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THE NSW doctor

THE OFFICIAL PUBLICATION OF THE AUSTRALIAN MEDICAL ASSOCIATION OF NSW

AMA NEW SOUTH WALES

PAYROLL TAX: COURT DECISION THREATENS MEDICAL PRACTICES

HOW DO NSW PUBLIC HOSPITALS COMPARE?

COVID -19 AND THE ROLE OF OCCUPATIONAL HYGIENISTS

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Letter from the Editor

A US burns and critical care surgeon, Dr Callie Thompson, recently re-shared a photo on Twitter of herself heavily pregnant in scrubs. She wrote, "Yes, I did my job while being pregnant. Yes, I had my baby after finishing this case. It was safe for all because I know my body & I'm really good at my job."

She added, "I'm going to share this photo every dang year because the first year I did I got so much hate."

As an editor, I have the joy of looking through countless photo libraries to find images to illustrate our articles. If you type in 'pregnant doctor' into our stockshot photo library you get 325 pages of search results that feature pregnant patients with their doctor (who is holding a cheap stethoscope). Searching for 'doctor working while pregnant' reveals the same. I could not find one photo of a pregnant doctor on the job.

According to recent ABS statistics, almost three-quarters of women in Australia work during their pregnancy. Of those who had a job while pregnant, almost half worked 35 hours or more in their job prior to the birth of their child, and 23% were working 40 hours or more.

Working during pregnancy is normal, but we rarely see images of pregnant women working.

It's important to see these images, because we need to normalise pregnancy in medicine. Anecdotally, we know female doctors still get asked about their pregnancy plans during interviews for jobs as well as specialist training programs. The AMA has taken a zero-tolerance attitude to this discriminating behaviour. We are also on the cusp of launching our parental leave campaign. This campaign is also about normalising behaviour – in particular, the ability for one's partner to take paid parental leave. It's a future worth picturing. dr.

Andrea Cornish,
Editor

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CLEARING THE JUNK DRAWER

DR DANIELLE MCMULLEN
PRESIDENT, AMA (NSW)

We have a public and private system that is delicately balanced. And while everything may seem ok on the surface, if we don't take care of funding issues now things will get very messy, very quickly.

EVERYONE HAS that drawer in their house. You know, the drawer that serves as refuge for the wayward rubber bands, Allen keys from your last Ikea project, and batteries that may or may not be dead.

The best thing about that drawer is closing it. Once it's closed, you don't have to deal with that stuff anymore. It can sit there in junk drawer purgatory pretty much until you move house again. And, as a bonus, once the drawer is shut, the kitchen looks clean and organised.

Healthcare's junk drawer

On the surface, we have a world-class system. For more than two decades, Australia has enjoyed strong public and private health systems. We have a guarantee of excellent quality care when we need it most in our public hospitals, and our private system offers choice and often speed. Without the private system, our public one would crumble under the pressure. The balance between public and private is essential to the world-class system we know.

This delicate balance, however, is on a knife's edge. It is under threat by poor uptake of health insurance by young people. Even before COVID-19 impacted the livelihoods of so many Australians, private health membership numbers started to nosedive.

This is particularly frightening given the already over-stretched public health system.

Our public hospitals – particularly in NSW – are at peak capacity.

COVID-19 galvanised the health system to work collaboratively. For a while there was a common goal. From the top down and the bottom up, everyone's sole focus was just on getting through the worldwide pandemic in one piece.

We put the system's problems in a drawer, and we closed it.

But now that we're eight months and two waves into this, it's time to open up some of the longstanding issues again and come up with a plan to deal with them.

Since the last edition of *The NSW Doctor* magazine, the AMA has released two significant reports: the Prescription for Private Health and the AMA Public Hospital Report Card 2020.

These reports warn Governments of the dual threats facing the system – a private health insurance system that is under real stress and a public hospital system at breaking point.

Inadequate funding levels for public hospitals needs to be addressed. We also need to make private health insurance attractive, affordable and valuable to more Australians, especially young Australians.

The AMA has developed a blueprint for reform and is advocating for urgent changes to ensure the delivery of high-quality healthcare continues to be met.

If we don't act now, the junk drawer will overflow and the mess will be there for all to see. The Spring cleaning is overdue. dr.

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GETTING BACK TO OTHER BUSINESS

FIONA DAVIES
CEO, AMA (NSW)

NSW's success at keeping COVID relatively contained has meant we can get back to other issues that matter to members.

LIKE MANY of you are probably experiencing, the tide of COVID-related meetings and advocacy is slowing receding. What were once daily catch ups have now slowly disappeared from the diary and, as a result, non-COVID-related topics are coming back on the agenda.

Hospital Health Check

Recently, we met with LHD Chief Executives to discuss the 2020 Hospital Health Check (HHC) results. We congratulated Wagga Wagga and Hornsby Hospital for once again topping the HHC – Wagga having done so for the fourth year in a row.

These hospitals reflect a whole-of-hospital approach to supporting not only doctors-in-training but senior doctors. We have been particularly pleased to see improvements in the claiming of overtime and positive feedback from hospitals using the online claiming app. And while results have improved this year, there are remaining issues around access to leave – particularly study leave.

Serious adverse events

We have also been working with the Ministry on the review of the serious adverse events policy – previously known as root cause analysis.
As I write this column, there has been media coverage of an event in which, unfortunately, doctors were named. This is contrary to the ethos and intention of the serious adverse event review.

Recent legislative and policy changes have been developed to provide more immediate information to hospitals and families. However, information provided to families should appropriately balance the needs of closure and the important process of reflection and review associated with a proper serious adverse events process.

All participants in a serious adverse events review process need to be confident that their feedback will be respected and will contribute to a genuine, no blame, system improvement process. Where this does not occur, or confidence in such a process is undermined, the process will not be successful.

iCare – in name only?

We have also responded to a significant number of submissions, including many initiated by SIRA. While we value our strong relationship with SIRA, we have been very concerned by iCare's decision to leak information out of context in a clear attempt to impugn the integrity of doctors. Our message to all stakeholders in the workers compensation system is that you must engage with doctors and treat them with respect if they are to provide the best input to supporting injured workers. Doctors are the most critical point of contact for an injured worker. If the system is to succeed, then it is imperative iCare lives up to its name. dr.

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Delicate operation

BALANCING PUBLIC AND PRIVATE HEALTHCARE

Declining take-up of private health insurance by young Australians and greater representation of older people threatens to disrupt the delicate balance between public and private health.

IT'S TIME to stop the death spiral of private health insurance. The AMA released its prescription for private health reform to provide policy solutions for Government to 'stem the tide' of insurance decline.

The AMA's Prescription for Private Health Insurance reveals a trend in declining membership among young people and the impact that decrease has on the wider system.

The report finds that the take up of private health insurance has decreased for 20 quarters (or five years). The biggest drop in membership is among younger Australians.

Between December 2015 and December 2019, the number of hospital-insured young people aged 20-54 years dropped

by 4.9%, while the number of hospital-insured people aged 65 years or older rose by 14%.

This has resulted in a greater representation of older Australians in the insurance pool, who make greater claims, which in turn pushes up premiums.

As premiums rise and affordability decreases, more Australians are priced out – including younger Australians and families.

Our healthcare system depends on its balance between public and private health.

Australia has buttressed diminishing capacity in the public hospital system by providing patients with treatment options in private hospitals. The private health system delivers nearly 60% of the elective surgery. Underpinning this balance is government subsidised private health insurance.

The decline in private health insurance threatens to destabilise this balance at a time when public hospitals are already being pushed to the brink of their ability to cope.

COVID-19 and its effect on wages and the economy threatens to exacerbate affordability issues. In April, 2.7 million people either lost their jobs or lost hours of work. The Australian Bureau of Statistics reported the official unemployment rate for May had increased to 7.1%, while the underemployment rate for May was 13.1%. Reduced employment and wages will likely force many Australians to limit outgoing costs, including private health insurance.

The AMA's analysis suggests existing policy settings are no longer fit for purpose, partly due to premium cost changes, lower wages (compared to older generations), and Medicare and health fund rebates that lag behind the cost of service provision.

Despite the current predicament, the AMA suggests there are several levers Government could pull to reverse the backslide of private health insurance.

As it states in the AMA Prescription for Private Health Insurance, "To stem the exodus of policy holders, we need to increase the value and decrease the pressure on premiums, at the same time."

The AMA recommends changes to the premium rebate, lifetime health cover loadings, Medicare surcharge levy, and discounts to young Australians and those on lower incomes, while also incentivising people to maintain their membership in the longer term.

In addition, the AMA recommends redesigning policies to ensure a minimum level of benefits are provided to improve transparency and provide value. dr.

AMA'S CALL FOR ACTION

PREMIUM REBATE RESTORED

Restore the private health insurance rebate for targeted groups to make private health hospital insurance affordable for younger Australians and those in the workplace on lower incomes.

MEDICARE SURCHARGE LEVY

The Government should reconsider the MLS levels and thresholds, in order to determine what settings are required to deliver on the policy intent, in a coordinated way with all future reforms.

MINIMUM PAYOUT

A minimum amount returned to the health consumer for every premium dollar paid. There needs to be a standardised return that is higher than the current private health insurance industry average right now.

LIFETIME HEALTH COVER LOADING

Review of the Lifetime Health Cover loading and penalties – especially the starting age to make it an easy choice for Australians to stay in private health insurance for life. Review the way in which penalties ramp up for late entrants who join later in life and pay premiums just before they are most likely to claim.

YOUTH DISCOUNTS

Government youth discounts need to be enhanced and promoted. They also need to be aligned with our recommended change to Lifetime Health Cover loadings and premium rebate increases for targeted sections of the community.

TRANSPARENCY AND OUT OF POCKET COSTS

There needs to be a higher standard of transparency applied to health insurer policy documentation to clarify insurer policy benefit entitlements. Under policy fine print, benefit entitlements change according to the patient's choice of doctor(s), choice of treating hospital, timing of treatment and insurer hospital/doctor contracting strategies. Private health insurance benefit variability generated by these factors is not addressed by Gold, Silver, Bronze and Basic.
The AMA considers transparency essential to restoring consumer confidence in private health insurance.

REGULATION OF PRIVATE HEALTH INSURERS

The AMA calls for the establishment of an independent, well resourced, statutory body to regulate the legal conduct of the private health insurance industry. Although we have a well-resourced Ombudsman, a greater level of oversight will help instil confidence in the system, especially during periods of policy change.

**Source: The AMA Prescription for Private Health Insurance*

Overseas model shown.

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EXPERIENCE AMAZING

The AMA's Public Hospital Report Card reveals a public hospital system that is struggling to cope with record demand. The message is clear: change is needed.

DELAYS TO treatment, bed shortages, and lengthy waiting lists for elective surgery will come as no surprise to doctors.

In our recent Senior Doctors' survey, AMA (NSW) members told us that some of the biggest hurdles they face include inadequate hospital funding, increasingly complex and demanding work environments, ED overcrowding, and a healthcare system that is "groaning under the weight of bureaucracy."

One doctor noted, "The operating waiting lists have become longer, and I cannot see any plan on how to help this. Patients have dropped insurance or are not using because of COVID. I see patients in my private rooms that then can get booked on one of the two public waiting lists I have. This means that the waiting lists will become even longer with less patients going private. What is the Government's provision for this and how to manage these patients?"

Using data published by the Australian Institute of Health and Welfare, the AMA Public Hospital Report Card substantiates these comments. It paints a clear picture of a system that is deteriorating.

The findings reveal access to public hospital treatment in many jurisdictions and public hospital waiting times are getting worse. Compared to 2017-18, no State or Territory improved public hospital performance in 2018-19 by one per cent or more for the four indicators examined.

ACROSS AUSTRALIA

Emergency Department Trends

The Report Card finds the number of emergency patients is increasing – in 2018-19 more than 8.3 million patients presented to public hospital emergency for treatment, an increase of 4.2% on the previous year.

Patients are more likely to need urgent treatment. Nine years ago, 43% of patients were in the resuscitation, emergency or urgent categories. By 2018-19, this proportion had risen to 53%.

In that same year, more than 3 million emergency patients required urgent treatment. While two-thirds were treated on time, more than a million of those patients waited longer than clinically recommended.

The Report also finds patients are more likely to need a subsequent admission. Between 2013-14 and 2018-19, the number of emergency patients who required a subsequent admission

increased by 5 per cent on average, each year. The increase is 1.73 times the rate of growth in total emergency presentations each year, and 3.5 times the rate of population growth.

It's particularly alarming that bed block on public hospital wards means patients least likely to leave an emergency department within 4 hours are the sickest.

In 2018-19 only half of all patients who needed resuscitation or emergency care, and 61 per cent of urgent patients, left emergency within four hours.

The Report notes, "delayed patient treatments risk the development of patient complications, poorer patient outcomes, longer admissions and higher costs for already tight public hospital budgets."

Bed numbers

Comparing the number of available beds to the size of the population is a good indicator of public hospital capacity. Unfortunately, this number is declining. Available hospital beds per 1,000 population in 2017-18 dropped to 2.51, lower than the 2.55 beds per 1,000 resident population the previous year (2016-17).

Australia's ageing population of baby boomers helps explain this trend, as the likelihood of requiring a hospital bed increases with age. Cohorts aged 65 years or more, used 40 per cent of all public hospital separations in 2017-18. Once admitted, this cohort remain hospitalised for 33 per cent longer than all other age cohorts. The report notes the public hospital services utilisation rate for this older cohort is also intensifying.

At the same time, the numbers reveal that in 2017-18, the ratio of public hospital beds for every 1,000 people aged 65 years and older declined for the 26th consecutive year to 16.0. One hospital bed per 1,000 population aged 65 years or more has been lost in just the last two years.

Elective surgery

Even before COVID 19, elective surgery waiting and treatment times have continued to blow out.

In 2018-19, the national median waiting time for public elective surgery was 41 days – the worst performance since 2001-02.

Overall, in 2018-19, more patients were added to the elective surgery wait list than were admitted for their surgery. At a national level, 80.5% of Category 2 elective surgery patients were admitted within 90 days, compared with 83.2% the year before.

As the report notes, the official elective surgery numbers are likely underbaked, as the data does not include how long patients wait for elective surgery from the time they are referred by their GP.

HOW DOES NSW COMPARE?

The performance data for NSW reveals a decrease or stagnation in performance across four of the five categories analysed in the report.

AIHW figures reveal an increase in emergency department presentations in the state of 2.6% from 2014-15 to 2018-19.

"Throughout each year, NSW hospitals are facing record or near-record demand and this pressure continues to build. We can no longer blame these increases on one-off surges due to "a bad flu season", says AMA (NSW) President, Dr Danielle McMullen.

In 2018-19, the percentage of Triage Category 3 (urgent) emergency department patients seen within the recommended time (<30minutes) dropped to 74% from 76% the previous year.

There was also a decline in 2018-19 in the percentage of emergency department visits completed in four hours or less.

In terms of waiting time for elective surgery, NSW patients are worse off than other patients around the country, with the median time climbing to 51 days.

"NSW has invested in hospital redevelopments; however, whilst we have bigger buildings and greater capacity, workforce shortages mean hospitals are not operating to their full potential. Our surgical waitlists are unacceptably long. We need a long-term solution to improve the capacity of our public hospital system to treat these patients," Dr McMullen said.

She adds that workforce levels have not kept pace with demands from a growing and ageing population that is presenting with increasingly complex, chronic conditions.

"These factors will continue to challenge NSW, as the population is expected to grow by 14 per cent across the next 10 years. Meanwhile, the 65-year-old demographic is predicted to grow by 33 per cent, to make up nearly one-fifth of the State's population by 2026. The NSW public hospital system is busting at the seams and needs strategic intervention to reduce presentations, reduce admissions, and optimise public hospital care to make sure we are treating our patients in the right place, at the right time."

The Report did find that there has been an increase in per person average annual growth in public hospital funding by government source of 1.08% from 2007-08 to 2018-18.

PUBLIC HOSPITAL FUNDING

The Report Card suggests the public hospital funding formula that has been extended to 2025 will not alleviate some of the current challenges the system faces in the previously discussed performance measures.

Under the current formula, the Commonwealth contributes 45% of the efficient growth in public hospital activity, capped at 6.5% per annum.

The AIHW reports State public hospital funding increased by 3.6% on average each year over the decade (2007-08 to 2017-18) while Commonwealth funding increased 3.9% each year over the same 10-year period.

As indicated in the report, most of

the Commonwealth growth funding reflects increased public hospital services volume.

In 2020-21, the Commonwealth share of public hospital funding will be indexed by just 2.1% – a rate that is too low to accommodate for growth in service volume.

The AMA is warning the Commonwealth that more funding is needed, particularly as public hospitals are struggling to meet higher costs due to COVID-19, a backlog of cancelled elective surgeries and an expected surge in demand for medical care from patients who delayed seeking treatment in 2020.

If this funding shortfall isn't addressed, the AMA suggests the current funding agreement between the Commonwealth and States will leave States in a precarious position at a time when they face increased costs.

To remedy the situation, the AMA is calling on the Government to:

1. Provide adequate funding to cover the predicted increase in demand for public hospital services;
2. Recognise the impact of COVID on state government budgets and the limits on their ability to fund growth in public hospital services;
3. Act immediately to address the ongoing fall in private health insurance rates in order to preserve the capacity of the public hospital system to provide care to those who need it most;
4. Support General Practice to deliver high quality primary and preventive care in order to prevent avoidable hospital admissions.

"The AMA will continue to advocate for changes to support high quality health care delivery in public hospitals, but the very clear message is that change is urgently needed to keep our public hospitals at a world standard as the impact of the COVID pandemic flows through the economy and our health system," stated Federal AMA President, Dr Omar Khorshid in the report.

Table: State and Territory performance 2018-19 compared to previous year. Latest public hospital per person funding data is for the year 2017-18.

State/ Territory	Improved access to emergency treatment – urgent category (within 30 mins) 2018-19	Improvement in proportion of patients leaving emergency within 4 hours 2018-19	Improvement in median wait time for elective surgery (all categories) 2018-19	Improvement in Elective Surgery Category 2* – patients seen on time 2018-19	Commonwealth public hospitals per person funding (constant prices) 2017-18 (latest data)	State public hospitals per person funding (constant prices) 2017-18 (latest data)
NSW	✘	✘	✘	static	✘	✓
VIC	✘	✘	✓	✓	static	✓
QLD	✓	✘	✘	static	✓	static
WA	✘	✘	✘	✘	✘	✓
SA	✘	✘	✓	static	✓	✓
TAS	static	✘	✘	✘	✘	static
ACT	✘	✘	✓	✓	✓	✘
NT	✓	✓	✘	✘	✓	✓

Source: Australian Institute of Health and Welfare (AIHW). Elective surgery waiting times 2017-18 to 2018-19: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Emergency department care 2017-18 to 2018-19: Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Health Expenditure Australia 2017-18, data visualisation.

*Treating patients within clinically recommended time – Category 2 (within 90 days)

or indicates a change of at least 1 per cent compared to 2017-18. Median wait time for elective surgery expressed in days.

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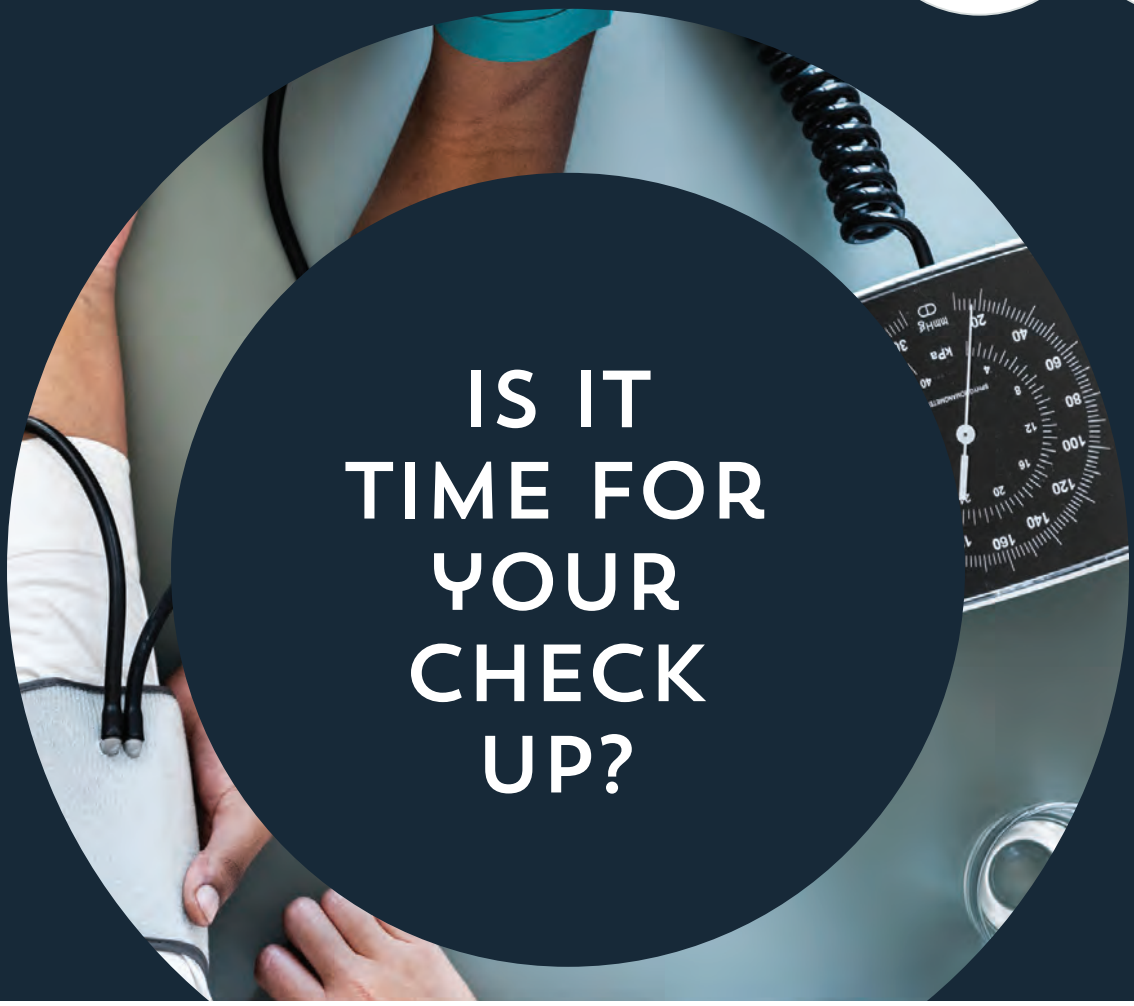

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PAYROLL TAX AND MEDICAL PRACTICES

Payroll tax threatens medical practices at a time when many are already struggling with the fallout from devastating bushfires and a global pandemic.

AMA (NSW) RECENTLY met with Revenue NSW to discuss the increase in payroll tax audits undertaken in relation to medical practices.

During discussions, Revenue NSW indicated that following the Optical Superstore decisions it will regard any 'payment' of money to medical practitioners by medical practices as being a relevant payment for the purposes of payroll tax.

While much has been written about the Optical Superstore decisions and what it means for medical practices, members are advised to seek accounting and legal advice about their arrangements given what Revenue NSW has indicated to AMA (NSW).

The Service Arrangement model described below had, until recently, been considered an arrangement which would not give rise to a potential liability under the Payroll Tax Act 2007.

Payroll Tax Act in NSW

Under the provisions of the Payroll Tax Act 2007 (NSW) payments made under relevant contracts may be considered wages for the purposes of payroll tax. A relevant contract is one under which a person:

- supplies to another person services for, or in relation to, the performance of work; or
- has supplied to him or her the services of persons for, or in relation

to, the performance of work.

The current payroll tax threshold is $1 million.

There are some exemptions, including where the services are provided for less than 180 days in a financial year.

The Optical Superstore Decisions

In Optical Superstore:

- All fees charged for the provision of optometric services by the optometrists were required to be paid to the trustee to be held in its bank account;
- For bulk-billed patients, the optometrists had to nominate the trustee as the recipient of Medicare payments;
- For privately-billed patients, the invoice was rendered by the optometrist, but payment was required to be made direct to the trustee;
- Consultation fees were paid into the trustee's main operating account;
- At the end of each month the optometrist submitted the number of hours worked in a store. A monthly payment was made to the optometrist (calculated by multiplying the number of hours worked by the applicable rates at the time) (the reimbursement amount);
- No invoice was raised by the optometrist for the reimbursement amount;
- In cases where the amount to be reimbursed was less than the payment due, Optical Superstore would make a payment to the optometrist to effectively make up the balance.

Service Arrangements and the decision in Optical Superstore

Arrangements whereby a medical practitioner who is conducting his or her own business, providing services to his or her own patients, and acquiring support services from the medical practice have been regarded to be arrangements that did not give rise to a potential payroll tax liability (the Service Arrangement). Under the Service Arrangement, the services provided by the medical practice to the medical practitioner include billing services. Commonly, medical practices collect fees on behalf of the practitioner, bank them in a practice bank account, and on a regular basis, following deduction of the applicable service fee, remit the balance to the medical practitioner.

It has been long understood that the remittance of fees by the medical practice to the medical practitioner under the Service Arrangement was not a payment for, or in relation to, the performance of work and further was not a payment subject to payroll tax because the money belongs to the medical practitioner and is being held by the medical practice on behalf of the medical practitioner.

The Victorian Court of Appeal in the Optical Superstore case found that the ordinary meaning of payment readily embraced a 'payment' of money to a person beneficially entitled to the money.

Optical Superstore did not appeal the finding made in the Victoria Supreme Court that the amounts paid or payable were for, or in relation to, the performance of work under a relevant contract.

Discussions with Revenue NSW

Based on our discussions with Revenue NSW, the position adopted by Revenue NSW is that amounts 'paid' to the medical practitioner under the above Service Arrangement may be subject to payroll tax unless one of the exceptions under the Act applies.

What do we suggest members do next?

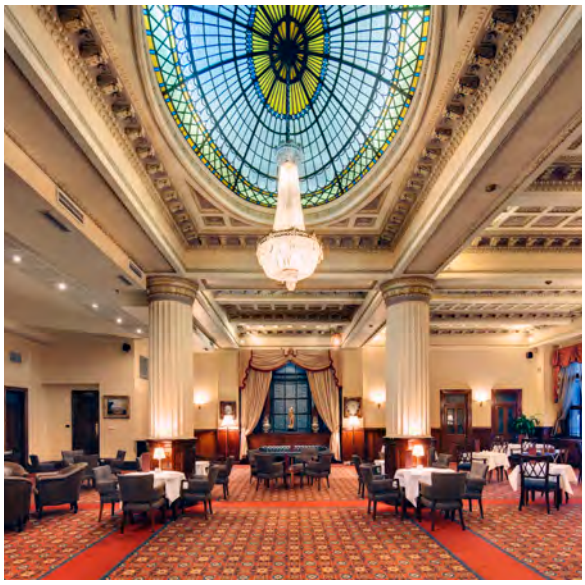
While there may be arguments that Optical Superstore is distinguishable from the Service Arrangements described above, such as the fact that the amount of the money to be returned and / or paid to the optometrists was calculated by reference to hours worked which is not the case under the Service Arrangement described above, given the position Revenue NSW has foreshadowed we believe it is prudent for members to seek advice about whether they should continue to bank fees into practice accounts and remit balances to medical practitioners working under Service Arrangements.

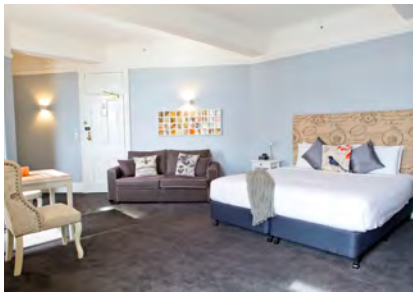
Members should speak with their accountant and seek review of their contracts. AMA (NSW) has arranged for members to access a one-hour consultation with HWL Ebsworth Lawyers to seek advice about their existing contracts and / or obtain an updated agreement for $500 inclusive of GST. If you wish to access this service, email workplace@amansw.com.au.

AMA (NSW) Advocacy

The recent bushfires and COVID-19 have had a significant impact on medical practices across NSW, particularly in rural and regional communities. These disasters, together with Revenue NSW's proposed change of approach in relation to payroll tax following the Optical Superstore decisions, threaten the ongoing viability of many medical practices.

AMA (NSW) raised these concerns with the NSW Health Minister and the Treasurer. We have asked the Treasurer to consider an exemption for medical practices under the Payroll Tax Act 2007 and / or a period of amnesty to allow medical practices to review and seek advice about their arrangements. dr.





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Making doctors' mental health a priority

Looking after doctors' health and wellbeing not only protects the medical workforce, it's conducive to good patient care.

GET ON WITH IT. POWER THROUGH. Suck it up. There is a pervasive attitude in medicine that doctors have a duty of care to patients only and not to colleagues or themselves.

This culture is not only a disservice to doctors, it actually has the opposite of the intended effect on patient care.

To better serve patients and themselves, doctors need to take a life lesson from the airplane industry – in case of a cabin pressure emergency, put your own mask on first before assisting others.

Medicine has always been stressful and demanding, but there's never been a more critical time to support doctors' mental health and wellbeing than during the global pandemic.

The time is right for a national commitment to prioritise the mental health and wellbeing of Australian doctors and medical students, says AMA President Dr Omar Khorshid.

Launched in October, The Every Doctor, Every Setting: A National Framework establishes a national commitment to prioritise doctors' mental health and wellbeing.

The Framework was developed by a national working group in consultation with doctors, doctors-in-training and medical students and incorporates a review of best practice evidence.

The purpose of the Framework is to guide coordinated action on the mental health of doctors and medical students through target areas, including these five pillars for coordinated action and key targets:

1. Primary prevention
Improve training and work environments to reduce risk.
2. Secondary prevention
Improve capacity to recognise and respond to those needing support.
3. Tertiary prevention
Improve the response to doctors and medical students impacted by mental ill-health and suicidal behaviour.
4. Mental health promotion
Improve the culture of the medical profession to enable wellbeing.
5. Leadership
Improve coordinated action and accountability.

Government bodies, organisations and services, as well as individuals are encouraged to support Every Doctor, Every Setting: A National Framework by implementing it in various ways.

Step 1: The first step for stakeholders is to sign up to the framework vision, guiding principles and pillars for coordinated action.

Step 2: Develop an action plan to improve doctors' mental health and wellbeing that is appropriate to the role of your organisation.

Step 3: Report annually on progress.

All stakeholders are encouraged to set up a leadership team that is accountable for the development and reporting of the plan. In addition, organisations should involve the medical profession in the process, map current activity and gaps, allocate resources for implementation and set up mechanisms to monitor and review the plan.

What will success look like? According to the Framework, it will result in improvements for the medical profession, the health system, as well as patients and carers. dr.

Find more complete **details on the Framework here**.

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Patient advocates

Integration between health and legal services can benefit patients facing socioeconomic adversity.

AS THE SOCIAL and economic impacts of the COVID-19 pandemic ripple across the country, doctors are seeing patients who are experiencing increasingly complex circumstances. Factors such as financial uncertainty, housing instability and family upheaval can interact with mental health issues to create multidimensional problems that extend beyond the expertise of health services. While much attention has been focused on how these problems are being exacerbated by the pandemic, there has been less discussion about how services can respond.

One approach is for health services to include legal help in their teams. Known as health justice partnerships, these collaborations between health and legal services have become increasingly common across Australia and are a response to the way socioeconomic adversity and health can interact.

Take Sashi as an example. She was dealing with health issues but was also facing a range of other challenges. She was sleeping on friends' couches, had struggled to find secure employment after being made redundant twice and had accumulated significant debt. Fortunately, the Royal Melbourne Hospital where she was receiving treatment had a health justice partnership with Inner Melbourne Community Legal. The partnership's lawyers helped her to have most of the debts waived and to negotiate payment plans for the others. They also connected her to assistance by submitting a disability claim to her superannuation insurer. Dealing with these financial issues was a key step in helping Sashi regain a sense of control over her life. She said, "[Without this service] I would have just gotten into more and more debt…My mental health had a lot to do with it…the debts were impacting my ability to think straight and my ability to cope.

"Now I am actually able to breathe I can fully focus on my therapy… You have given me a new life… I can plan for my future."

Sashi's experience highlights the profound effect that help with practical problems can have on a patient's wellbeing and for some, on their ability to engage with healthcare. Many issues in areas such as credit, debt, fines, housing, social security, employment and family violence have legal elements and help from a lawyer can be invaluable in resolving them. Although legal problems are widespread, the reality is that many go unmanaged, leaving them to impact other areas of a person's life, such as their health, and opening the door to escalation. Even when people do seek help, often this is sought from a non-legal adviser, such as a doctor or social worker. For those facing mental health challenges, barriers to legal assistance can be compounded by factors such as: difficulty keeping appointments and following up on referrals; communication and behaviours that make it difficult to receive help; mistrust of lawyers or legal services and problems having a mental illness recognised.

Embedding legal help in healthcare settings helps connect patients with the help they need, when they need it. When legal practitioners are co-located with health practitioners, health and legal services can work closely together, building capability and effective referral processes. For health practitioners, the option of connecting patients to legal assistance provides an avenue to address some of the problems that affect wellbeing, but do not have medical solutions.

Thinking about mental health support in the wake of COVID-19 provides an opportunity to consider more holistic responses to intersecting life issues. Broadening the range of expertise in a healthcare team to include legal help supports patients to gain control of underlying stressors that can impact mental health. As we all find our way through unprecedented circumstances, new ways of working may help get us closer to the solutions we need. dr.

To read more about the intersection of health and legal assistance in a mental health context, go to Health Justice Australia's "Legal help as mental healthcare".

Contributed by Marie Nagy, Researcher, Health Justice Australia

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BEHIND THE SCENES


Jane Whitelaw

The role of occupational hygienists in the COVID-19 response has attracted attention recently, but there still seems to be some confusion or lack of awareness about what an occupational hygienist does and how their work protects healthcare workers. Contributor Jane Whitelaw explains…

OCCUPATIONAL HYGIENE is a science and engineering-based discipline of anticipating, recognizing, evaluating and controlling health hazards in the working environment, with the objective of protecting worker health and wellbeing and safeguarding the community at large. We protect and promote the health of workers, including healthcare workers.

Certified Occupational Hygienists (COH)® specialise in the assessment and control of workplace hazards including biological hazards such as viruses. We conduct risk assessments in collaboration with frontline workers and utilise the Hierarchy of Control to determine a range of controls to reduce worker exposure to dangerous hazards.

Unfortunately, respiratory protective equipment (RPE) is one of the most commonly adopted control measures to protect worker health. Why do I say unfortunately? Well, it is not controlling the hazard at the source, or even in the exposure pathway, it only controls the exposure to the worker when correctly selected, fitted and worn 100% of the time.

Occupational hygienists are involved in the selection, training, and recommendations for use of respiratory protection in the workplace and therefore uniquely placed to provide valuable information to policy makers, procurement agencies and end-users such as hospitals, clinics and aged care facilities.

Whilst surgical masks have been recommended extensively in national and state guidelines to protect healthcare workers, they don't have a 'protection factor' per se, as they are not respiratory protection. They are recommended to interrupt the chain of infection transmission for the general public in low risk settings where social distancing isn't possible and designed to protect other people from droplets and aerosols expelled by the wearer. Respiratory protection, such as a P2/N95 on the other hand, is designed to be tight fitting and protect the worker from airborne particles, whether aerosols or droplets. The Australian/New Zealand Standard 1715 (Table 4.1) states that suitable protection for a Risk Group 3 Micro-organism is respiratory protection of at least a P2 level.

Where respiratory protection is selected for use as a control measure to protect worker health, a Respiratory Protection Program becomes necessary. All the elements of this are contained in the Australian Standard, but broadly they include:

- roles and responsibilities
- appointment of a program administrator
- selection of respiratory protection equipment
- education and training
- issue of RPE
- fitting of RPE (fit testing)
- wearing of RPE (including fit checking)
- maintenance, record keeping, and program evaluation.

Most states provide Guidelines for Respiratory Protection Programs. Some of these are good examples, but you should refer to Australian/New Zealand Standard 1715 to really understand its application and apply it to your organisation and facility.

What are Occupational Hygienists doing to protect healthcare workers during the pandemic?

1. Many of us would have noticed an increase in demand for P2 respiratory protection driven by both the bushfires and more immediately for CoV-SARS-2. This has resulted in non-compliant respiratory protective equipment entering the supply chain, which has been highlighted by several bodies including SafeWork NSW and WorkSafe New Zealand. "A Guide to Buying P2, or Equivalent, Respiratory Protection for use in the Australian & New Zealand Work Environment" is targeted towards those who buy disposable respiratory protection and will help them make sure that it meets suitable standards. Over 500 products have been withdrawn from the Therapeutic Goods Administration since that guide was published.
2. To support the current high demand for experienced fit-testers for healthcare workers; and promote the value of the Occupational Hygiene profession to provide solutions-based focus, the Australian Institute of Occupational Hygienists launched the RESP-FIT program early. This website provides a list of persons who are experienced at performing respirator fit testing, provides a syllabus for an approved training provider and competencies for an accredited fit tester. It also has a comprehensive set of resources and FAQ's.
3. The AIOH and the Australian Society of Anaesthetists hosted a joint Webinar in late October with over 500 attendees.

We are continuing to work with the State Health Infection Control groups and other stakeholders on RPE and higher order controls for COVID-19. For specific questions on respiratory protection please feel free to contact respfit@aioh.org.au.

Contributed by Jane Whitelaw FAIOH, Certified Occupational Hygienist (COH)®, CIH®, The University of Wollongong
Jane is a Certified Occupational Hygienist, Certified Industrial Hygienist and Fellow of the AIOH.
She joined the University of Wollongong in 2009, where she is Academic Program Director for the Occupational Hygiene Program.
She is a Quantitative researcher whose primary area of research is in the evaluation of controls for prevention of occupational diseases with a particular focus on respiratory illnesses. She is Chair of the AIOH RESP-FIT Accreditation Committee and a member of SF10 Australian Standards Committee. A member of the DHHS Infection Prevention Working Group, she has actively developed and influenced guidelines on PPE and infection control. She is currently a PhD candidate at the University of Wollongong in the Faculty of Medicine. dr.

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Hospital 'wellbeing environments'

Liverpool Hospital has turned its walls into an art gallery in a bid to boost the mental health of frontline workers.

CLINICALLY proven to relieve stress, lower blood pressure, and elevate your mood, art has long been positively associated with good health.

Capitalising on this connection, Liverpool Hospital launched 'The Healing Hospital Arts Project – Creating Wellbeing Environments' to support the mental health of frontline healthcare workers.

"By bringing the visual arts into the Hospital, it has created an extraordinary environment and has transformed the experience of countless patients, visitors and staff," said Dallas Rae, Allied Health Director, Mental Health.

Miriam Cabello, Resident Health and Arts Consultant introduced the curatorial and educational model that connects art with health.

"Based on the success of the program to date, our vision is now to transform all hospitals in the South Western Sydney Local Health District into similar 'Wellbeing Environments'," Ms Cabello said. "Our aim is to be a leader in providing innovative art and healing programs that address mental health and wellbeing." dr.

Weight loss surgery cuts cancer risk

Up to 80% of pancreatic cancer patients present with either new-onset type 2 diabetes or impaired glucose tolerance at the time of diagnosis. Weight loss surgery is increasingly being looked at with interest in relation to these conditions.

NOVEMBER is not only pancreatic cancer awareness month – World Diabetes Day is recognised on 14 November. But there is a connection between the two conditions that goes beyond the calendar.

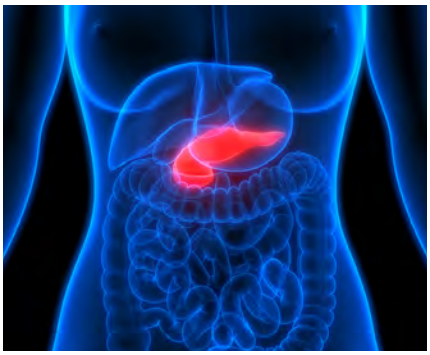
New findings suggest weight loss surgery significantly cuts the risk of developing pancreatic cancer in people who are obese with diabetes.

The study looked at more than 1.4 million patients with concurrent diabetes and obesity over a 20-year period. It found that the 10,620 patients who underwent bariatric surgery were significantly less likely to develop pancreatic cancer (prevalence of 0.32% vs 0.19%, $p<0.05$). Almost three quarters of patients that underwent surgery within the study were female.

Lead author Dr Aslam Syed said, "Obesity and diabetes are well-known risk factors for pancreatic cancer via chronic inflammation, excess hormones and growth factors released by body fat. Previously, bariatric surgery has been shown to improve high blood sugar levels in diabetic patients and our research shows that this surgery is a viable way in reducing the risk of pancreatic cancer in this growing, at-risk group."

There were 3,933 new pancreatic cancer cases diagnosed in 2020 in Australia. It has the highest mortality rate among all main cancer types. Over the last 40 years, the incidence of pancreatic cancer in Australia has increased from 9.6 in 100,000 to 11.6 in 100,000.

Weight loss surgery is also proving successful in reversing infertility, sleep apnoea and other comorbidities typically associated with Type 2 Diabetes, according to Strathfield Private Hospital bariatric surgeon Dr David Martin.



An analysis of Dr Martin's extensive prospective surgical database reveals Type 2 Diabetes was reversed in 90 per cent of patients who underwent a gastric bypass and 65 per cent of patients who had a sleeve gastrectomy.

With World Diabetes Day occuring on 14 November, Dr Martin said it was timely to raise awareness amongst the medical profession and patients alike that bariatric surgery is not solely about cosmetic results.

Strathfield Private Hospital Chief Executive Officer Rowann O'Mullane said there had been a 20 per cent annual increase in the number of bariatric surgeries in recent years at Strathfield with a 100 per cent rise in patients since the hospital first started providing the treatment. dr.

Advertorial

By Katherine Fasal
Financial Adviser

The changing face of personal risk insurances

The life insurance industry is facing major changes. What will it mean for you?

The life insurance industry is looking at a shake-up as pressure increases to create products that are sustainable for the long term. The Australian Prudential Regulation Authority (APRA), which regulates life insurers and friendly societies, has called for change. The overhaul of provisions aims to ensure the ongoing availability and sustainability of the life insurance industry in Australia and APRA have stated that it's not just Income Protection in its sights, stating life companies must also apply the underlying principles to other insurance products, where applicable.

The intervention was triggered by reported losses in relation to Income Protection products of up to $3 billion over a five-year period up until September 2019, which, as of the June quarter of 2020, was still showing losses of $179 million (as a total net loss after tax on individual protection products).

The first round of significant changes was seen effective from 31 March 2020, where individual disability income insurance contracts were modified to remove the ability to have an 'Agreed Value & Endorsed Agreed Value Contract'.

On 30 September, APRA confirmed that further changes to Income Protection policies are expected to come into effect from 1 October 2021. The major changes are:

- Policyholders with a predominantly stable income should have their income assessment based on "annual earnings at the time of the claim event not older than 12 months". For variable incomes, it should be an "average annual earnings over a period of time appropriate for the occupation of the policyholder and reflective of future earnings lost as a result of the disability."
- "Insurance benefits…do not exceed 90% of earnings at time of claim for the first six months of the claim and do not exceed 70% of earnings thereafter".
- The indexation of benefit payments to the claimant throughout the claim should "be limited to a suitable inflation index".
- "The policy contract is for a term not exceeding five years. The policy contract may allow the policyholder the right to enter into new policy contracts upon the expiry of the existing contract for further periods (not exceeding five years), without a medical review, on the terms and conditions applicable to new contracts then on offer by the life company. Changes to the policyholder's occupation, financial circumstances and dangerous pastimes should be updated on renewal and reflected in the new policy terms and conditions".

In addition, APRA expect that insurers "have effective controls in place to manage the risks associated with long benefit periods".

The insurers have a strict mandate to ensure the sustainability of life insurance products which will likely lead to further reduction in benefits and modification of available contracts going forward. A valid question might be, is it worth having life insurances, especially Income Protection considering the above? The answer is predominantly yes! Having the right type of cover, the correct levels and the best suited contract(s) for your needs is still critical to ensure that you can protect everything that you work for and to ensure that you and/or your family are looked after should an unwelcome event occur.

The above is supported by recent statistics published by APRA which show that insurance claims do get paid (with an admittance rate across all types of cover and distribution channels being 94% over a rolling period of 12 months up to 30 June 2020). Plus, statistics also indicate that, in general, having an individual advised contract had higher acceptance rates compared to those that were individual non advised. In practical terms, that meant that it allowed more policy holders to access critical financial support at a time when they needed it most.

In conclusion, now is a great time to complete a 'health check' on your insurances to ensure that you are best placed to face the upcoming changes are on the horizon for personal life insurance policies.

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News

Hand sanitiser confusion

ONE HAND sanitiser company found itself in a sticky situation when CHOICE unveiled the product failed a lab test, following consumer complaints.

The test found AIR Clean Instant Hand Sanitizer sold by Mosaic Brands had an alcohol content of 23% – well below the amount required to be effective.

The test sparked CHOICE to call on the Australian Government to improve regulation and monitoring of hand sanitiser products.

Further research by CHOICE has revealed 68% of Australians 'don't know' or are wrong about which sanitisers are effective against COVID-19.

In addition, 74% of Australians trust sanitisers sold in supermarkets and chemists are effective against COVID-19.

CHOICE found almost half of the 30 supermarket sanitiser labels it looked at lacked key information such as the percentage of alcohol in products.

Hand sanitiser must contain between 60%-80% alcohol (depending in type) to be effective. dr.

UK'S NHS COMMITS TO EMISSIONS TARGET

BRITAIN'S largest employer, the National Health Service (NHS) has become the world's first health system to commit to a net zero target.

Climate councillor and public health physician, Dr Kate Charlesworth welcomed the announcement and suggested Australia needs to follow the UK's lead.

"The Australian health sector is a significant contributor to our national carbon emissions. We need to see the same leadership from our healthcare system," Dr Charlesworth said.

"Right now, coming out of the Coronavirus pandemic, we have an incredible opportunity to act on climate change and invest in a cleaner, healthier, and more prosperous future . dr.

Survey: digital mental health program

THE BLACK DOG Institute is looking for health professionals to participate in a new survey about online mental health programs.

Participants will be asked about their views, as well as what features and functionality they might need and expect. The research will help ensure future apps and development of services for people with anxiety and/or depression are more readily used within routine clinical care.

The survey takes approximately 20 minutes to complete and participants will go into a draw to win a $100 e-gift voucher. More information is available here. dr.

USING GP PRACTICE DATA TO IMPROVE HEALTH OUTCOMES

CAN YOU name the most common issues GPs see in their consultation rooms?

According to the third General Practice Insights Report, the most common issues include hypertension, low back pain, dyslipidaemia, depression and gastro-oesophageal reflux disease.

The report looks at around 2.9 million patients' de-identified data showing common chronic health conditions in 2018-19 and aspects of the clinical management the patients received.

It examines MedicineInsight data general practices and provides vignettes that show how the data can be used to support quality improvements in clinical practice and health service planning. dr.

AMA Fees List available

THE FEES List 1 November 2020 indexed preview files are now available for access and/or download into members' business or practice software.

The indexed fees came into effect on 1 November 2020 and are available on the AMA Fees List website. This replaces the 1 November 2019 edition and subsequent updates.

The 2020 edition includes annual fees indexation and MBS changes up to, and including, 1 August 2020. dr.

Target: 90% survival rate for all cancer patients by 2030

THE NATIONAL Oncology Alliance (NOA) is calling on Governments and the community to support an Australian Cancer Futures Framework that seeks to achieve a greater than 90% survival rate across all cancer types and subtypes by 2030.

"Our understanding of cancer and how to treat it is changing at an astonishing rate. There is real hope that over the next decade cancer will transform from a death sentence to a chronic disease that allows patients to live long productive lives," said Mr Richard Vines, Chief Executive of Rare Cancers Australia and Founder of the Alliance.

The NOA' Vision 20-30 report, which was launched in early November, was developed in consultation with more than 50 Australian experts and 500 members of the cancer community. It provides a national direction on how cancer care will evolve over the next 10 years for all cancer patients – regardless of cancer type, patient geography or financial situation. dr.

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The Devastating Cost of Downtime
Revenue, Patients & Reputation

The cost of a few hours of downtime, never mind days or weeks, can be devastating for a clinic. When a clinic is down, clinicians cannot access critical clinical information to assist their patients. This is also true for day surgeries and major hospitals. When the IT system is down, operations stop, theatre rooms close and all procedures are re-scheduled. The lost revenue adds up quickly and the thought of a potential data breach (or data loss) can be incredibly stressful.

There was a time when taking days or weeks to recover didn't have the lasting impact it does now. Basic backups that required physical transportation were reliable enough for the time. But in 2020, healthcare businesses can't wait weeks or even days to get moving again. In today's world, downtime or data loss is no longer acceptable.

A healthcare business (clinic, day surgery, hospital) would traditionally relate IT downtime with hardware failure. This is no longer the case, the vast majority of disastrous IT outages are due to data corruption, data breaches and data unavailability. It's not only about hardware failure anymore, it's about the failure to access clinical data and resources when needed.

Luckily enough, with the availability of good internet, low cost Business Continuity & Disaster Recovery (BCDR) solutions and a number of excellent vendors, healthcare business can address the concerns of downtime and the inability to access clinical data.

What is IT BCDR exactly?

Business Continuity & Disaster Recovery (BCDR) are a set of technology processes and techniques used to help organisations recover from a disaster and continue to routine business operations.

How Can I Calculate the Cost of An IT Outage (Downtime) For My Business?

There are many different ways to calculate the potential financial cost of an IT disaster to a healthcare clinic. One simple method is to multiply the number of clinical staff you have in your clinic by $1800 per day of downtime. More complex calculations include calculating the number of patient records impacted, size of data lost and using other metrics.

The true cost of an IT outage also translates to reputational damage or legal implications. Those are more difficult to quantify and are generally more expensive to resolve.

How Does BCDR Work?

From an IT aspect, BCDR aims to provide you with a redundant set of infrastructures with your complete data being available should your existing IT infrastructure fail.

Simply put, if you use a server which hosts your clinical data, user profiles and emails, then by using BCDR, you would have a replica server to use straight away, should your main server fail.

Obviously, it's a little more complicated than this, but the idea is that you have a redundant set of IT resources (servers, storage) ready and available should your own practice resources fail. This minimises downtime and massively reduces data loss.

Are Backups Enough?

For most healthcare businesses, unless they are using enterprise grade backup solutions then a simple backup is not enough. A simple backup supports the assumption that you have a copy of your data in a separate location. It does not validate whether you can or can't restore this data.

Enterprise backup solutions give the business a greater degree of confidence that the data they are backing up is restorable.

The issue with backups is that they only work when you need to recover data, if your server hardware fails, then a backup is useless until you repair the server. This could take days if not weeks.

Why Should I Spend More On BCDR?

We don't except clinicians and their staff to stay ahead of the technology curve all the time. For starters, many business owners aren't aware how BCDR differs from a traditional backup. It's hard to justify spending more for data protection than in previous years, particularly when they've never suffered any server data loss or outages.

For clinics that cannot afford to be offline for days or weeks without their IT system, or clinics which need the guarantee of a working secure data replication solution, only BCDR can meet those requirements.

Is BCDR More Focussed on Cyber Security or Backup?

Both. Nowadays, most Cyber-Crime comes in the form of ransomware attacks. Where the attacked encrypts your data (clinical, business, email) and then requests a huge amount of money (usually in bitcoin) as ransom to then decrypt the data.

There are no guarantees that your data will be decrypted after you've paid the ransom and furthermore, the ransom amount is usually very expensive.

The much more effective strategy is BCDR, this means that you don't need to pay any ransomware and there is a guarantee that your data is safe.

How Complex Is It to Setup A BCDR Solution?

The BCDR solution is usually provisioned and configured before it is setup in your clinic. It's then just a process of configuring your server(s) to backup and replicate to the cloud environment. This requires some technical assistance from your current IT provider and if you don't have one, we can assist.

What Are The Costs of A Standard BCDR Solution?

This all depends on the type of solution you are looking at using and how long you wish to keep your data backed up in the cloud? For example, a basic solution (backup only) which is not considered to be BCDR could cost up to $150 per month for a small clinic. On the other hand, a complete BCDR solution, with a local appliance (i.e. backup server) and unlimited cloud backups, could cost around $300 per month for a small to medium size clinic.

As your requirements grow (size of data, number of servers), then the costs will scale up accordingly.

If you wish to find out more about BCDR or the Exclusive AMA NSW member offer, please in touch with the team at REND Tech Associates via ama.nsw@rend.com.au

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Jessica Rankin
Manager, Medical Careers Service

"Having Jessica from the AMA Careers Service review my resume gave me confidence that my application was going to be competitive. Then following that with an interview preparation session online made me feel prepared to face interview panels."

Rene L, O&G Registrar

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Financial**Paracetamol**

November 2020

Cutcher&Neale
ACCOUNTING AND FINANCIAL SERVICES

Welcome to the November edition of Financial Paracetamol.

In this issue:

As always, if you have any questions relating to any of the articles in this edition, please don't hesitate to get in touch.

Jarrod Bramble
PARTNER

Top tips for starting in private practice. **The things you can't afford to get wrong!**

The transition from being an employee or contractor to establishing your own private practice is a significant step in any medical practitioner's career.

Whilst this decision and next step is exciting, it can also be challenging and at times overwhelming given the laundry list of things to consider before you even start.

We understand this dilemma and have compiled a list of our top tips and important decisions that you simply can't afford to get wrong from the start.

Structuring

Working out which structure best meets your needs is a key consideration when starting in private practice.

Not all structures are the same and its important you know the advantages and disadvantages of all the potential options.

The following table gives you a quick snapshot of the potential structure available and their features, remembering that there are several taxation and non-taxation implications that need to be considered when looking at the above, it is not just one size fits all approach:

ISSUE	SOLE TRADER	PARTNERSHIP	COMPANY	UNIT TRUST	TRUST
Complexity	Simple	Simple	Complex	Complex	Complex
Tax Rate (Max)	47%	47%	30% *	47% or Beneficiary Marginal Rate	
Who Controls	Individual	Partners	Director / Shareholder	Trustee / Unit Holder	Trustee / Appointor
Limited Liability	No	No – Joint & Several	Yes	Yes if Company Trustee	
Asset Protection	Low	Low	Medium	High	High
Costs	Low	Medium	High	High	High
Legislation	No Specific Act	Partnership Act	Corporations Act	Trustee Act	

**lower company tax rate is 27.5%*

continued on next page...

Agreements

Once you have decided on which structure will be most suitable for you and your speciality, another key consideration is ensuring you have the appropriate documentation and agreements to support it. If a service entity is part of your overall practice structure, correctly executed service agreements will be required.

A poorly constructed service agreement can lead to unanticipated costs for the practice.

If going into business with a third-party, additional agreements may also need to be considered.

Having the right agreements in place will go a long way to safeguard you and your practice.

Finance and Debt

Let's be honest, no one ever really wants to be in debt, but it is important to make sure its structured correctly.

Whether its purchasing rooms, fitting out the space or financing medical equipment, the structure of your finance is important to ensure its as tax efficient as possible and to also help manage cashflow commitments, especially in the early days.

Insurance

Insurance is very important for a medical practitioner and their practice. Not only does it reduce potential financial risk, but it also helps protect your biggest income producing asset, you.

Keep in mind some insurances are simply compulsory. Workers compensation insurance for employees for example is a compulsory insurance that is required across all industries and in all states.

Being in private practice is by no means an easy task however taking some time to consider the above steps at the start will help set you on the right path.

Purchasing a medical practice? **Get it right.**

Purchasing a medical practice is a big investment into your financial future.

Getting it right from the beginning can be crucial in not only limiting your risk but also reducing your future tax implications.

Which entity you purchase your medical practice in is pivotal and can sometimes be overlooked by medical professionals when considering how to purchase.

Understanding how you will be receiving income, and what potential liabilities you may be exposing yourself to needs to be understood when balancing the trade off between asset protection and tax minimisation.

While there is no one-size-fits-all solution when it comes to purchasing your practice premises, there are many factors to consider. So, let's look at the tax implications of some of the more common structures often considered.

Individual (Medical Practitioner)

Buying in an individual name can sound the most appealing; least expensive and complex to set up, ability to access the 50% Capital Gains Tax discount (50% reduction on all capital gains held for longer than 12 months) and access to the land tax threshold. However, this may not necessarily be the case.

Buying in the medical practitioners name offers no asset protection, meaning you are not protecting your assets from potential litigation. Despite holding insurances which may mitigate some of these risks to a certain degree, medical practitioners should err on the side of caution when looking at holding assets personally.

If an asset is held by the medical practitioner and there is a significant capital gain on the property it will be taxed in their name at generally a higher rate of tax.

However, if the small business CGT tax concessions apply, the practitioner may be eligible for tax concessions on the capital gain.

Company

A company is a good vehicle for protection as the medical practitioner is protected from liability up to a point. Personal assets are safe from creditors, provided directors duties are adhered to, which provides a layer of asset protection not afforded if holding the premises in their personal name.

A company is assessed for land tax purposes in the same way as an individual.

Companies do provide a capped rate of tax however do not have access to the 50% Capital Gains Tax discount which could prove to be costly if on the sale of the premises the company realises a significant capital gain.

A company may be eligible for tax concessions on the capital gain if the small business CGT tax concessions apply. However, additional basic conditions need to be satisfied first to access.

Discretionary Trust

Another option is a discretionary trust structure. Trusts generally offer an effective form of asset protection as beneficiaries do not own the assets, the trustee does.

Trusts provide flexibility in the way profits can be distributed. It allows consideration of beneficiaries' specific threshold to achieve a better tax result. Nevertheless, Trusts can't distribute losses, therefore they are trapped until there is income in the trust to be offset.

Most discretionary trusts are considered 'Special Trusts' for land tax purposes in NSW.

These types of trusts do not receive the land tax threshold which means additional land tax will most likely be due if your medical practice is held in this type of structure.

An alternate option to a discretionary trust may be the utilisation of a fixed or unit trust. Unlike discretionary trusts, fixed trusts are typically eligible for the land tax threshold.

A fixed trust primarily differs to a discretionary trust as the beneficiaries and their interests are identified in the trust deed according to the proportion of 'units' they hold, rather than the distribution at the trustee's discretion.

A trusts capital gain can be distributed to its beneficiaries in order to access the 50% Capital Gains Tax discount.

Again, like companies, if a trust can further satisfy the additional basic conditions, they may be eligible for tax concessions on the capital gain if the small business CGT tax concessions apply.

SMSF

A Self-Managed Super Fund (SMSF) can be a tax-effective vehicle for acquiring your medical practice premises. Under the right circumstances and executed correctly, this can be an efficient investment vehicle.

With a low tax rate of 15% (when in accumulation phase), or tax free (when in pension phase) a SMSF certainly provides a concessional tax environment.

A SMSF can also access a one third discount on any capital gain made on the sale of the medical practice if held for more than 12 months.

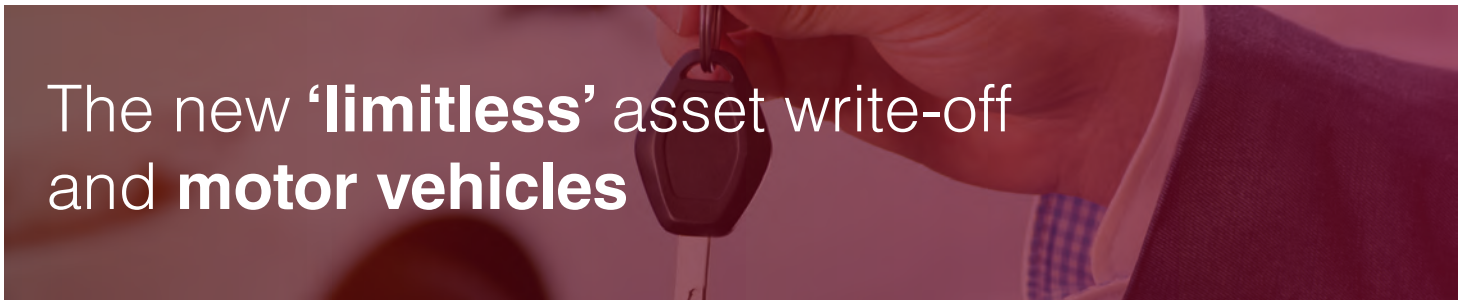
However, as the rules for purchasing property under the superannuation legislation are quite onerous, advice must be obtained before buying your premises in a SMSF.

In conclusion, strong considerations should be made before purchasing a medical practice.

It is critical to select the appropriate structure for your specific circumstances as well as understanding the income tax consequences and ability to provide asset protection prior to making any significant investment decisions.

For such an important life decision it pays to consult with an expert before you do make your decision.

If you are thinking about buying a medical practice, contact our office for a no-obligation discussion.



The new **'limitless'** asset write-off and **motor vehicles**

The Federal Government has recently announced its plans to further extend its instant asset write-off scheme for eligible businesses as part of the 2020 Federal Budget.

However, it's important to keep in mind that despite these changes, the car limit for motor vehicle purchases must still be applied. The car limit is the maximum depreciation expense you can claim for a motor vehicle.

The car limit is:

- **$57,581** for the 2019–20 income tax year.
- **$59,136** for the 2020–21 income tax year.

The instant asset write-off for a motor vehicle is limited to the business portion of the car limit for the relevant income tax year.

For example, the car limit is $59,136 for the 2020–21 income tax year. If a medical practitioner operating as a sole trader was to use their vehicle for 75% business purposes, they are able to claim 75% of $59,136, being $44,352 under the instant asset write-off provisions.

Importantly a log book must be maintained in order to determine the applicable deductible business use portion for not only the cost of the motor vehicle but also the ongoing associated running costs.

As the legislation currently stands as at the date of publication, eligible businesses looking to access the instant asset write-off must have used the vehicle, or had it delivered ready for use, between 12 March and 31 December 2020.

Federal budget summary
for medical professionals

The Federal Budget announcements on 6 October 2020 detailed many incentives with an overall focus on securing our future, growing our economy and getting people back to work, whilst not increasing income taxes.

The previous federal budget proposed to put in to a surplus, however the underlying cash deficit is now expected to be $213.7 billion for 2020/21. This is expected to improve over the next four years.

Some of the key highlights of the budget include the increasing of the instant asset write off concession to allow eligible businesses to write off the full cost of assets purchased from 6 October 2020 to 30 June 2022, the introduction of the JobMaker program and the bringing forward of previously legislated tax cuts.

We have put together a summary of federal budget highlights for Medical Professionals which can be found on our website or by scanning the following QR code.

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