opportunities to reduce the impact of alcohol and other drugs.

Social Services Legislation Amendment (No Jab, No Pay) Bill

The AMA submission to the Senate Community Affairs Legislation Committee inquiry into the *Social Services Legislation Amendment (No Jab, No Pay) Bill 2015* supported measures to increase immunisation rates among children, including the very real possibility that some parents would reconsider their anti-immunisation stance in light of becoming ineligible for some Centrelink payments.

The submission highlighted the need to closely monitor the data in order to measure effectiveness and whether there continued to be geographic pockets of lower immunisation rates (including those in more affluent areas). The submission also noted the need to closely monitor whether vulnerable children were being removed from childcare or preschool as a result of the measure. The submission called for full funding of catch-up vaccinations, and recommended any savings resulting from the measure be invested into research and other activities that seek to further increase immunisation rates.

Dr Richard Kidd represented the AMA at the Committee's public hearing in Brisbane on November 2.

Parliamentary Joint Committee on Law Enforcement – *Inquiry into illicit tobacco*

In December, the AMA made a submission to the *Inquiry into illicit tobacco*. The submission noted the AMA's recently updated policy position and statement on *Tobacco Smoking and E-Cigarettes*.

The AMA reiterated its support for measures that seek to reduce the trade in, and consumption of, illicit tobacco and warned that a lack of action has the potential to undermine Australia's world leading stance on tobacco control.

Tackling Alcohol-Fuelled Violence Legislation Amendment Bill 2015

The AMA made a submission to the Queensland Government's Legal Affairs and Community Safety Committee inquiry into the *Tackling alcohol-fuelled violence Legislation Amendment Bill 2015*. The AMA welcomed this initiative as a measure that seeks to reduce Australia's culture of binge drinking. The AMA noted that reduced availability and access to alcohol will have positive impacts on the health system and on the broader community. Reducing the availability of alcohol via lockouts and designated last drink times, as well as restriction on the availability of takeaway alcohol, should noticeably reduce the incidence of alcohol-related violence.

The Role of the International Health Regulations in the Ebola Outbreak and Response

The AMA was invited to provide a submission on the Role of the International Health Regulations in the Ebola Outbreak and Response. The AMA played a highly visible and active role in public debate in Australia during the Ebola crisis. The AMA was a strong advocate for an immediate response from Government and was critical of delays in sending qualified and trained personnel to West Africa. The submission noted that Professor Owler took a lead role in calling for an urgent response from the Government and led the advocacy for sending medical and logistical support, not just financial assistance.

Medicinal Cannabis Submission

The AMA submission to a Senate inquiry into the *Regulator of Medicinal Cannabis Bill 2014* opposed the introduction of a separate regulator of medicinal cannabis. The Bill, proposed by Senator Di Natale, would have established a system for regulating medicinal cannabis, distinct from the current Therapeutic Goods Administration processes, and proposed a process for accrediting medical practitioners to prescribe medicinal cannabis.

The AMA's submission stated that medicinal cannabis should be treated consistently with other medicines, and therefore should not have a separate process for regulation. It also noted concerns with proposals that medical practitioners provide 'authorisation' for patients and their carers.

Dr Parnis met with Senator Di Natale to discuss the AMA's submission. The Coalition Government has subsequently indicated its intention to introduce legislation covering the cultivation and supply of medicinal cannabis.

Commercial Television Code of Practice Submission

Free TV Australia, the industry body representing commercial free to air television, undertook consultations on a proposed update of the current Commercial Television Code of Practice, which regulates television content in accordance with community standards. A number of amendments were proposed, the most significant for the AMA being the relaxation of restrictions on alcohol and gambling advertising.

The AMA submission argued against any expansion in the times alcohol products and gambling services could be advertised on television. Unfortunately, the recently released revised Code is likely to increase the exposure of children and young people to alcohol and gambling advertising.

Pertussis Vaccination for Pregnant Women – Correspondence

Following the death of a newborn infant from pertussis, there was increased interest in how best to protect infants too young to be vaccinated. The Australian Technical Advisory Group on Immunisation (ATAGI) recommended pregnant women be vaccinated in their third trimester. This advice was included in the 10th Edition of the *Immunisation Handbook*.

Some jurisdictions fund pertussis vaccination for pregnant women, but not all, and it is not always well promoted. Professor Owler wrote to the Health Minister encouraging her to work towards listing the pertussis vaccine for pregnant women on the National Immunisation Program (NIP).

The Minister responded, indicating that due to the lack of a sponsored application to the Pharmaceutical Benefits Advisory Committee (PBAC), the vaccine could not be considered for the NIP. However, the Minister did note that all pregnant women, except for those living in Tasmania, would soon have access to the pertussis vaccine through State-funded initiatives.

AMA Submission to Senate Standing Committee on Economics - *Inquiry into Personal Choice and Community Impacts*

The AMA provided a written submission to the *Inquiry into Personal Choice and Community Impacts*, informally known as the 'nanny state' inquiry. The submission explained the importance of public health measures and why some measures need to be implemented in ways that appear to restrict personal choice. The submission contained formal support for a range of measures relating to alcohol, tobacco use and cycling helmets.

The AMA argued that doctors treat those affected by poor decision-making on a daily basis, and that providing this type of care made medical professionals strong supporters of public health measures that seek to reduce harms. The submission noted that governments are uniquely placed in their ability to influence and regulate people's behaviour on a much larger scale than individual doctors.

Health Star Rating Advisory Committee

Professor Geoff Dobb participated in a number of Health Star Rating Advisory Committee meetings to discuss issues including:

- refinement of the Health Star Rating (HSR) calculator;
- a report from the Australia and New Zealand Ministerial Forum on Food Regulation;
- major retailers agreeing to use the HSR on their own branded products;
- updates on the HSR social media campaign;
- implementation of the HSR in New Zealand; and
- consideration of anomalies.

The number of products carrying the Health Star Rating labelling has significantly increased. The Heart Foundation of Australia is undertaking an evaluation of the labelling, but preliminary research suggests that this food labelling approach is assisting consumers to compare products and make healthier food choices.

Briefing papers/talking points

The Public Health section provided briefings or talking points on:

- asylum seekers and health;
- air quality and human health;
- climate change and health;
- Indigenous health issues; and
- methamphetamine.

Simon Tatz
Manager, Public Health

AMA

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