Australian Medical Association

Annual Report 2016

AMA

Editor

John Flannery, Federal AMA

Sub Editors

Maria Hawthorne, Federal AMA

Odette Visser, Federal AMA

Graphic Design

CRE8IVE

Contents

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

AMA 2016 Federal Council

From back left to bottom right: A/Prof Susan Newhaus, Dr Iain Dunlop AM, Dr Stuart Day, Dr Roderick McRae, Dr John Zorbas, Dr Chris Moy, Dr Andrew Miller, Dr Helen McArdle, Prof Mark Khangure, Dr Steve Kisely, A/Prof Robert Parker, Dr Omar Khorshid, Dr Andrew Mulcahy, Prof Brad Frankum, Dr Richard Kidd, Dr Beverley Rowbotham, Dr Jill Tomlinson, Dr Sandra Hirowatari, Dr Elizabeth Gallagher, Dr Paul Bauert, Dr Lorraine Baker, Dr Tony Bartone, Ms Elise Buisson, Dr Michael Gannon, Dr Janice Fletcher, A/Prof Julian Rait

Photograph taken at Federal Council Meeting August 2016

Absent: Dr Chris Zappala, Dr Andrew J Miller, A/Prof Saxon Smith, Dr Shaun Rudd, Prof Gary Geelhoed, A/Prof David Mountain, Dr Gino Pecoraro, Dr Bradley Horsburgh, Prof Robyn Langham

1. President's Report

The AMA has enjoyed another outstanding year of advocacy on behalf of members, the broader medical profession, and the community. We are regarded by political commentators and the media as one of the most successful and high-profile lobby groups in the country. We are regularly quoted in Parliament, from the Prime Minister down.

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

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

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

As a result, we are usually the first port of call for news programs seeking comment on health issues – from the latest infectious disease outbreak to the newest drugs and treatments, or to respond to policy announcements from the Government, Opposition, or minor parties.

Dr Michael Gannon
President

The AMA voice resonates in political circles every year, but even more in election years like 2016. We used our influence in the lead-up to and during the election campaign.

The effectiveness of our advocacy – and ability to influence policy – was on show right from the early weeks of the year, first with the release of our Budget Submission and our Public Hospital Report Card, followed closely by our Roundtable on the Medicare Benefits Schedule (MBS) Review, which was attended by the Colleges, Associations, and Societies.

This round of activity spelt out clearly our position on public hospital funding, the objectives of the MBS Review, general practice and primary care, private health insurance, public health priorities, Indigenous health, and mental health – all core issues that win or lose votes for governments.

In February, the AMA staged its first Asylum Seeker Forum, which gave medical experts an opportunity to share their concerns about the health care provided to refugees and asylum seekers.

In March, we released our first ever Private Health Insurance Report Card, providing people with an easy-to-understand guide to the range of private health products on the market – the good, the bad, and the ugly.

We responded positively to the Government's announcement of the Health Care Homes trial, but warned that insufficient funding would hinder the trial.

We also welcomed the COAG decision to put an extra $2.9 billion into our public hospitals, although it was well short of the funding levels needed to give the hospitals confidence and certainty to meet demand over the longer term.

One of the most important actions of the AMA in 2016 was assisting in the establishment of Doctors Health Services across Australia, with the support of the Medical Board of Australia. This new entity comes at a time when we need to put a greater focus on doctors looking after their own health.

The AMA voice resonates in political circles every year, but even more in election years like 2016.

Our relationship with the Government hit a speed hump in the May Budget with the announcement of an extension of the reviled Medicare patient rebate freeze to 2020. This Budget decision was a body blow to our members, especially GPs, and was the catalyst for an AMA campaign throughout the election campaign that followed soon after.

The AMA anti-freeze campaign was at the core of our Key Health Issues election manifesto, which was released in late May.

We were a constant voice throughout the election campaign, primarily on the freeze – with pathology, diagnostic imaging, and general practice headlining our advocacy.

Late in the campaign, I added a bit of common sense to the so-called 'Mediscare' campaign, pointing out that the Government's privatisation plans were all about backroom processing systems, and nothing at all about frontline health services.

It took nine days before the Coalition was declared the election winner, following a knife-edge vote. Health, including 'Mediscare', had figured prominently in the close election, which gave the AMA a solid platform to engage with the new Government.

We had positive engagement with Health Minister Sussan Ley following the election, with close consultation on the MBS Review, the Primary Care Review, the Private Health Review, the Health Care Homes trial, and other key issues, including our continuing push to have the Medicare freeze lifted.

It has been especially gratifying to have had regular direct contact with Prime Minister Turnbull. He genuinely wants to work with the AMA to deliver better health services to the Australian people.

I am in regular contact with Bill Shorten and Catherine King. Our relationship with the Greens and other crossbenchers is also cooperative and positive.

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

I look forward to further building on my relationship with the new Health Minister Greg Hunt to deliver outcomes for patients within the four pillars of our health service: public health and prevention measures; our world-class GP workforce; the private health system; and our public hospitals.

I also look forward to ongoing work with Ministers Ken Wyatt and David Gillespie on issues relating to Indigenous health and rural health.

In November, we completed the review of our position on Euthanasia and Physician Assisted Suicide. This is the launching pad for wider advocacy on this important issue, and on improvements to end of life care and palliative care services.

The AMA will continue to focus on ethical medical practice in Australia, and internationally through my elected role on the Council of the World Medical Association (WMA).

I would like to thank my predecessor Professor Brian Owler and his Vice President Dr Stephen Parnis for their outstanding contributions.

My thanks also to my Vice President Dr Tony Bartone, the Federal Council and its Committees, the talented AMA Secretariat, the State and Territory AMAs, and all our members for contributing to our success.

Finally, I would like to thank my wife and family, recognising their sacrifices in allowing me and assisting me to perform the task of leading this genuinely exceptional organisation.

Dr Michael Gannon
President

2.

Secretary General's Report

The past year has been a busy and productive one for the AMA. The Association experienced a smooth transition of leadership when the first of the Presidents to hold a fixed two-year term, Professor Brian Owler, completed his term and handed over to Dr Michael Gannon. Dr Tony Bartone replaced Dr Stephen Parnis as Vice President.

The changes within the AMA occurred following the Federal Government's double dissolution and very long election campaign that resulted in the return of the Turnbull Government by a slim majority. The election outcome again resulted in a Senate requiring careful negotiation to ensure the passage of legislation.

From a health policy perspective, 2016 could be framed as the year of reviews with the Government establishing reviews of private health insurance, prostheses, after hours GP services, and the ongoing reviews of the Medicare Benefits Schedule items. The reviews, coupled with the announcement of new initiatives such as Health Care Homes, ensured that the policy and media teams within the Secretariat were kept busy.

One of the significant changes during the year was the extent to which social media rapidly evolved as part of regular AMA communication with active accounts operated by AMA Media, Australian Medicine, the AMA President, Council of General Practice, and Council of Doctors in Training.

The AMA continued its investment in digital services for members with the initiation of online learning, the broadening of doctorportal, and launch of learning pathways, which maps the pathways to specialisation and has become the go-to site for medical students and doctors in training.

Anne Trimmer
Secretary General

The AMA subsidiary, Australasian Medical Publishing Company Pty Ltd (AMPCo), had a successful year with a refresh of the design of the *Medical Journal of Australia* under Editor in Chief Emeritus Prof Nicholas Talley, and the introduction of MJA CPD events. AMPCo has had an independent skills-based board since 2014. It took the initiative to sell AMPCo's mid-city premises in Sydney at the height of the market and relocate to more suitable premises nearby, providing both AMPCo and the AMA with capital for future investment.

Doctors Health Services Pty Limited (DrHS), the AMA subsidiary set up with funding from the Medical Board of Australia and AHPRA, completed the roll out of arrangements to provide nationally-consistent medical services to medical practitioners and medical students. The independent board of DrHS has taken significant steps in establishing this important service with contracts with service providers in place in every State and Territory, and the launch of its website.

I reported last year on the beneficial effect of the constitutional changes that have enabled AMA Federal Council to focus on policy debate and development. Under the leadership of the Chair, Dr Beverley Rowbotham, the Council has concentrated on major policy issues at each meeting, in addition to receiving reports from its Committees and Councils.

These have ranged from a debate on changes to the AMA's Position Statement on Euthanasia and Physician Assisted Suicide, to the Medical Board of Australia's consideration of revalidation, and identification of the AMA's policies for the Federal election.

In 2015, two new Councils were established – the Council of Rural Doctors (CRD) and the Council of Private Specialist Practice (CPSP). Each of these became active during the year under their new Chairs – Dr Sandra Hirowatari as Chair of CRD, and Associate Professor Julian Rait as Chair of CPSP. They joined the Chairs of the three other Councils of Federal Council – Council of General Practice (chaired by Dr Brian Morton until May, and then by Dr Richard

Kidd); Council of Doctors in Training (chaired by Dr Danika Thiemt until May, and then Dr John Zorbas); and Council of Public Hospital Doctors (chaired by Dr Barbara Bauert, and then Dr Roderick McRae).

Federal Council made extensive use of working groups during the year to develop and review a significant number of public health position statements. The working groups have enabled the AMA to be responsive to policy as it emerges and contribute to the wider public debate on the issues that impact doctors and society.

For the first time, in 2016 an electronic ballot was used for the election of members to Federal Council. It was effective in engaging members with a higher voter participation than had been the case with paper postal ballots.

The AMA has had a solid year financially. The Board appointed an external financial advisory firm and an internal audit firm to strengthen the management of its assets and its risks. The Chair has reported further on these initiatives in his report.

A significant development during the year was the establishment of a new trust for the AMA Indigenous Medical Scholarship. The previous trust did not qualify for tax deductible status, which limited the number of members and corporate entities attracted to donating to the fund. The fund is now registered with both the Australian Tax Office and the Australian Charities and Not-for-profits Commission. A communication will be sent to members during 2017 urging members to consider support for the fund to grow its base and provide additional scholarships for Indigenous medical students.

During the year, the integration of corporate services across the AMA Group was completed with shared services in information technology, finance, and human resources. The Secretariat has been strengthened by the addition of skilled and engaged staff during the year in finance, IT, member services, database management, media, and policy and advocacy.

I thank the Secretariat staff for their hard work and dedication to the AMA and its members. I also thank the two Chairs of the Board during the year, Dr Elizabeth Feeney (until May) and Dr Iain Dunlop (from May), for their support and guidance, together with Dr Rowbotham as Chair of Federal Council. The members of the Board and the members of the Federal Council contribute considerable time and expertise to the AMA. Their contribution is reflected in the strength of the advocacy of the organisation and its standing in the community.

Anne Trimmer
Secretary General

Federal Council made extensive use of working groups during the year to develop and review a significant number of public health position statements.

3.

Chair of Board Report

I am pleased to report on a successful year for the company, during which it has embedded improved governance processes, expanded online member services, focused policy development under the revamped Federal Council, and delivered efficiencies through expanded shared services across the AMA Group.

The strengthened governance processes introduced in 2016 include the appointment of an internal audit firm to work with the Audit and Risk Committee of the Board, and the appointment of an investment advisory firm to work with the Investment Committee of the Board.

The Board has been committed over the past year to investment in member services that can be delivered to members, no matter what the location of the member. These services are primarily online tools and resources and, increasingly, learning pathways that will continue to expand in the coming 12 months. During the year, the AMA subsidiary, Australasian Medical Publishing Company Pty Limited (AMPCo), expanded the *Medical Journal of Australia* brand to deliver MJA CPD. These sessions will also evolve into an online format in the coming year, delivered through the shared platform, doctorportal.com.au.

Federal Council has had a successful year in developing and approving medico-political policy across a number of complex areas of health. The revised structure of the Association, introduced in 2014, has facilitated an improved focus on policy by the Association's peak policy-making body.

In keeping with its strategic plan 2015-2017, the Board has supported the expansion of a shared services model across the AMA Group with human resources, information technology, and financial services delivered on a Group

Dr Iain Dunlop AM
Chair

basis. This has served to better integrate the Group businesses, and has resulted in improved efficiency and cost savings. Financial reporting to the Board on the basis of this shared services model has been clear, efficient, and effective.

The Board has had two meetings with representatives of State and Territory AMA Boards during the year. The first of these was a breakfast at National Conference, where attendees discussed challenges in common, such as strengthening membership. The breakfast was initiated the previous year by my predecessor, Dr Elizabeth Feeney, and was well supported at National Conference in 2016.

Later in the year, I chaired a joint meeting of the Board with the Chairs or Presidents of the State and Territory AMA Boards with a view to agreeing objectives for membership retention and growth. These meetings continue to be important for the AMA 'family'.

The Board was pleased during the year to observe the growing maturity of its subsidiary, Doctors Health Services Pty Limited, as it finalised agreements with State and Territory service providers to deliver health services to doctors and medical students consistently across the country.

I thank my fellow directors for their commitment to the Association, and acknowledge the leadership of my predecessor, Dr Elizabeth Feeney, who was the inaugural Chair of the new Board. I also acknowledge the contribution made by the AMA Secretariat, and particularly our Secretary General, Ms Anne Trimmer, in delivering a successful year for the company.

Dr Iain Dunlop AM
Chair

The Board was pleased during the year to observe the growing maturity of its subsidiary, Doctors Health Services Pty Limited

4.

Board Members

Dr Iain Dunlop AM

MBBS (Hons), FRANZCO, FRACS, FAMA

Chair (from June 2016)
ACT nominee
Ophthalmologist

Dr Elizabeth Feeney

MBBS, MHL, FANZCA, FAICD, FAMA

Chair (to June 2016)
NSW nominee
Investment Committee member
Anaesthetist

Prof Brian Owler

MBBS, PhD, FRACS, GAICD

President, AMA (to May 2016)
Neurosurgeon

Dr Michael Gannon

MBBS, MRCPI, FRANZCOG, FAMA

President, AMA (from May 2016)
Obstetrician and Gynaecologist

Dr Stephen Parnis

MBBS, DipSurgAnat, FACEM, FAMA, GAICD

Vice President, AMA (to May 2016)
Emergency Physician

Dr Anthony Bartone

MBBS, FRACGP, MBA, FAMA

Vice President, AMA (from May 2016)
General Practitioner

Dr Peter Beaumont

MBBS, MRACGP, FAMA

NT nominee
Audit and Risk Committee member
General Practitioner

Prof Geoffrey Dobb

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

WA nominee
Investment Committee member
Intensive Care Physician

Dr Richard Kidd

BHB, MBChB, DipObs, FAMA

QLD nominee
General Practitioner

Dr Bavahuna Manoharan

BSc (BioMed), MBBS

CDT nominee
Registrar, General Surgery

Dr Helen McArdle

BMedSc, MBBS, MPH, FAFOEM, FRACMA, FAICD

TAS nominee
Audit and Risk Committee Chair
Specialist Medical Administrator and Occupational Physician

Dr Peter Sharley OAM

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

SA nominee
Intensive Care Specialist

Dr Gary Speck AM

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

VIC nominee
Investment Committee Chair
Orthopaedic Surgeon

5.

Advocacy

Above left: Dr Gannon with Opposition Leader Bill Shorten
Above Right: Dr Gannon at media conference at Parliament House
Right: Prof Owler addressing AMA Asylum Seeker Forum in Sydney

Below: Dr Gannon with Prime Minister Malcolm Turnbull and Health Minister Sussan Ley in Perth
Bottom: Prime Minister Malcolm Turnbull in discussion with AMA Federal Council in Canberra

386
Meetings with Government and Departments

65
External Committees with AMA representation

58
Policy Submissions

44
AMA Policy Committee meetings

Top left: Prof Owler doorstop in Parliament House courtyard
Centre Left: Dr Gannon with Greens Leader Senator Richard Di Natale
Centre right: Prof Owler with Assistant Health Minister Senator Fiona Nash
Right: Dr Gannon with Shadow Health Minister Catherine King

AMA says attempts to help asylum seekers on Nauru frustrated by immigration department

theguardian

Election 2016: AMA renews call for Coalition to lift Medicare rebate freeze

NEWS

Top: Launch of AMA Rural Health Plan
Centre left: Launch of Academy of Science Immunisation booklet
Left: Media pack at Immunisation launch

6.

Media Reach

Facebook

Australian Medical Association

124
Facebook posts

9,125
Total fans

1,486,297
Impressions

Twitter

@ama_media

14,036 Followers

1,053 Tweets

2,252,424 Impressions

@amaausmed

3,639 Followers

649 Tweets

625,437 Impressions

@amapresident

13,229 Followers

850 Tweets

3,145,367 Impressions

230 **Media releases**
sent by the AMA in 2016

7.

Year in Review

Left: Dr Parnis and Prof Owler launching AMA Public Hospital Report Card 2016 in Sydney
Below left: AMA Asylum Seeker Forum
Bottom Right: Prof Owler and Human Rights Commissioner Gillian Triggs

Above: Prof Owler visiting Indigenous community in the Northern Territory
Left: Prof Owler on the Today Show
Below: Launch of AMA MBS Freeze campaign

Top and above left: Dr Gannon media conference at Parliament House during Federal election campaign

Above right: Dr Bartone, Dr Rowbotham, Dr Joanna Flynn AM, Chair of the Medical Board of Australia, and Dr Gannon

Right: Dr Gannon addressing the National Press Club of Australia

Left: Dr Gannon addressing the National Press Club of Australia
Below left and right: Dr Gannon at the Confederation of Medical Associations in Asia and Oceania meeting in Thailand
Below: Dr Gannon and Dr Bartone with the AMA Council of Doctors in Training

Top: Prof Peter Doherty, Dr Gannon, Health Minister Sussan Ley, Dr Mike Freelander, Prof Andrew Holmes at launch of Academy of Science Immunisation booklet
Left and above right: Launch of AMA Indigenous Health Report Card

Top: Dr Gannon live on Radio National discussing Position Statement on Euthanasia and Physician Assisted Suicide
Left and below: Launch of AMA Position Statement on Autism Spectrum Disorder in Sydney

8.

General Practice, Legal Services, and Workplace Policy

During 2016, the AMA revised or developed the following Position Statements/Policy Documents that related to general practice, after-hours, medical training, rural health, and workplace conditions for doctors and medical students:

- General Practice Standards 2005 – Revised 2016
- General Practice in Primary Health Care 2016 – replacing Primary Health Care 2010
- Out-of-Hours Primary Medical Care – 2004 – Revised 2016
- Vaccinations Outside of General Practice – 2011 – Revised 2016
- Measuring Clinical Outcomes in General Practice – 2016
- Better access to high speed broadband for rural and remote health care – 2016
- AMA Position Statement on Support for non-vocational trainees – 2016
- Revised National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors – 2016
- Revised AMA Position Statement on Equal Opportunity in the Medical Workforce – 2016
- AMA National Code of Practice – Flexible work arrangements and revised doctors' guidelines for implementing flexibility 2016
- AMA Plan for Better Health Care for Regional, Rural, and Remote Australia
- Building a sustainable future for rural practice: the Rural Rescue Package

Reports/Surveys

- 2016 Rural Health Issues Survey
- PIP E-Health Survey
- 2016 Safe Hours Audit

Submissions

- Driving Innovation, Fairness, and Excellence in Australian Higher Education discussion paper
- Selection criteria and operational guidelines for the proposed Co-Funded GP Training Program
- Medical Deans of Australia & New Zealand Inherent Requirements for Studying Medicine in Australia and New Zealand
- Australian Medical Council (AMC) Consultation on the national standards for intern programs and domains for assessing intern accreditation authorities
- Reforms to the Specialist Training Program
- AMC Review of training provided by the Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
- Royal Australasian College of Physicians (RACP) Fellowship Standards consultation
- RACP Selection into Basic Training Quality and Feasibility Study
- Second Draft National Strategic Framework for Chronic Disease consultation
- Royal Australian College of General Practitioners (RACGP) first and second draft of the General Practice Standards 5th Edition
- Department of Veterans' Affairs (DVA) review of dental and allied health arrangements
- Practice Incentive Program (PIP) redesign – Quality Improvement Incentive consultation
- Draft National Immunisation Education Framework consultation
- 2017/18 Skilled Occupations Review
- Royal Australasian College of Surgeons (ACS Code of Conduct Review)

Key advocacy wins during 2016

General Practice

- **PIP Digital Health Incentive** – the AMA successfully lobbied the Government to allow general practices more time to comply with the requirement for GPs to upload Shared Health Summaries to the My Health Record and successfully argued for a more modest SHS upload target.
- **Red tape issues** – Following pressure from the AMA, the Department of Human Services has clarified Medical Evidence requirements for Disability Support Pension claims and detailed the circumstances where GPs can claim remuneration for the paperwork involved.
- **PBS Authorities** – An Online PBS Authority system has been introduced to reduce the need for GPs to spend time waiting on the phone for an authority. The Government is also committed to integrating this initiative into practice management systems.
- **Health Care Homes** – Based on member feedback, the AMA has given cautious support to the Government's vision for Health Care Homes. While it represents a potential revolution in the treatment of chronic disease in general practice and recognises the central role of GPs, the AMA has highlighted the potential risks of proposed changes and ensured that the HCH will be trialled and evaluated before being rolled out more broadly.
- **Pharmacists in General Practice** – The AMA developed a proposal to integrate non-dispensing pharmacists within general practices. A research trial is now underway in 14 general practices in Queensland to assess the benefits of this concept and the results will help build the case for Commonwealth funding in the longer term.
- **After-Hours** – To address PIP eligibility concerns from some rural practices utilising triage services for their after-hours calls, the AMA worked to ensure that practices in RRMAs 5-7 could use localised nurse triage services and still be eligible for the after-hours PIP incentive.

- **Pathology Collection Centre Rental Reform** – Following strong representations from the AMA, the Government agreed to delay planned changes to the definition of market value in the Health Insurance Act to allow further consultation with general practice as well as the pathology sector.
- **National Terms and Conditions for the Employment of Registrars (NTCER)** – The AMA brokered an agreement between the General Practice Registrars Australia (GPRA) and General Practice Supervisors Australia (GPSA) 2017 NTCER. The NTCER details working conditions for GP registrars and is considered to provide a fair outcome for both training practices and registrars.

Medical Workforce and Training

- With growing pressure on the medical training pipeline, the AMA has continued to oppose proposals to create additional medical school places. The Government has now publicly recognised these concerns and agreed that future changes to medical school places should focus on the distribution of places, as opposed to additional places.
- The Department of Education and Training reviewed the Skilled Occupations List, which is used to underpin independent applications for permanent residency. Following AMA representations, a number of medical occupations have been flagged for removal from the SOL, recognising the growth in locally trained graduate numbers.
- Following sustained advocacy from the AMA, there is now broad stakeholder support for the implementation of a National Training Survey to provide more timely and comprehensive data to inform workforce and medical education and training policy and planning, and measure the quality of the medical education and training. The Medical Board of Australia has promised funding support, with an NTS having the potential to help address ongoing concerns about bullying and harassment in the profession.
- The COAG National Review of Medical Intern Training delivered its report at the end of 2015. The AMA argued against radical reforms, and proposed changes remain on hold while the report is further considered.
- The AMA successfully opposed changes seeking to establish co-funded GP training places, highlighting serious issues such as conflicts of interest, diversity of training settings, and the protection of registrars.
- Following representations from the AMA, the Government agreed to be more accommodating in applying return of service obligations on medical graduates enrolled in the Bonded Medical Places (BMP) program and the Medical Rural Bonded Scholarship Scheme (MRBS), particularly those who need to upskill in otherwise ineligible locations.
- Responding to pre-Budget speculation that the Government would change the tax treatment of work-related expenses, the AMA successfully urged the Government to back away from changes to tax deductions for work-related self-education expenses, including caps on deductions.

Rural Health Care

- The AMA ensured that the under-spend in the Rural and Regional Training Infrastructure Grants Program stayed in general practice and successfully worked to have the program redesigned so that more practices would be encouraged to participate.
- The AMA supported the Government's plan to appoint a National Rural Health Commissioner, whose role will include developing a National Rural Generalist Pathway. The AMA has long advocated for the establishment of a national rural generalist pathway and looks forward to working with the Commissioner, when appointed, on this important initiative.

Doctors' Health

- The AMA, through its subsidiary company, Doctors Health Services Pty Ltd (DrHS), coordinated the roll out of Medical Board funding to support the establishment of accessible and consistent doctors' health services across the country. National coverage was achieved by the end of 2016, with DrHS working closely with existing State/Territory based services.

9.

Medical Practice

Private Health Insurance Report Card

The inaugural AMA Private Health Insurance Report Card was released in February this year and was well received, with over 100,000 visits to the website. This, combined with intense awareness raising, has been successful in managing numerous problems within the Private Health Insurance industry.

Firstly, we sought removal of junk policies and called for improved clarity for consumers. The Government has announced that it will create a three-tiered system of policies that will allow customers to more easily choose a product that is right for them, and also remove junk policies.

The AMA argued that the operations of third party comparator sites for Private Health Insurance were not transparent.

We have also been in discussion with the Government about some egregious behaviour by health insurers. Subsequent to these conversations, the ACCC has taken action against Medibank Private for allegedly misleading consumers, and the Commonwealth Ombudsman has advised that they will be investigating funds seeking 'pre-approvals' for medical procedures. These behaviours are in direct contravention of government regulations designed to protect consumers.

Finally, we argued that the operations of third party comparator sites for Private Health Insurance were not transparent; 'comparisons of best value' excluded some policies, and commissions were kept secret. The Government has also announced that these third party comparator sites will need to publish commissions received, similar to the requirements for other financial products.

Public hospital funding

The AMA maintained its strong advocacy on public hospital funding, using the Government's publicly available data to produce the 2016 edition of the *AMA Public Hospital Report Card*.

The AMA Public Hospital Report Card is the only report that presents core measures of hospital performance in a time series. It reflects the experiences of the AMA doctors who work in public hospitals.

The AMA highlighted the growing funding crisis facing public hospitals as a result of significant reductions in Commonwealth funding over the Budget and out years from 2017–18, as well as in media briefings and evidence to Parliamentary committees.

The 2016 Report Card showed that, against key measures, the performance of public hospitals is virtually stagnant, or even declining.

The Report Card was released to have maximum impact on the public debate regarding hospital funding leading up to COAG's deliberations at its meeting on 1 April 2016.

The Commonwealth provided an additional $2.9 billion in public hospital funding at this meeting.

Shared electronic health record

In 2016, the AMA released its updated *Position Statement on the Shared Electronic Medical Record (EMR)*.

The Position Statement makes clear that shared electronic medical records should contain core clinical information that is not subject to access controls.

Patient safety and the quality of care will be improved if treating doctors can promptly and easily access and contribute to accurate, reliable, and comprehensive electronic medical information about the patients they are treating.

Any doubts about the completeness or accuracy of the information on an electronic medical record will undermine the confidence of the user.

During 2016, the Government re-launched its My Health Record and trialled 'opt-out' arrangements. The AMA has consistently advocated for participation in the shared health record to be on an 'opt-out' basis.

Stewardship

The AMA's Health Financing and Economics Committee (HFE) recognised 'stewardship' is an important and useful approach for clinicians to take an influential role in health financing issues and decisions.

In April 2016, HFE developed the AMA *Position Statement on Doctors' role in stewardship of healthcare financing and funding arrangements 2016*.

Stewardship in relation to health financing and funding means ensuring health funding is directed to achieving health outcomes, does not have adverse impacts or involve wasteful expenditure, and is sustainable and able to meet future needs.

Stakeholder forums – AMA taking the lead

In February, the AMA convened its second meeting of medical profession leaders to discuss the progress of, and concerns about, the MBS Review – with over 60 representatives from the Colleges, Associations, and Societies attending.

The then AMA President, Professor Brian Owler, said that all in attendance wanted to achieve an MBS that reflected modern medical practice, and that benefited patients, and noted that delays in listing new MBS items to replace removed items could create an incomplete MBS, with serious implications for patient care.

The AMA remains concerned that the Government is aiming to make savings from the MBS Review. Professor Bruce Robinson, Chair of the MBS Review Taskforce, advised the forum that the Taskforce did not have a savings target, and its aim was to align the MBS with current clinical practice.

The AMA is advocating that any savings identified through this process are reinvested in health.

MBS review

In November, the AMA called on the Health Minister and the Government for increased transparency around the MBS Reviews after substantive changes to the Medicare schedule were rapidly introduced without clinical consultation.

In November, the Government discreetly implemented a number of changes to skin services banding classifications without consulting clinicians. The results had detrimental impacts to clinical care and the ability to claim private health insurance rebates.

The AMA responded rapidly with President, Dr Michael Gannon, personally raising concerns with Health Minister Sussan Ley about the Government's conduct as it relates to the broader MBS Reviews.

The AMA also made strong representations to the Department of Health, calling for a reversal of the banding changes and transparent consultations with clinicians throughout the MBS Review process.

The skin issue gained national media attention, and the AMA has been working with the Department of Health to shape stronger MBS Review processes.

The AMA's support for the MBS Reviews has been contingent on adequate and relevant clinician guidance and input.

Revalidation

The AMA strongly advocated for a clearer articulation of the problem that the Medical Board of Australia is trying to solve with its recent push towards Revalidation.

This is needed to allow the medical community to identify and comment on potential solutions.

We advocate that the proposal to screen doctors to identify *At risk and poorly performing medical practitioners* requires significant further development before being seriously considered by the Government.

With regard to the enhanced Continuing Professional Development (CPD) proposal, we have argued that the profession should lead improvements to CPD and that, without a problem or an end goal, the impact of the proposed CPD changes are impossible to identify.

Finally, the AMA requested a detailed proposal be put back to the medical community for feedback prior to recommending implementation options. We are expecting to see further work from the Board in 2017.

PBS Authority wins cut red tape

AMA lobbying over several years to cut red tape associated with prescribing PBS Authority Required medicines bore fruit this year with three key wins for doctors.

Following a Government review initiated by the AMA, over 200 PBS listings were moved from 'Authority required' status to either 'streamlined' arrangements or 'restricted benefit' or no restriction status.

Again, following AMA lobbying, online approvals are now available for most PBS Authority Required medicines.

Since 1 July 2016, prescribers can log in to Medicare's Health Professionals Online System (HPOS).

The AMA also lobbied the Medical Software Industry Association to encourage medical software providers to include this functionality on doctors' own clinical and prescribing software as quickly as possible. In 2017, the AMA will closely monitor the progress of this initiative.

Finally, AMA intervention led to the development of a secure email facility, accessed through HPOS, to allow prescribers to send all complex medicines documentation instantly by email rather than post, cutting down the turnaround time for approvals from weeks to days.

Since 1 July 2016, prescribers can log in to Medicare's Health Professionals Online System (HPOS).

10.

Public Health

Public Health Position Statements

In 2016, the AMA released five new Public Health Position Statements.

Autism Spectrum Disorder (ASD)

The AMA called for coordinated action to speed up the diagnosis of ASD in children, and to provide early intervention therapies to give children with ASD the best outcomes possible.

The Position Statement specifically called on the Government to make an ongoing commitment to providing services through the National Disability Insurance Scheme (NDIS) to all children with an ASD diagnosis, and to ensure that there will not be a narrowing of eligibility requirements for access to the NDIS.

The AMA noted that the number of paediatricians, child psychiatrists, and clinical psychologists working specifically in ASD is limited, and the problem is magnified in rural and remote areas, where few, if any, clinicians can make the diagnosis.

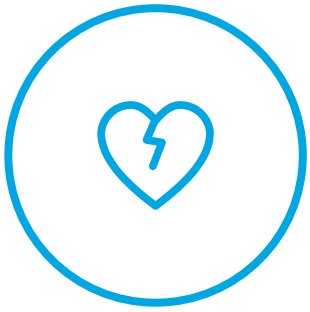
Early detection and diagnosis is critical, as brain plasticity – the ability of the brain to respond and remodel itself – means early intervention can make a huge difference. The earlier ASD is diagnosed, the better the outcome.

Obesity – 2016

Obesity is the biggest public health challenge facing the Australian population, and the revised AMA Position Statement called on the Government to take national leadership in implementing a multi-faceted strategy to address the serious health threat that obesity poses to individuals, families, and communities.

Combating obesity demands a whole-of-society approach, and the AMA strongly recommended that a national strategy to address obesity includes: a sugar tax; stronger controls on junk food advertising, especially to children; improved nutritional literacy; healthy work environments; and more and better walking paths and cycling paths as part of smarter urban planning.

The national obesity strategy must involve all governments, non-government organisations, the health and food industries, the media, employers, schools, and community organisations.



Family and Domestic Violence – 2016

The AMA Position Statement highlighted that family doctors have a key role to play in early intervention and treatment.

Women experiencing domestic violence share their experiences with GPs more often than with any other professional group.

Doctors have a role to play in community-wide efforts to advocate and strengthen resources for victims and perpetrators, and to encourage preventive education programs through schools, the media, and community organisations.

The AMA said all doctors need access to training that exposes the extent of different forms of family and domestic violence, and the medical and psychiatric consequences for the victims – be they men, women, children, young, or old.

Fetal Alcohol Spectrum Disorder (FASD)

FASD is the leading cause of preventable birth defects and intellectual disability. The AMA called for FASD to be included on the list of recognised disabilities so that families can have access to much-needed support services.

FASD has a significant impact on education, criminal justice, and child protection services in Australia, and yet has not been included by the Government on the list of recognised disabilities.

The AMA stated that the safest option for women who are pregnant or planning a pregnancy is to completely abstain from alcohol consumption. The message is simple and safe – no alcohol during pregnancy.

The AMA continued its support for the Close the Gap campaign in 2016, and remains a committed and active member of the Close the Gap Steering Committee.

Concussion in Sport

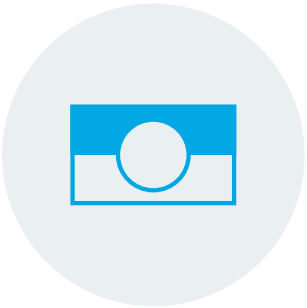
The AMA and the Australian Institute of Sport (AIS) launched a long-running project to produce resources and a website (concussioninsport.gov.au) to help identify key symptoms of sports-related concussion, and how to respond.

Both the AMA and the AIS want to help make sport and physical activity safer for everyone.

Concussion can affect athletes at all levels of sport, from school children to full-time professionals, and sports-related concussion is a type of brain injury that is not always obvious, and symptoms may change over time.

The AMA/AIS message is: if in doubt, sit them out. In most instances, with correct medical diagnosis and treatment, concussion symptoms resolve within seven to 10 days. The concussioninsport.gov.au website provides athletes, coaches, parents, and medical practitioners with timely, simple, evidence-based information on how to identify and manage concussion in sport.

Public Health Advocacy



Indigenous Health

AMA President, Professor Brian Owler, visited remote communities in the Northern Territory to see firsthand how health services are being delivered at the local level.

In Alice Springs, Professor Owler met with representatives of the Central Australian Aboriginal Congress, Purple House, Baker IDI Heart and Diabetes Institute, the Poche Centre for Indigenous Health and Wellbeing, the Centre for Remote Health, and the Alice Springs Hospital to discuss the challenges associated with improving Indigenous health. Some of these challenges include a lack of GPs in remote communities, inadequate housing, insufficient access to clean water, and food security.

Professor Owler also flew to three remote communities – Utopia, Ampilatwatja, and Kintore – to meet medical practitioners, nurses, health workers, and community members.

The AMA released its 2016 Report Card on Indigenous Health, *A Call To Action To Prevent New Cases of Rheumatic Heart Disease in Indigenous Australia by 2031*, which urges governments to strengthen their efforts to eliminate this disease. Rheumatic Heart Disease (RHD) is an entirely preventable condition that affects the valves of the heart, and almost exclusively affects Indigenous people in Australia – a result of poverty, poor quality and overcrowded housing, and limited access to health services. The Report Card was launched at the Danila Dilba Health Service in Darwin on 25 November 2016, by AMA President, Dr Michael Gannon.

The AMA became a founding member of an END RHD Coalition – an alliance of organisations with a vision to see the end of RHD in Australia. The six peak bodies that comprise the END RHD Coalition include the AMA, the National Heart Foundation, the National

Aboriginal Community Controlled Health Organisation, RHD Australia, and Aboriginal Medical Services Alliance Northern Territory.

The AMA Taskforce on Indigenous Health continued to provide support to the AMA President on Aboriginal and Torres Strait Islander health issues, and set the direction of the annual AMA Report Card on Indigenous Health.

The AMA Indigenous Peoples' Medical Scholarship supports more Aboriginal and Torres Strait Islander people to become doctors. The AMA awarded the 2016 Indigenous Peoples' Medical Scholarship to Mr Darren Hartnett, an Indigenous medical student studying at the University of Newcastle. The Indigenous Medical Scholarship is now registered as a charity with the Australian Charities and Not-for-Profits Commission, and has Deductible Gift Recipient status.

The AMA continued its support for the Close the Gap campaign in 2016, and remains a committed and active member of the Close the Gap Steering Committee.

Alcohol and alcohol-fuelled violence

The AMA continued to play a leading role in advocacy to reduce alcohol-related violence and excessive alcohol consumption. The AMA lobbied the Government to finalise and release the *2016-2021 National Alcohol Strategy*. The AMA pursued the goals set out at the AMA National Alcohol Summit 2014.

The AMA *Position Statement on Fetal Alcohol Spectrum Disorder (FASD)* received coverage through print and social media, and AMA President, Dr Michael Gannon, conducted numerous television and radio interviews on FASD and alcohol.

The AMA provided a submission to Queensland's Parliamentary Consultation on Tackling Alcohol-Fuelled Violence Legislation Amendment Bill and Senate Standing Committee on Legal and Constitutional Affairs' Inquiry into the Need for a Nationally-consistent Approach to Alcohol-Fuelled Violence.

Domestic Violence

The AMA *Position Statement on Family and Domestic Violence 2016* received extensive media coverage and was a valuable contribution to the political and community debate on domestic violence.

The AMA worked with the National Centre for Health Justice Partnerships and the Law Council of Australia to promote access to justice through pro bono legal services within health care settings.

The AMA provided evidence to the Australian Law Reform Commission (ALRC) inquiry into Elder Abuse in Australia.

Autism

In November, AMA President, Dr Michael Gannon, and past AMA President, Professor Brian Owler, launched the AMA *Position Statement on Autism Spectrum Disorder* at NSW Parliament with Nicole Rogerson, founding Director and CEO of Autism Awareness Australia, and the Hon John Ajaka MLC, NSW Minister for Disability Services.

The AMA spoke out strongly against mixed martial arts (MMA) fighting after an athlete died following a knock-out in an overseas bout.

Combat Sports

The AMA/AIS Concussion in Sport position was covered by national media. The Concussion in Sport webpage (concussioninsport.gov.au) received thousands of views and hundreds of downloads.

The AMA spoke out strongly against mixed martial arts (MMA) fighting after an athlete died following a knock-out in an overseas bout. The *AMA Position Statement on Combat Sport* continued to garner media coverage, with the call that boxing, MMA, and kick-boxing pose an unacceptable health risk to participants.

Vaccination and Immunisation

The AMA President, Dr Michael Gannon, co-launched the Australian Academy of Science's immunisation booklet, *The Science of Immunisation: Questions and Answers* at Parliament House in October with Professor Andrew Holmes, President of the Australian Academy of Science; The Hon Sussan Ley MP, Minister for Health and Aged Care; Professor Peter Doherty, Nobel Laureate; and Dr Mike Freelander MP.

Researched and produced by the Australian Academy of Science, with input from Australia's leading researchers in immunology, the booklet provides compelling evidence about the benefits of immunisation to the health of children and the community. Dr Gannon noted that the booklet was the perfect response to the lies, misinformation, and fear that is peddled by the anti-vaccination movement.

The AMA advocated in support of the Government's 'No Jab No Pay' measure and the establishment of an Australian School Vaccination program to provide a record of all school-based immunisations, such as HPV, varicella, diphtheria, tetanus, and pertussis boosters.

The AMA provided input to the National Health Performance Authority (NHPA) in relation to an upcoming publication, *Healthy Communities: Immunisation rates for children 2014-15*.

The AMA advocated in support of the Government's 'No Jab No Pay' measure and the establishment of an Australian School Vaccination program.

Road Safety

The AMA engaged with Road Safety Education Limited, the Amy Gillett Foundation, Australasian College of Road Safety, NSW Motor Accidents Insurance Regulation, Intelligent Transport Systems Australia, and the Federal Chamber of Automotive Industries on a range of road safety matters.

AMA President, Professor Brian Owler, gave evidence on road safety issues to the Standing Committee on Rural and Regional Affairs and Transport in February.

Professor Owler participated in National Road Safety Week (2-8 May 2016), and also provided material on the risks of speeding, fatigue, and risk-taking behaviours for Safer Australian Roads and Highways (SARAH).

Asylum Seekers

The AMA held a Forum in Sydney in February 2016 on the health of asylum seekers.

The Forum was attended by more than 350 doctors, nurses, allied health professionals, and medical students.

The AMA called for the immediate release of all children being held in immigration detention and for all political parties to adopt humanitarian policies to provide quality health care for all asylum seekers and refugees. The AMA Forum generated great interest and built significant community support.

The AMA called for the immediate release of all children being held in immigration detention and for all political parties to adopt humanitarian policies to provide quality health care for all asylum seekers and refugees.

The AMA continued its public campaign for a transparent national statutory body of clinical experts, independent of Government, with the power to investigate and report to the Parliament on the health and welfare of asylum seekers and refugees in Australia and in offshore detention.

The AMA made a submission to the Senate Legal and Constitutional Affairs Committee *Inquiry into Serious Allegations of Abuse, Self-harm and Neglect of Asylum Seekers in relation to the Nauru Regional Processing Centre, and any Like Allegations in relation to the Manus Regional Processing Centre*.

The AMA previously made a submission to the Legal and Constitutional Affairs Committee *Inquiry into Conditions and Treatment of Asylum Seekers and Refugees at the Regional Processing Centres in the Republic of Nauru and Papua New Guinea*. This submission updated the Committee on the AMA's engagement on the health care of asylum seekers and detainees.

The Secretariat provided details of asylum seekers' health care issues to the Department of Immigration and Border Protection and IHMS, noting instances brought to the AMA's attention of those in offshore detention not receiving adequate and appropriate health care.

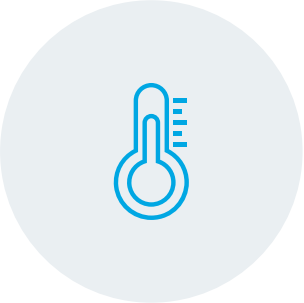
AMA Presidents, Professor Owler and Dr Gannon, held meetings with Dr John Brayley, Chief Medical Officer and Surgeon General, Australian Border Force, regarding health care being provided to detainees, and the Secretariat continued to liaise with the Government and IHMS providers.

Tobacco

The AMA was given responsibility to lead the revision of the World Medical Association (WMA) Resolution on the Implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC). The WHO FCTC is the first treaty negotiated under the auspices of the World Health Organisation.

It was developed as a response to the global tobacco epidemic and included evidence-based strategies to reduce the demand for tobacco, as well as addressing supply related issues.

The AMA Secretariat incorporated feedback from other medical associations and provided the final proposed amendments back to the WMA for consideration during the recent 203rd WMA World Council session.



Climate Change and Health

AMA Vice President, Dr Stephen Parnis, gave a keynote address – Heatwaves and the Health Sector – to the Australian Summit on Extreme Heat and Health in Melbourne in March 2016.

The AMA Secretariat participated in the Climate and Health Alliance Health Leaders Roundtable at Parliament House in Canberra.

AMA President, Dr Michael Gannon, addressed the AMSA conference on climate change and health in July 2016.

Prisoner Health

The AMA joined with leading health experts to advocate for people subject to incarceration and youth detention to have access to Medicare and the PBS.

Under the Health Insurance Act, the Health Minister has the power to grant an exemption to end prisoners' exclusion from Medicare, paving the way for rebates to be claimed for prison-based health care services in limited circumstances where gaps exist in health service delivery.

Physical Activity

The AMA worked with the Confederation of Australian Sport, Heart Foundation, and other national health, education and sport organisations to support initiatives to reduce physical inactivity in Australia by 15 per cent by 2021.

The AMA promoted the benefits of physical activity for all Australians, and collaborated with stakeholders for the development and implementation of a national physical activity strategy.

11.

Ethics

Review of AMA policy on euthanasia and physician assisted suicide

After an extensive 12-month review process, the AMA updated its policy on euthanasia and physician assisted suicide in November 2016, now referred to as the *Position Statement on Euthanasia and Physician Assisted Suicide 2016*.

In recognising the increased community interest in euthanasia and physician assisted suicide, the AMA conducted a thorough member consultation, providing a range of opportunities for members to express their views on AMA policy and on euthanasia and physician assisted suicide more broadly.

Should laws change, doctors must be involved in the development of legislation, regulations and guidelines.

Consultation highlights included the AMA member survey on euthanasia and physician assisted suicide, the 2016 AMA National Conference Q&A Session on Assisted Dying, and extensive consultation with AMA State and Territory offices.

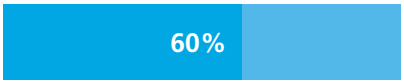
Ultimately, in regard to the position that doctors should not be involved in interventions that have as their primary intention the ending of a person's life, it was clear that the results of the consultation process did not yield a mandate for change; however, the new statement makes it clear that, should laws change, doctors must be involved in the development of legislation, regulations and guidelines to protect all those who do or do not wish to participate, as well as

vulnerable groups and the functioning of the health system as a whole. Irrespective of the laws, doctors will always have a central role in the critical assessment of their patients and, as indicated in the survey, there are a majority who feel that doctors should be the group providing euthanasia and assisted suicide should these procedures become legal.

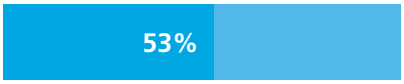
Beyond this though, and beyond the debate regarding the legalisation of euthanasia and physician assisted suicide, the *Position Statement on Euthanasia and Physician Assisted Suicide 2016* contains a clear message that doctors will not abandon their patients or the community whatever the legal landscape, and that patients who are suffering or dying can be assured that doctors will stand alongside them to care for them until the end.

3,733

Respondents to the AMA member survey on euthanasia and physician assisted suicide.



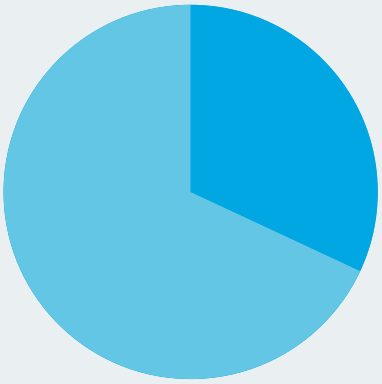
60% of respondents believe euthanasia should be provided by doctors if legal in Australia.



53% of respondents believe physician assisted suicide should be provided by doctors if legal in Australia.

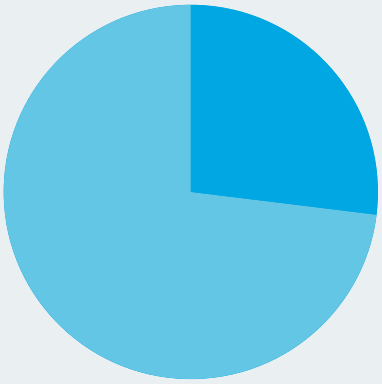
50% of members agreed, **38%** disagreed, and **12%** neither agreed nor disagreed with the AMA policy position that 'medical practitioners should **not be involved** in interventions that have as their primary intention the ending of a person's life.'

If euthanasia or PAS were to become lawful, **how likely would you provide it if requested by a patient?**



32%

said it was likely (or very likely) they would provide euthanasia.



27%

said it was likely (or very likely) they would provide physician assisted suicide.

AMA Code of Ethics 2004. Editorially Revised 2006. Revised 2016

The AMA's *Code of Ethics* undertook its first major review in 10 years. The updated Code provides ethical guidance to doctors in their relationships with patients, colleagues, other health care professionals, and society.

Additions to the updated Code include specific guidance on patients with impaired or limited decision-making capacity; patients' family members, carers and significant others; bullying and harassment; supervising and mentoring; and health standards, quality and safety.

More explicit guidance is provided on issues such as consent, conscientious objection, managing complaints, patient information, fees, professional boundaries, managing interests, stewardship, medico-legal responsibilities, and protecting others from harm.

As one of the AMA's foundational documents, the *Code of Ethics* is accessed and used extensively by AMA members, the wider medical profession, regulatory authorities, patients, family members and carers, and the wider public.

12.

Membership Services

Services for members

In 2015, 2,329 members responded to a national survey that asked what services and benefits members would like to see developed or enhanced by the AMA. The online survey was supported by seven focus groups held around the country.

AMA members cited the following as key priorities for investment:

- Training including career development
- Corporate benefits including discounts
- Online resources

In response to this member feedback, the AMA has continued to enhance and develop new services and resources for members.

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

Dr Eleanor Chew, GP, AMA Member of 31 years

AMA Career Advice Hub

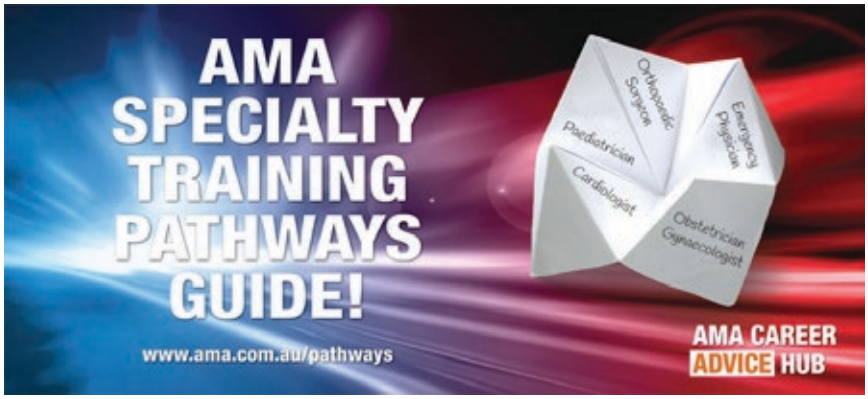
The AMA introduced individual careers consultation for members to better support the wide range of medical career advice available on the AMA Career Hub.

The AMA offers specialised medical career advice to members for free, including resume reviews, advice on interviews, and more. The service caters for medical students through to members retiring from practice.

AMA Career Adviser, Christine Brill FAHRI, FSAE, AFACHSM, MAICD, also ran *Interview Skills* workshops for junior doctors and medical students, and *Becoming a Doctor* information sessions for high school students.

The AMA gave the AMA Career Hub a digital facelift to better connect members with this valued service. This online resource is very popular, attracting over 800 sessions every day.

The AMA offers specialised medical career advice to members for free, including resume reviews, advice on interviews, and more.



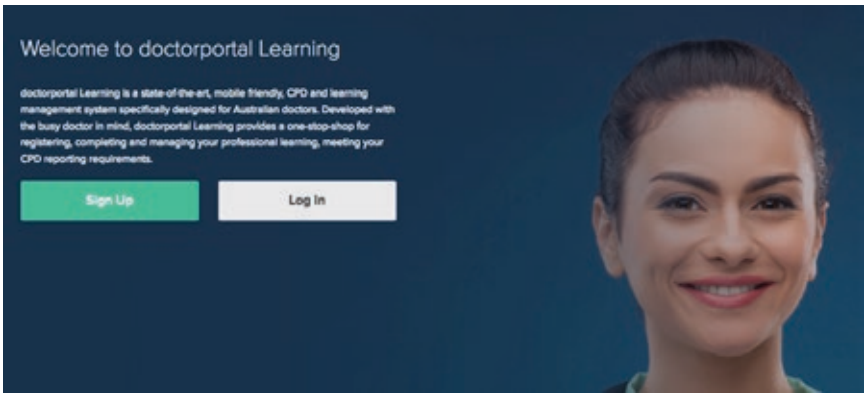
Specialty Training Pathways Guide

In collaboration with members, the AMA launched the Specialty Training Pathways Guide; a free, online resource for members that can be used to research particular specialties or compare the key attributes of all 64 specialties, such as entry requirements, cost, and positions available.

Within the first week of launch, this new resource was viewed over 2,000 times.

"I am keen to represent regional doctors, and those who work too hard to represent themselves. I would like to see doctors advocate for their own quality of life and set an example of healthy living. I am interested in the role doctors have to play in advocating for change in nutrition and activity practices across their communities."

Dr Sarah Coll, Specialist, Orthopaedic Surgeon,
AMA Member of 13 years



Training for members

The AMA continued to develop doctorportal Learning in 2016 by introducing more continuing professional development (CPD) accredited content that members could participate in, online, to help meet their CPD obligations to their medical college or to the Medical Board of Australia.

Member Services

In 2016, the member services team spoke with 2,312 members who needed assistance or had questions about services and resources for AMA members.

AMA working with Medical Students

The AMA attended AMSA's Convention and Global Health Conferences.

The Associate Student AMA Member program was enhanced with a new discount for Associate Student Members of the AMA on medical educational supplies from Mentone Educational.

A new medical jobs board

Through doctorportal, the AMA introduced another benefit for members – a jobs board dedicated to medical professionals.

doctorportal Jobs provides job seekers and medical employers with a secure, user-friendly, and affordable way to connect.

Medical professionals can anonymously search for jobs, and AMA member employers are offered a 50 per cent discount on employment advertising.

This new service for members adds another offering to the many ways the AMA supports medical professionals throughout their careers.

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

Dr Shaun Rudd, GP, AMA Member of 18 years

"My main motivation for being involved with the AMA is that, without that focus on the profession, we can't adequately take care of the population of Australia."

Dr John Zorbas, Emergency Trainee, AMA Member of 8 years

National Conference 2016

The AMA's National Conference in 2016 welcomed delegates with a bold, controversial, and contemporary mix of program topics that firmly put the spotlight on health policy during the election year.

Featured speakers included Shadow Health Minister, Catherine King, and Greens Leader, Senator Richard Di Natale, who addressed delegates in the opening plenary session and answered questions from the audience.

ABC's *Q&A* host, Tony Jones, facilitated the controversial discussion on *Physician Assisted Dying*, supported by a panel of experts representing a broad range of views, and who brought a wealth of experience to the debate.

Paul Bongiorno AM moderated an informative and entertaining session on *Health Policy in an Election Year*, where Australia's most respected political journalists provided behind-the-scenes insights on the battle to form the next Government.

The *Bullying and Harassment – Changing Culture* policy session brought together experts in medicine and discrimination law to explore how the medical profession can change attitudes and behaviours that feed into the current culture in medicine.

The AMA also discussed the role of private health insurers, medical self-regulation, and the medical profession's role in closing the gap, with SBS's Brooke Boney sharing her views.

Health Minister, Sussan Ley, addressed the Gala Dinner and stayed on to discuss health policy with members.

The Conference introduced a partner program to offer delegates' family members, friends and colleagues a tour of the National Arboretum and attendance at key sessions.

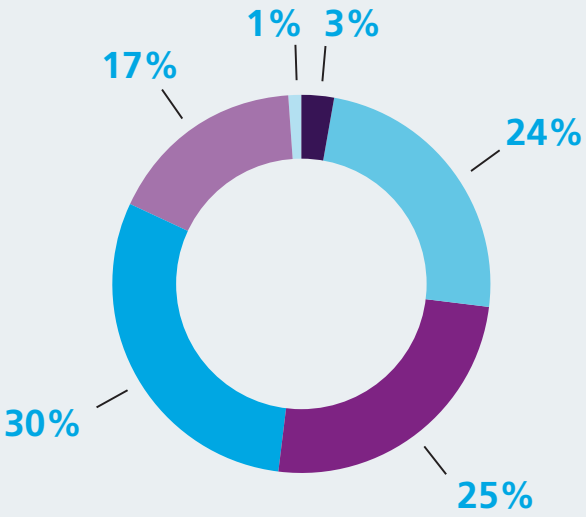
The AMA also recognised leaders in medicine through AMA awards. It was a successful and engaging event.

"By being a student member of the AMA, I have access to irreplaceable careers and training advice."

Ms Rebecca Singer, Medical Student, AMA Student Member of 3 years

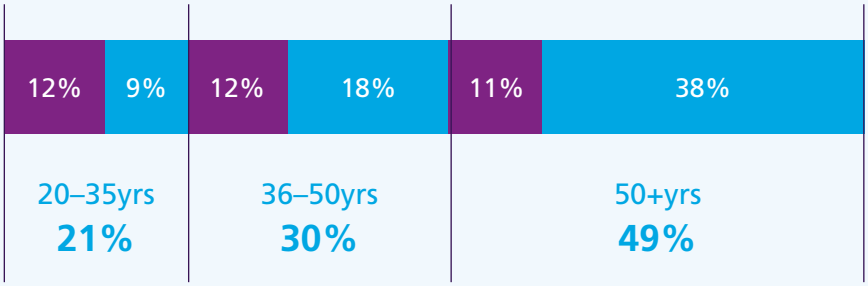
Membership by category

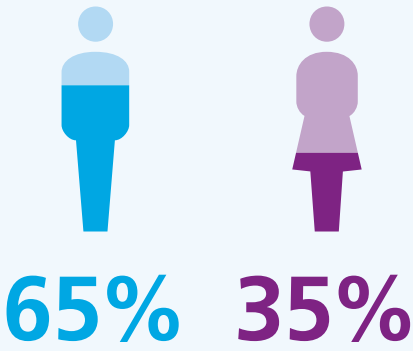
Category	Total
DiT	6979
GP	7356
Specialist	8777
Salaried Doctors	4901
Other	338
Retired	1064
	29,425



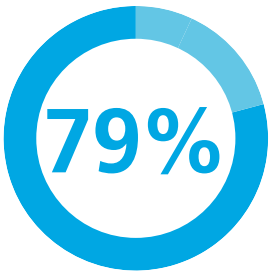
8664 AMA medical student associate members 2016

Membership by group

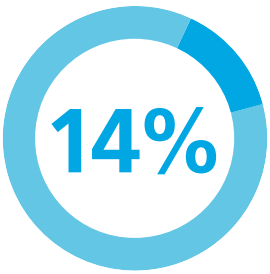




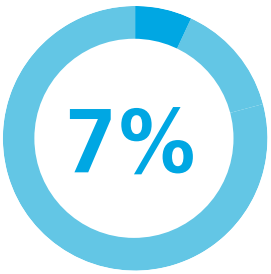
Membership by location



Major City



Inner Regional Australia



Outer Regional/Remote

13.

Financial Report

General Purpose Financial Report
Australian Medical Association Limited and Controlled Entities
ABN 37 008 426 793
For the financial year 31 December 2016

Contents

Directors' Report

Directors

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

Dr Iain Dunlop AM
MBBS (Hons), FRANZCO, FRACS, FAMA
Chair (from June 2016)
Ophthalmologist

Dr Elizabeth Feeney
MBBS, MHL, FANZCA, FAICD, FAMA
Chair (to June 2016)
Investment Committee member
Anaesthetist

Prof Brian Owler
MBBS, PhD, FRACS, GAICD
President, AMA (to May 2016)
Neurosurgeon

Dr Michael Gannon
MBBS, MRCPI, FRANZCOG, FAMA
President, AMA (from May 2016)
Obstetrician and Gynaecologist

Dr Stephen Parnis
MBBS, DipSurgAnat, FACEM, FAMA, GAICD
Vice President, AMA (to May 2016)
Emergency Physician

Dr Anthony Bartone
MBBS, FRACGP, MBA, FAMA
Vice President, AMA (from May 2016)
General Practitioner

Dr Peter Beaumont
MBBS, MRACGP, FAMA
Audit and Risk Committee member
General Practitioner

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

Dr Richard Kidd
BHB, MBChB, DipObs, FAMA
General Practitioner

Dr Bavahuna Manoharan
BSc (BioMed), MBBS
Registrar, General Surgery

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

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

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

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.

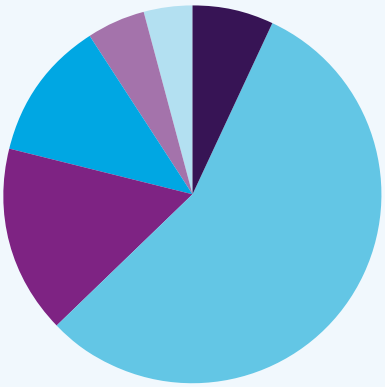
The AMA provides services and communications to its members and through a subsidiary, publishes and circulates the *Medical Journal of Australia*. The consolidated Group owns property and investment assets to support revenue earned from membership subscriptions.

Financial Results

Review and result of operations

The consolidated loss after income tax was $0.6 million (2015: profit $0.4 million). The operations of the Group during the financial year included: promoting the interests of the medical profession in the medico-political arena and more widely; advocating for patient health and the health of the community; servicing members through the provision of a range of membership services and benefits; publishing, among other things, the highly recognised and peer reviewed general medical journal, the Medical Journal of Australia; the management and rental of commercial properties and maintenance and operation of a comprehensive data base containing both member and non-member information.

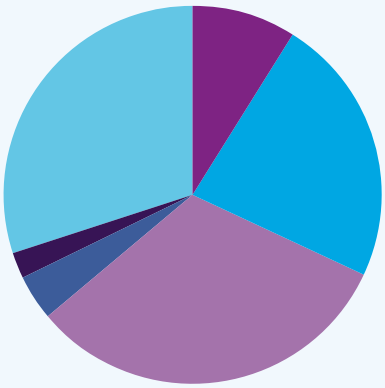
Revenue



Doctors Health Services	4%
Other income	7%
Membership subscription	56%
Database and data sales	16%
Commercial and member services	12%
Rental	5%

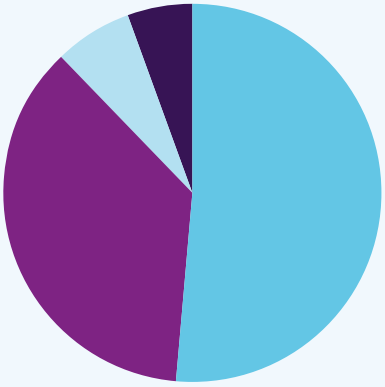
Total revenue has increased by 4.2% (2015: -0.14%) to $21.6 million (2015: $20.7 million) compared to the last financial year. During the financial year, funding income was recognised for Doctors Health Services Pty Limited of $0.9 million (2015: nil) from the Medical Board of Australia and Australian Health Practitioner Regulation Agency, for the national delivery of a health service for medical practitioners and medical students. This funding income is profit neutral and an equivalent expense amount has been recognised as pass through costs.

Expenses



Other expenses	2%
Commercial and member services	30%
Property and occupancy	9%
Publications	23%
Advocacy and policy	32%
Doctors health Services	4%

Assets



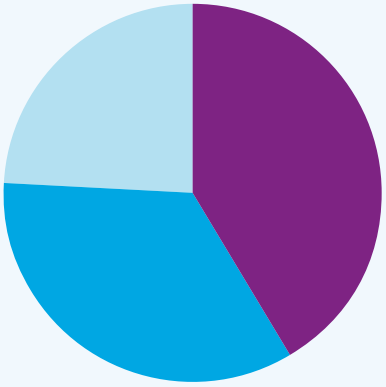
Other	7%
Property, plant and equipment, investment properties and intangibles	50%
Cash and investments	36%
Receivables	6%

Total expenses (excluding income tax) has increased by 6.9% (2015: 0.1%) to $22.6 million (2015: $21.1 million) compared to the last financial year. A funding expense was recognised for Doctors Health Services Pty Limited of $0.9 million (2015: nil) as the abovementioned for payment to state providers of the services.

Review of financial conditions

Net assets decreased by 2.9% (2015: increase 1.8%) from $19.9 million to $19.3 million during the financial year.

Liabilities



Payables	42%
Employee benefits	34%
Income in advance	24%

Rounding

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

Dividends

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

State Of Affairs

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

Strategic Direction

The strategic objectives for the company 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 2016 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.

Likely Developments

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

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

The AMA Indigenous Medical Scholarship Fund received Deductible Gift Recipient status during the year and has been registered with the Australian Charities and Not-for-Profit Commission. During the coming year fundraising will be undertaken to grow the corpus of the Fund to increase the number of scholarships available for the education of Indigenous medical students.

The Board established an investment committee in 2015 which works 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 was wound up in 2016 with final processes to be finalised in 2017.

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 99.

Indemnification And Insurance Of Officers And Auditors

Indemnification

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

Insurance premiums

During the financial year the Group paid premiums in respect of Directors' and Officers' Liabilities and Professional Indemnity for the year ended 31 December 2016, insuring the directors of the company and all executive officers of the Group against a liability incurred by such a director or executive officer to the extent permitted by the *Corporations Act 2001*.

Information On Directors

The Board is comprised of 11 medically qualified Directors and includes the President and Vice President, one Director nominated by each State and Territory AMA and one Director nominated by the AMA Council of Doctors in Training. The Chair is elected from among the Directors. Dr Elizabeth Feeney, the inaugural chair stepped down from her position in June 2016 and Dr Iain Dunlop was elected by the Board as her successor.

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

Directors' interests

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

1. a benefit included in the aggregate amount of remuneration received or due and receivable by Directors shown in the financial statements in Note 22; and
2. the fixed salary of an employee of the AMA or an entity in the Group.

Directors Meeting Attendance

During the period 1 January 2016 to 31 December 2016 the Board met on twelve occasions, five were face to face meetings and seven were via teleconference/ videoconference.

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

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

The following tables summarise the meeting attendance of the Directors and Committee members during 2016, noting the number of meetings each Director/ Committee member was eligible to attend; and actually attended.

Board Meetings

	Eligible to attend	Attended
Professor Brian Owler	5	4
Dr Stephen Parnis	5	3
Dr Michael Gannon	7	7
Dr Anthony Bartone	7	7
Dr Elizabeth Feeney	12	11
Dr Iain Dunlop	12	10
Dr Peter Beaumont	12	10
Professor Geoff Dobb	12	12
Dr Richard Kidd	12	8
Dr Helen McArdle	12	11
Dr Bavahuna Manoharan	12	11
Dr Peter Sharley	12	12
Dr Gary Speck	12	11

Audit and Risk Committee

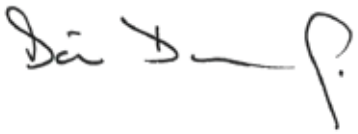
	Eligible to attend	Attended
Dr Iain Dunlop	4	4
Dr Helen McArdle	5	5
Dr Peter Beaumont	1	1
Mr Ed Killesteyn	5	4

Investment Committee

	Eligible to attend	Attended
Dr Gary Speck	10	10
Professor Geoff Dobb	10	10
Dr Elizabeth Feeney	10	10

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

Signed in accordance with a resolution of the Directors.



Dr Michael Gannon
Director
Australian Medical Association Limited

Dr Iain Dunlop
Director
Australian Medical Association Limited

Statement of comprehensive income

For the year ended 31 December 2016

	Note	Consolidated 2016 $'000	Consolidated 2015 $'000
Revenue		**21,113**	20,191
Other income		**441**	502
	2	**21,554**	20,693
Expenses			
Employment		**(12,130)**	(12,285)
Publications		**(1,775)**	(1,630)
Database and data		**(56)**	(71)
Advocacy and policy		**(1,563)**	(1,541)
Subsidies	2	**(493)**	(429)
Commercial and member services		**(385)**	(302)
Doctors Health Services		**(933)**	–
Property and occupancy		**(999)**	(773)
Depreciation and amortisation	21	**(858)**	(727)
Administration	2	**(3,376)**	(3,343)
		(22,568)	(21,101)
Loss before income tax		**(1,014)**	(408)
Income tax credit/(expense)	4	**426**	758
(Loss)/Profit for the year	21	**(588)**	350
Total comprehensive (loss)/income for the year		**(588)**	350

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

Statement of financial position

as at 31 December 2016

	Note	Consolidated 2016 $'000	Consolidated 2015 $'000
Assets			
Current assets			
Cash and cash equivalents	5	**4,475**	8,787
Trade and other receivables	6	**1,496**	2,010
Inventories	7	**38**	34
Prepayments	8	**436**	475
Income tax receivable	16	**173**	924
Total current assets		**6,618**	12,230
Non-current assets			
Other investments	9	**3,782**	–
Intangible assets	10	**100**	100
Investment properties	11	**600**	711
Property, plant and equipment	12	**10,934**	10,956
Deferred tax assets	13	**1,016**	561
Total non-current assets		**16,432**	12,328
Total assets		**23,050**	24,558
Liabilities			
Current Liabilities			
Trade and other payables	14	**2,434**	3,433
Employee benefits	15	**1,165**	1,140
Total current liabilities		**3,599**	4,573
Non-current liabilities			
Employee benefits	15	**117**	63
Total non-current liabilities		**117**	63
Total liabilities		**3,716**	4,636
Net assets		**19,334**	19,922
Equity			
Retained earnings		**19,334**	19,922
Total equity		**19,334**	19,922

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

Statement of changes in equity

for the year ended 31 December 2016

Consolidated	Attributed to equity holders of the parent		
	Retained earnings $'000	Asset revaluation reserves $'000	Total equity $'000
At 1 January 2015	14,778	4,794	19,572
Profit for the year	350	–	350
Reclassification	4,794	(4,794)	–
At 31 December 2015	**19,922**	–	**19,922**
Loss for the year	**(588)**	–	**(588)**
At 31 December 2016	**19,334**	–	**19,334**

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

Statement of cash flows

for the year ended 31 December 2016

	Note	Consolidated 2016 $'000	Consolidated 2015 $'000
Cash flow from operating activities			
Receipts from membership subscriptions		**13,218**	13,108
Other receipts from customers		**10,806**	10,991
Payment to suppliers and employees		**(24,800)**	(23,718)
Interest received		**374**	88
Interest paid		**(5)**	(89)
Income tax refund/(paid)		**722**	(837)
Net cash flow from/(used in) operating activities	21	**315**	(457)
Cash flow from investing activities			
Payments for intangible assets	10	**(37)**	(30)
Payments for property, plant and equipment	12	**(809)**	(1,708)
Proceeds from sale of property, plant and equipment		**–**	7,625
Proceeds from other investments	21	**–**	24
Payments for other investments		**(3,782)**	–
Dividends received	2, 21	**1**	–
Net cash flow (used in)/from investing activities		**(4,627)**	5,911
Cash flow from financing activities			
Repayment of bank borrowings		**–**	(1,013)
Net cash flow used in financing activities		**–**	(1,013)
Net (decrease)/increase in cash held		**(4,312)**	4,441
Cash and cash equivalents at the beginning of the year		**8,787**	4,346
Cash and cash equivalents at the end of the year		**4,475**	8,787

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

Notes to and forming part of the financial statements

Note 1 Statement of Significant Accounting Policies

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

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

Basis of preparation

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

Australian Accounting Standards set out accounting policies that the AASB has concluded 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 20 April 2017.

(a) Principles of consolidation

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

Where controlled entities have entered or left the Group during the year, the financial performance of those entities is included only for the period of the year that they were controlled. A list of controlled entities is contained in Note 20 to the financial statements.

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

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

Note 1 Statement of Significant Accounting Policies (continued)

(b) Functional and presentation currency

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

(c) Use of estimates and judgements

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

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

Key estimates and judgements

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

(d) Revenue recognition

Revenue is recognised for the major business activities using the methods outlined below.

Membership subscription

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

Database, Data sales and Editorial

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

Commercial and member services

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

Note 1 Statement of Significant Accounting Policies (continued)

(d) Revenue recognition (continued)

Doctors Health Services

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

Rental income

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

Interest income

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

Dividend income

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

(e) Finance income and expense

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

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

(f) Tax consolidation

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

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

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

Note 1 Statement of Significant Accounting Policies (continued)

(g) Goods and services tax

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

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

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

(h) Non-derivative financial instruments

The Group initially recognises loans, receivables and deposits on the date that they 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.

Held-to-maturity investments

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

Note 1 Statement of Significant Accounting Policies (continued)

(h) Non-derivative financial instruments (continued)

Financial liabilities

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

(i) Cash and cash equivalents

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

(j) Trade and other receivables

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

(k) Trade and other payables

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

(l) 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.

Note 1 Statement of Significant Accounting Policies (continued)

(n) Property, plant and equipment

Recognition and measurement

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

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

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

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

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:

	2016	2015
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:

	2016	2015
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:

	2016	2015
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.

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

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

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

Note 1 Statement of Significant Accounting Policies (continued)

(r) Impairment (continued)

Financial assets (continued)

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

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

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

(s) Employee Benefits

Short-term benefits

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

Other long-term employee benefits

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

(t) Grants

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

(u) Parent entity financial information

The financial information for the Parent Entity, as disclosed in Note 26 has been prepared on the same basis as the consolidated financial statements, except as set out below.

Investments in controlled entities

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

Note 1 Statement of Significant Accounting Policies (continued)

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

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

Note 1 Statement of Significant Accounting Policies (continued)

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

Title	Key requirements	Effective date	Expected impact
AASB 15 Revenue from Contracts with Customers AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15 AASB 2016-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15 AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	The AASB has issued a new standard for the recognition of revenue. This will replace AASB 118 which covers contracts for goods and services and AASB 111 which covers construction contracts. The new standard is based on the principle that revenue is recognised when control of a good or service transfers to a customer – so the notion of control replaces the existing notion of risks and rewards.	1 January 2018	Not yet determined
AASB 16 Leases	AASB 16 will affect primarily the accounting by lessees and will result in the recognition of almost all leases on balance sheet. The standard removes the current distinction between operating and financing leases and requires recognition of an asset (the right to use the leased item) and a financial liability to pay rentals for virtually all lease contracts.	1 January 2019	Not yet determined
AASB 2016-1 Amendments to Australian Accounting Standards – Recognition of Deferred Tax Assets for Unrealised Losses	Amendments made to AASB 112 in February 2016 clarify the accounting for deferred tax where an asset is measured at fair value and that fair value is below the asset's tax base.	1 January 2017	Not yet determined
AASB 2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107	Entities will be required to explain changes in their liabilities arising from financing activities. This includes changes arising from cash flows (eg drawdowns and repayments of borrowings) and non-cash changes such as acquisitions, disposals, accretion of interest and unrealised exchange differences.	1 January 2017	Not yet determined

Note 2 Revenue and Expenses

	Note	Consolidated 2016 $'000	Consolidated 2015 $'000
Revenue			
Membership subscription		**12,091**	12,038
Database and data sales		**3,434**	3,404
Editorial		**665**	707
Commercial and member services		**2,525**	2,839
Doctors Health Services		**933**	–
Rental		**1,091**	1,115
Interest		**374**	88
Other income			
Dividend income	21	**1**	–
Other revenue including recoveries		**440**	502
		21,554	20,693
Expenses			
Contributions to employee superannuation plans		**904**	927
Cost of goods sold		**33**	38
Repairs and maintenance		**153**	286
Subsidies			
Subsidies to AMA States		**397**	316
Other subsidies		**96**	113
		493	429
Administration			
Finance costs		**5**	89
Loss on disposal of assets	21	**2**	–
Bad debt expense	21	**5**	12
Insurance		**168**	179
Consultants and contractors		**934**	594
Travel and accommodation		**420**	396
Other		**1,842**	2,073
		3,376	3,343

Note 3 Auditor's Remuneration

Audit services		
Auditors of the Group		
RSM Australia Partners		
–Audit of financial report	**58**	60
Other services		
Auditors of the Group		
RSM Australia Pty Ltd		
–Taxation services	**38**	61
–Consulting services	**7**	38
	103	159

Note 4 Income tax (expense)/credit

	Consolidated	
	2016	2015
	$'000	$'000
Current tax (expense)/credit		
Current year provision for income tax	**–**	–
Prior year adjustments	**(29)**	331
	(29)	331
Deferred tax credit/(expense)		
Origination and reversal of temporary differences	**458**	353
Prior year adjustments	**(3)**	74
	455	427
Total income tax credit/(expense) in income statement	**426**	758
Loss before income tax	**1,014**	408
Income tax using the domestic corporation tax rate of 30% (2015: 30%)	**304**	122
Increase in income tax expense due to:		
Mutual expenditure	**(4,080)**	(4,048)
Non-deductible expenses	**(13)**	(7)
Sundry	**(47)**	(45)
	(4,140)	(4,100)
Decrease in income tax expense due to:		
Mutual income	**4,267**	4,286
Fully franked dividends	**17**	–
Intercompany transactions	**–**	(1)
Sundry	**10**	46
	4,294	4,331
Net change in income tax	**458**	353
(Under)/over provision for prior year - current tax expense	**(29)**	331
(Under)/over provision for prior year - deferred tax expense	**(3)**	74
	(32)	405
Income tax credit/(expense)	**426**	758
Attributable to:		
Continuing operations	**426**	758

Note 5 Cash and Cash Equivalents

		Consolidated	
		2016	2015
		$'000	$'000
Cash at bank	17	**2,273**	4,035
Short-term deposits		**2,200**	4,750
Cash on hand		**2**	2
Total cash and cash equivalents		**4,475**	8,787

Classification of cash equivalents

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

Note 6 Trade and other receivables

Trade receivables		**720**	1,350
Provision for impairment		**(13)**	(11)
		707	1,339
Other receivables		**789**	671
Total trade and other receivables	17	**1,496**	2,010

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

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

(i) Classification as trade and other receivables

Trade receivables are amounts due from customers for goods solds or services performed in the ordinary course of business. Other receivables generally arise from transactions outside the usual operating activities of the Group. Collateral is not normally obtained. If collection of the amounts is expected in one year or less, they are classified as current assets. If not, they are presented as non-current assets. Trade receivables are generally due for settlement within 30 days and therefore are all classified as current. The Group's impairment and other accounting policies for trade and other receivables are outlined in notes 1(n) and 1(g) respectively.

(ii) Fair values of trade and other receivables

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

Note 6 Trade and other receivables (continued)

(iii) Impairment and risk exposure

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

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

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

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

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

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

Note 7 Inventories

	Consolidated	
	2016	2015
	$'000	$'000
Finished goods	**38**	34
Total Inventories	**38**	34

Note 8 Prepayments

Prepayments	**436**	475
Total Prepayments	**436**	475

Note 9 Other investments

	Consolidated	
	2016	2015
	$'000	$'000
Non-current assets		
Available for sale financial assets		
Managed securities fund	**3,782**	–
Shares in AMA Member Services Pty Ltd	**–**	–
Total other investments	**3,782**	–

(a) Held-to-maturity investments

(i) Cash and term deposits

The fair value of the cash and term deposit is $404,611 (2015: nil). Fair value was determined by reference to published price quotations in an active market.

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

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

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

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

(iii) Fair values of held-to-maturity

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

(iv) Impairment and risk exposure

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

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

Note 9 Other investments (continued)

(b) Available for sale financial assets

(i) Investments in related parties

Investment in AMA Member Services Pty Ltd was disposed in 2016 at nil value with a cost $1 and the company was wound up during the financial year.

(ii) Classification of financial assets as available for sale

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

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

(iii) Impairment indicators for available for sale financial assets

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

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

(iv) Fair value

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

Note 10 Intangible assets

	Consolidated	
	2016	2015
	$'000	$'000
Membership database–at cost	**733**	733
Less: Accumulated amortisation	**(726)**	(729)
	7	4
Website–at cost	**56**	56
Less: Accumulated amortisation	**(56)**	(46)
	–	10
Computer software–at cost	**283**	205
Less: Accumulated amortisation	**(190)**	(160)
	93	45
IT Project developments–at cost	**–**	41
Less: Accumulated amortisation	**–**	–
	–	41
Total Intangible assets	**100**	100

Note 10 Intangible assets (continued)

Movement in carrying amounts:

Consolidated	Membership database $'000	Website $'000	Computer software $'000	IT Projects $'000	Total $'000
31 December 2015					
Opening written down value	13	16	54	21	104
Additions	–	–	10	20	30
Disposals	–	–	–	–	–
Amortisation	(9)	(6)	(19)	–	(34)
Closing written down value	4	10	45	41	100
31 December 2016					
Opening written down value	**4**	**10**	**45**	**41**	**100**
Additions	**–**	**–**	**37**	**–**	**37**
Transfers	**–**	**–**	**41**	**(41)**	**–**
Reclassification	**6**	**(6)**	**–**	**–**	**–**
Amortisation	**(3)**	**(4)**	**(30)**	**–**	**(37)**
Closing written down value	**7**	**–**	**93**	**–**	**100**

Note 11 Investment properties

	Consolidated	
	2016	2015
	$'000	$'000
Units 1 and 2 Tourism House–at cost	**2,610**	2,610
Add: Net capitalised lease costs	**–**	7
Less: Accumulated depreciation	**(2,010)**	(1,906)
Total Investment properties	**600**	711

Movements in carrying amounts:

Consolidated		**Units 1 and 2 Tourism House $'000**	**Total $'000**
31 December 2015			
Opening written down value		824	824
Expensing of capitalised leased costs	21	(9)	(9)
Depreciation		(104)	(104)
Closing written down value		711	711
31 December 2016			
Opening written down value		**711**	711
Expensing of capitalised leased costs	21	**(7)**	(7)
Depreciation		**(104)**	(104)
Closing written down value		**600**	600

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

Note 12 Property, plant and equipment

	Consolidated	
	2016	2015
	$'000	$'000
Leasehold land, AMA House–at cost	**1,600**	1,600
Buildings, AMA House–at cost	**9,482**	9,449
Add: Net capitalised lease expenditure	**12**	123
Less: Accumulated depreciation	**(4,962)**	(4,725)
	4,532	4,847
Property, Parap Rd, Parap–at cost	**381**	381
Less: Accumulated depreciation	**(53)**	(44)
	328	337
Office furniture–at cost	**3,098**	2,873
Less: Accumulated depreciation	**(2,706)**	(2,631)
	392	242
Office equipment–at cost	**270**	266
Less: Accumulated depreciation	**(209)**	(180)
	61	86
Fixtures and fittings–at cost	**6,820**	6,423
Less: Accumulated depreciation	**(2,981)**	(2,682)
	3,839	3,741
Computer hardware–at cost	**466**	358
Less: Accumulated depreciation	**(320)**	(259)
	146	99
Assets less than $300–at cost	**67**	67
Less: Accumulated depreciation	**(67)**	(67)
	–	–
Personal computer network–at cost	**123**	120
Less: Accumulated depreciation	**(87)**	(116)
	36	4
Total Property, plant and equipment	**10,934**	10,956

Note 12 Property, plant and equipment (continued)

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). The valuation was prepared by Ms Sandra Howells AAPI, Certified Practising Valuer, of Egan National Valuers (ACT). 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.

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

Note 12 Property, plant and equipment (continued)

Movement in carrying amount:

Consolidated

	Opening written down value $'000	Additions $'000	Disposals $'000	Depreciation $'000	Capitalised lease costs $'000	Capitalised lease costs expensed (Note 21) $'000	Work in Progress $'000	Closing written down value $'000
31 December 2015								
Leasehold land, AMA House	1,600	–	–	–	–	–	–	1,600
Buildings, AMA House	4,961	–	–	(236)	143	(20)	–	4,848
Property, Parap Rd Parap	346	–	–	(9)	–	–	–	337
Office furniture	95	205	–	(59)	–	–	–	241
Office equipment	76	37	–	(26)	–	–	–	87
Fixture and fittings	2,683	1,288	(451)	(209)	–	–	429	3,740
Computer hardware	90	52	–	(43)	–	–	–	99
Assets < $300	–	–	–	–	–	–	–	–
Personal computer network	10	–	–	(6)	–	–	–	4
	9,861	1,582	(451)	(588)	143	(20)	429	10,956
31 December 2016								
Leasehold land, AMA House	**1,600**	**–**	**–**	**–**	**–**	**–**	**–**	**1,600**
Buildings, AMA House	**4,848**	**32**	**–**	**(237)**	**–**	**(111)**	**–**	**4,532**
Property, Parap Rd Parap	**337**	**–**	**–**	**(9)**	**–**	**–**	**–**	**328**
Office furniture	**242**	**225**	**–**	**(75)**	**–**	**–**	**–**	**392**
Office equipment	**87**	**8**	**(4)**	**(30)**	**–**	**–**	**–**	**61**
Fixture and fittings	**3,740**	**398**	**–**	**(299)**	**–**	**–**	**–**	**3,839**
Computer hardware	**99**	**109**	**–**	**(62)**	**–**	**–**	**–**	**146**
Assets < $300	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Personal computer network	**4**	**37**	**–**	**(5)**	**–**	**–**	**–**	**36**
	10,957	**809**	**(4)**	**(717)**	**–**	**(111)**	**–**	**10,934**

Note 13 Deferred tax assets and liabilities

Consolidated	Deferred Tax Assets		Deferred Tax Liabilities		Total	
	2016 $'000	2015 $'000	**2016 $'000**	2015 $'000	**2016 $'000**	2015 $'000
Property, plant and equipment	**431**	172	**–**	–	**431**	172
Accruals	**124**	91	**–**	–	**124**	91
Employee benefits	**134**	121	**–**	–	**134**	121
Other	**(19)**	3	**–**	–	**(19)**	–
Carried forward losses	**346**	174	**–**	–	**346**	174
Total Deferred tax assets/(liabilities)	**1,016**	561	**–**	–	**1,016**	561

Movement in temporary differences:

Consolidated	Property, plant and equipment $'000	Accruals $'000	Employee benefits $'000	Other $'000	Carried forward losses $'000	Total $'000
31 December 2015						
Opening written down value	(62)	42	154	–	–	134
Recognised in income statement	234	49	(33)	3	174	427
Closing written down value	172	91	121	3	174	561
31 December 2016						
Opening written down value	**172**	**91**	**121**	**3**	**174**	**561**
Recognised in income statement	**259**	**33**	**13**	**(22)**	**172**	**455**
Closing written down value	**431**	**124**	**134**	**(19)**	**346**	**1,016**

Note 14 Trade and other payables

	Note	Consolidated 2016 $'000	Consolidated 2015 $'000
Trade payables		**480**	478
Other payables and accruals		**1,063**	2,442
Income in advance		**891**	513
Total Trade and other payables	17	**2,434**	3,433

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

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

Note 15 Employee benefits

Current		
Long service leave provision	**481**	671
Annual leave provision	**684**	469
	1,165	1,140
Non-current		
Long service leave provision	**117**	63
Total Employee benefits	**1,282**	1,203

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

Note 16 Income tax receivable

Income tax receivable	**173**	924
Total Income tax receivable	**173**	924

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

Note 17 Financial Instruments and Risk Management

Risk management

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

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

(a) Credit risk

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

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

		Consolidated	
	Note	**2016 $'000**	2015 $'000
Financial assets			
Cash and cash equivalents	5	**4,475**	8,787
Trade and other receivables	6	**1,496**	2,010
Available for sale financial assets	9	**3,782**	–
		9,753	10,797

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

Past due but not impaired

As at the reporting date, trade receivables of $501,000 (2015: $812,000) were past due but not impaired. These relate to a number of independent customers for whom there is no recent history of default. The ageing analysis of these trade receivables is as follows:

Not due and not impaired	**995**	1,198
Past due and not impaired		
Up to 3 months	**338**	689
3 to 6 months	**150**	79
Over 6 months	**13**	44
	501	812
Total Trade and other receivables	**1,496**	2,010

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

Note 17 Financial Instruments and Risk Management (continued)

(b) Market risk

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

(i) Interest risk

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

		Consolidated	
	Note	**2016 $'000**	2015 $'000
Fixed rate instruments			
Held to maturity investments			
Short term deposits	5	**2,200**	4,750
		2,200	4,750
Variable rate instruments			
Financial assets			
Cash at bank	5	**2,273**	4,035
		2,273	4,035

Fair value sensitivity analysis for fixed rate instruments

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

Cash flow sensitivity analysis for variable rate instruments

Profit or loss is sensitive to higher or lower interest income from cash and cash equivalents as a result of changes in interest rates. The impact of 100 basis points in interest rates would have increased or decreased the Group's profit or loss by $45,000 (2015: $88,000). This analysis assumes that all other variables remain constant.

(ii) Currency risk

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

(iii) Equity risk

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

Note 17 Financial Instruments and Risk Management (continued)

(b) Market risk (continued)

(iv) Price risk

Financial assets	Note	Consolidated 2016 $'000	Consolidated 2015 $'000
Non-current assets			
Available for sale financial assets			
Managed fund–Australian securities		**2,474**	–
Managed fund–International securities		**1,308**	–
Shares in AMA Member Services Pty Ltd		**–**	–
	9, 17	**3,782**	–

Exposure

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

The investment in AMA Member Services Pty Ltd at a cost of $1 has been written-off to nil due to the company being wound up during the financial year.

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

Sensitivity

The impact of a 1% change in price, arising from the Group's available for sale financial assets, would have increased or decreased the Group's profit or loss by $38,000 (2015: nil). This analysis assumes that all other variables remain constant.

Note 17 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 $'000	Contractual cash flows $'000	6 months or less $'000	6–12 months $'000	1–2 years $'000	2–5 years $'000	More than 5 years $'000
Non-derivative financial liabilities								
31 December 2015								
Trade and other payables	14	3,433	(3,433)	(3,433)	–	–	–	–
		3,433	(3,433)	(3,433)	–	–	–	–
31 December 2016								
Trade and other payables	14	**2,434**	**(2,434)**	**(2,434)**	**–**	**–**	**–**	**–**
		2,434	**(2,434)**	**(2,434)**	**–**	**–**	**–**	**–**

(d) Fair values versus carrying amount

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

(e) Capital management

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

Note 18 Operating leases

Leases as lessee:

Non-cancellable operating lease rentals are payable as follows:

	Consolidated	
	2016 $'000	2015 $'000
Not later than 1 year	**11**	11
Later than 1 year but not later than 5 years	**21**	32
	32	43

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	**12**	381
Later than 1 year but not later than 5 years	**–**	–
	12	381
Other property		
Not later than 1 year	**406**	510
Later than 1 year but not later than 5 years	**1,362**	1,987
	1,768	2,497
Total		
Not later than 1 year	**418**	891
Later than 1 year but not later than 5 years	**1,362**	1,987
	1,780	2,878

The Group has entered into commercial property leases for 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 building lease for that property under a term of 5 years and nine months, ended on 30 September 2016. Commercial leasing of carparks continue into the foreseeable future.

Lease payments escalate each year by CPI. The future minimum rent receivable has been calculated on the assumption that CPI will average 2.5% each year. The lease does not contain any contingent rentals.

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

Note 18 Operating leases (continued)

The future minimum rent receivable has been calculated on the assumption that where applicable, CPI will average 2.5%. Fixed percentage escalations apply in accordance with existing lease contracts.

During the year ended 31 December 2016, $1,091,000 was recognised as rental income in the Statement of Comprehensive Income (2015: $1,115,000). Direct operating expenses recognised in the Statement of Comprehensive Income relating to property was $1,371,000 (2015: $1,229,000).

Note 19 Commitments

	Consolidated	
	2016 $'000	2015 $'000
Expenditure commitment:		
Not later than 1 year	**480**	678
Later than 1 year but not later than 5 years	**1,313**	2,697
	1,793	3,375
Commitments receivable		
Not later than 1 year	**46**	34
Later than 1 year but not later than 5 years	**23**	70
	69	104

Note 20 Controlled entities

	Consolidated	
	2016	2015
Parent entity		
Australian Medical Association Limited	**n/a**	n/a
Controlled entities		
Australasian Medical Publishing Company Proprietary Limited	**1**	1
AMA Pty Limited	**2**	2
AMA NT Pty Ltd	**1**	1
Actraint No. 110 Pty Limited	**2**	2
Doctors Health Services Pty Ltd	**1**	1
AMA Commercial Pty Ltd	**2**	2
	9	9

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

AMA Commercial Pty Ltd has ceased operations and is in the process of winding up, which is expected to be completed by early 2017.

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

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

Note 21 Reconciliation of Cash Flows from Operating Activities

	Note	Consolidated 2016 $'000	Consolidated 2015 $'000
(Loss)/Profit for the year		**(588)**	350
Less: Items classified as investing activities			
Dividends received	2	**(1)**	–
Receipts from investment		**–**	(24)
Add/(Less): Non-cash items			
Depreciation and amortisation		**858**	727
Loss on disposal of assets		**2**	–
Bad debt expense		**5**	12
Expensed of capitalised leased costs	11, 12	**118**	29
Net movement in provision for employee entitlements		**79**	(258)
		473	836
Changes in operating assets and liabilities:			
Decrease–Trade and other receivables		**553**	335
(Increase)/Decrease–Inventories		**(4)**	9
(Decrease)–Trade and other payables		**(1,003)**	(297)
Increase/(Decrease)–Provision for tax liabilities		**296**	(1,340)
Net cash flow from/(used in) operating activities		**315**	(457)

Note 22 Directors and Executive disclosure

Transactions with Directors and Key Management Personnel

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

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

Short-term employee benefits	**2,692**	2,501
Termination benefits	**374**	–
	3,066	2,501

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

Notes to and forming part of the financial statements

Note 23 Trust funds

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

	Consolidated	
	2016 $	2015 $
The Mervyn Archdall Medical Monograph Fund	**19,273**	23,194
The Federal Medical War Relief Fund	**5,546**	7,822
The Federal Independence Fund	**3,210**	4,776
The Indigenous Peoples' Medical Scholarship Trust Fund	**148,933**	157,647
The AMA Indigenous Medical Scholarship Foundation	**10**	–
	176,972	193,439

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

Note 24 Subsequent events

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

Note 25 Company details

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

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

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

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

Note 25 Company details (continued)

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

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

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

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

AMA Commercial Pty Ltd is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th Floor, 42 Macquarie Street, Barton ACT 2600. This company manages the commercial member benefits program and associated commercial contracts. This company is in the process of winding up, which is expected to be completed by early 2017, with its business operation and commercial contracts transferred to AMA Limited.

Note 26 Parent entity

As at, and throughout the financial year ended 31 December 2016, 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.

	2016 $'000	2015 $'000
(a) Financial information		
(Loss)/Profit for the year	**(901)**	3,585
Total comprehensive (loss)/income	**(901)**	3,585

The (loss)/profit for the year includes a dividend of $234,000 from AMA Commercial Pty Ltd (2015: $3,920,000 from the Australasian Medical Publishing Company Proprietary Limited).

Statement of financial position		
Assets		
Current assets	**6,505**	6,668
Non-current assets	**10,596**	10,512
Total assets	**17,101**	17,180
Liabilities		
Current liabilities	**1,611**	1,950
Non-current liabilities	**343**	15
Total liabilities	**1,954**	1,965
Equity		
Retained earnings	**15,147**	15,215
Total equity	**15,147**	15,215

Note 26 Parent entity (continued)

(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 27 Related party transactions

Parent entities

The wholly owned group consists of Australian Medical Association Limited and its controlled entities. These entities are Australasian Medical Publishing Company Proprietary Limited, AMA Pty Limited, AMA Commercial Pty Ltd, AMA NT Pty Limited, Actraint No 110 Pty Limited, AMA Property Trust and Doctors Health Services Pty Limited. AMA Commercial Pty Ltd is in the process of winding up, which is expected to be completed in early 2017.

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:

		Equity holding	
Name of entity	**Class of shares**	**2016 %**	2015 %
Australasian Medical Publishing Company Proprietary Limited	Ordinary	**100**	100
AMA Pty Limited	Ordinary	**100**	100
AMA NT Pty Ltd	Ordinary	**100**	100
Actraint No 110 Pty Ltd	Ordinary	**100**	100
Doctors Health Services Pty Ltd	Ordinary	**100**	100
AMA Commercial Pty Ltd	Ordinary	**100**	100

Directors' Declaration

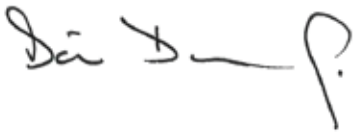
The Directors of the Company declare that:

1) the financial statements and notes, set out on pages 1 to 38 are in accordance with the Corporations Act 2001, and
   i) comply with Australian accounting standards; and
   ii) gives a true and fair view of the financial position as at 31 December 2016 and of the performance for the year ended on that date, of the Company and consolidated Group.

2) In the Directors' opinion there are reasonable grounds to believe that the Company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of Directors dated this 20th day of April 2017.

Dr Michael Gannon
Director
Australian Medical Association Limited



Dr Iain Dunlop
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

www.rsm.com.au

AUDITOR'S INDEPENDENCE DECLARATION

As lead auditor for the audit of the financial report of Australian Medical Association Limited and its Controlled Entities for the year ended 31 December 2016, 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
Chartered Accountants

GED STENHOUSE
Partner

Canberra, Australian Capital Territory
Dated: 27 April 2017

THE POWER OF BEING UNDERSTOOD
AUDIT | TAX | CONSULTING

RSM Australia Partners is a member of the RSM network and trades as RSM. RSM is the trading name used by the members of the RSM network. Each member of the RSM network is an independent accounting and consulting firm which practices in its own right. The RSM network is not itself a separate legal entity in any jurisdiction.

RSM Australia Partners ABN 36 965 185 036

Liability limited by a scheme approved under Professional Standards Legislation

RSM Australia Partners

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

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

www.rsm.com.au

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF

AUSTRALIAN MEDICAL ASSOCIATION LIMITED

Opinion

We have audited the financial report of Australian Medical Association Limited (the Company) and its subsidiaries (the Group), which comprises the consolidated statement of financial position as at 31 December 2016, the consolidated statement of comprehensive income, the consolidated statement of changes in equity and the consolidated statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies, and the directors' declaration.

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

(i) giving a true and fair view of the Group's financial position as at 31 December 2016 and of its financial performance for the year then ended; and

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

Basis for Opinion

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

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

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

THE POWER OF BEING UNDERSTOOD
AUDIT | TAX | CONSULTING

RSM Australia Partners is a member of the RSM network and trades as RSM. RSM is the trading name used by the members of the RSM network. Each member of the RSM network is an independent accounting and consulting firm which practices in its own right. The RSM network is not itself a separate legal entity in any jurisdiction.

RSM Australia Partners ABN 36 965 185 036

Liability limited by a scheme approved under Professional Standards Legislation

Other Information
The directors are responsible for the other information. The other information comprises the information included in the Group's annual report for the year ended 31 December 2016, but does not include the financial report and the auditor's report thereon.

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

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

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

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

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

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

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

RSM

RSM AUSTRALIA PARTNERS
Chartered Accountants

GED STENHOUSE
Partner

Canberra, Australian Capital Territory
Dated: 27 April 2017

AMA

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

www.ama.com.au