AMA SUBMISSION
IN RESPONSE TO THE
TREASURY DISCUSSION PAPER
REFORM TO DEDUCTIONS FOR EDUCATION EXPENSES

Opening comments

The tax measure canvassed in the Discussion Paper is unequivocally bad news for patients and for the medical profession in Australia. Its deleterious impact will be across the whole economy but with particularly strong effects in medicine. It is a tax on learning that will reduce economic growth, productivity and Government revenue in the long run. It produces unresolvable inequities in its current form and in our view it should be withdrawn.

The decision represents the triumph of short-term expediency over longer-term thinking. The Government has lost sight of the longer term. Education provides an enduring benefit, not only to the individual, but also to society as well as a revenue benefit to the government. Short-term policy decisions create havoc with longer term strategic planning. Changing existing policy to fund new government policy is equally flawed unless a greater benefit can be achieved. The decision will produce lower economic growth in the long run, lower productivity and lower Government revenue.

In announcing its decision to impose a cap on the tax deductibility of work related self education expenses, the Government said it would “better target work related self-education expense deductions as part of a package of reforms to make a down-payment on the National Plan for School Improvement.”

It went on to say “the Government values the investments people make in their own skills and recognises the benefits of a tax deduction for work related self-education expenses. However, under current arrangements these deductions are unlimited and provide an opportunity for people to enjoy significant private benefits at taxpayers' expense.”

In the Budget delivered on 14 May 2013, the Government announced savings of $250 million per year in the 2015-16 and 2016-17 financial years.

The announcement on 13 April 2013 was the first affected groups knew about the measure. The medical profession had received no advice or indication from the Government that it was unhappy with the way work related self-education expenses were being claimed. The Government had made no previous attempt to alter the method of determining reasonable entitlements and we are not aware of any particular Australian Taxation Office (ATO) concerns in this regard.
In addition, the Government subsequently gave the AMA assurances that it was not its intention that its measure would impact on legitimate work related self-education expenses and that it would not impact on work related self-education provided by the employer.

The Minister’s press release stated that “this is a targeted reform and the majority of those with self-education expenses will not be affected by this change.”

Quoting the most recent ATO data it states “the typical claim for formal qualifications is less than half the proposed cap at $905. For other expenses, such as conferences, seminars and workshops, including those held locally, the typical claim is only a few hundred dollars, remaining well below the cap.”


Issues

No understanding of health

The Discussion Paper makes no attempt to analyse the impact of the measure on the various sectors in the economy. It certainly makes no attempt to analyse the impact on the provision of medical services. It makes no allowance for the fact that year on year improvements in health outcomes are based on a lifelong commitment to skills and knowledge improvement through compulsory and self-motivated learning experiences.

The death rate from heart attack in Australia has halved and maternal and perinatal death rates have fallen because doctors are committed to continuous improvement in their skills and knowledge in better managing these patients. Male cardiovascular death rates have declined from a peak of 1,020 per 100,000 population in the late 1960s to 232 per 100,000 now. Female rates have declined from 718 per 100,000 to 170 per 100,000 now. Much of the decline in CVD death rates can be attributed to improvements in the prevention, detection and management of CVD that has occurred in the past 60 years (AIHW Cardiovascular Disease Australian Facts 2011).

Between 1991 and 2000, the perinatal death rate fell from 10.6 to 8.3 per 1,000 total births. This represents a decrease of 25 per cent (AIHW).

At the beginning of the 20th century, life expectancy at birth in Australia was approximately 55 years for males and 59 years for females. At the beginning of the 21st century, life expectancy for males had increased to 79 years (4th in the world) and females to 84 years (3rd in the world), an improvement of 24 and 25 years respectively.

Australia has one of the highest quality health systems in the world at a reasonable cost as measured by health as a proportion of GDP. We provide a high number of high quality low cost services and Australians value their health system highly. Our life expectancy is one of the highest in the OECD countries. The health system is a product of its workforce and our improved health outcomes are a result of maintaining a highly motivated, committed and trained workforce. The Government’s decision attacks and erodes the very strength of the health system, its medical workforce in particular.
Although many of the relevant learning opportunities are available in Australia, for many specialists for example, they are only realistically available in Europe and the United States. A $2,000 cap would not cover registration fees in most cases let alone airfares, accommodation, travel on top of unpaid absence from work, continuing office expenses, locum relief, etc.

Many junior doctors are undergoing training into their mid to late 30s in order to provide the highest level of care to the Australian people. While they are training, they are not enjoying the salary levels they may later access and the expenses they face are a substantial slice of their net income. Placing a $2,000 cap produces unjust outcomes year after year for these trainees. The cumulative impact is huge.

Being a tax on learning, the measure will reduce the demand for education activities. In health, this is likely to have serious implications for the wider Australian community. If medical practitioners are not up to date on current medical developments, this can lead to misdiagnosis or in the most extreme situation, death.

In short, the paper shows no understanding of the particular impacts in medicine.

**Quantification and scope - what does the Government data say?**

In the opening statement of the Discussion Paper, the Government correctly states the equity principle behind the tax law. At point 1.1.1 on page 1 it states “Under Australian income tax law, a deduction is allowed for the costs incurred in producing income. This recognises that people with the same level of income may incur very different costs in earning that income.”

Having correctly stated the principle, the Discussion Paper goes on to completely trash it by proposing a crude $2,000 cap on tax deductibility of work related self-education expenses. This assumes any expenditure over the $2,000 limit relates to a private benefit to the taxpayer. In the case of medical self-education expenses, this is completely wrong.

It is very disappointing that a Discussion Paper produced by one of Australia’s premier economic policy bodies contains so little quantitative analysis. There is no quantitative basis to support the contention that there is significant private benefit for medical practitioners, or any other employment category for that matter. There is no quantitative basis in the Discussion Paper to clarify the different levels of private benefit between or within professions. There is no quantitative basis for analysing the different claiming patterns between professions or within professions. There is no quantitative basis for selecting the cut off at $2,000.

The examples provided are wholly fictional and entirely irrelevant. Given the usual Treasury approach to such issues we can either assume that providing real data would not support the approach adopted and would give ammunition to its opponents, or that the Government doesn’t have the data. The AMA suspects a bit of both.

Our understanding is that the Government only has detailed information in relation to taxpayers completing an individual taxpayers return and answering question D4. It has no specific information in relation to a breakdown of expenses under D5. Nor does it have information for those taxpayers who complete business returns and for whom it is not compulsory to disclose individual claim details. What information it does have would be
obtained through detailed audits but this would not permit the Government to construct rigorous quantitative scenarios.

In addition the full scope of the tax is not clearly defined. We were told it would not apply to employer provided work related self-education expenses but Clause 68 of the Discussion paper states that “this may result in the employers being liable for FBT on any education expenses over the cap of $2,000, incurred by them on behalf of their employees.”

Many of our members are under the impression that the cap will not apply to practitioners who operate through a company structure and claim their conference/seminar expenses through their company. Our own advice on this point is that there is no support for this idea in the Discussion Paper and companies will be subject to the cap on expenses. In terms of equity considerations, to allow the deductions to be fully deductible for incorporated bodies but not for individuals, would be to compound inequities.

We cannot comment on other professions, but for the medical profession a very large proportion of practitioners complete business - not individual returns given the nature of their work. We expect the majority will be lodging business returns. The savings from the imposition of a cap on these practitioners would have been very difficult to include in the estimation in the budget papers and we seek an explanation from Treasury as to how the savings were estimated.

AMA estimations

The AMA has conducted several polls and one survey amongst its members in the short time available to us since the decision was announced.

Our initial poll on 22 April 2013 asked members “will the cap on tax deductions for work-related self-education expenses impair your professional development as a doctor?” The AMA would expect to get a few hundred responses to such a survey question posted on the AMA website. Such a response would indicate to us there is considerable unhappiness over the subject matter of the survey. In this case, the AMA received 4,581 responses, 4,504 of which stated that the cap would impair their professional development as a doctor and 77 saying it would not. In addition, about 300 medical practitioners went on to provide extensive comments on the decision advising how the $2,000 cap would seriously disrupt their self-education activities.

A second simple poll asked AMA members to advise the amount spent on self-education per annum. There were 585 responses to this poll with 92 per cent of respondents indicating they spent in excess of $2,000 and 46 per cent indicating they spent in excess of $10,000.

The AMA conducted an online survey commencing on 20 June 2013. For this survey, all members were notified by email of the location of the survey on the AMA website. There were 4,200 responses with the results outlined below.

AMA survey of members

The first point to note is that 4,200 responses from the AMA membership represents a very strong response showing the degree to which the membership is concerned by the decision.
The survey was extensive and required doctors to consult their taxation records in order to respond. The fact that 4,200 took the trouble to do so is an important indicator in itself.

There are significant differences in the average level of work related self-education expenses by specialty. While all are well in excess of the $2,000 figure arbitrarily chosen by the government ($12,637 for Fellows, $11,369 for Vocational trainees and $6,549 Pre-vocational trainees), there are significant differences between the specialties. For example, the self-education costs of Surgery ($16,578) are 70 per cent higher than the costs of General Practice ($9,744).

There are significant differences by State and Territory. There is a 44 per cent difference in the average cost between the most expensive region (SA) and the least expensive (NT).

There is a 37 per cent difference in the average cost between the most expensive location (remote) and the least expensive location (rural). These results in relation to rural are expected as there are relatively few specialists located in these areas. The cost outcome reflects the higher proportion of GPs in the rural doctor populations. Remote areas are more expensive as expected largely because of the travel costs.

Doctors in Training (DITs) will be a very hard hit group. The average self-education cost for Vocational trainees is $11,369. These costs are almost exclusively associated with the achievement of the basic qualification to practice in their chosen specialty. In addition, they are not in receipt of high incomes during their training phase. As a proportion of total income, their costs are the highest of any group by a long shot and they will be particularly hard hit by the measure. This measure will have a perverse affect on career choice, encouraging junior doctors to practice in areas where they will get the greatest return rather than in areas where community need is greatest.

What this shows is that the imposition of an arbitrary cap on the tax deductibility of these expenses creates a range of inequities that cannot possibly be justified.

Our belief is that those practitioners who operate through a company structure would be wrongly feeling less threatened by the measure and would not have felt as compelled as other groups to responded to our survey. Nevertheless, 44 per cent of the respondents used a business return in part or in full in 2011-12. Our financial advisers have provided advice that “most doctors operate under a PSB structure. As such, these education expenses are disclosed in their business schedule and not at items D4 and D5 of the income tax return. There is no possible way the data samples (used by Treasury) are reflective of the real expenditure incurred.”

The figures disclosed in the Discussion paper are not accurate and the potential impact of the $2,000 cap is far reaching beyond what is disclosed in the Discussion Paper.

**Advice from Cutcher and Neale Accounting and Financial Services**

Cutcher and Neale has extensive experience in accounting and financial services for the medical profession. Their advice attached confirms that the level of expenditure on work related self-education expenses for medical professionals using their services is consistent with the findings of the AMA survey (page 5) and therefore quite inconsistent with the comments in the Discussion Paper.
The advice also confirms that the measure is broad ranging in its effect (pages 2-3), that the Discussion paper in their view is poorly drafted, and ‘contains inconsistencies regarding its application and the scope of the proposed measures’ (page 6).

**Case studies**

The Discussion Paper contained a number of case studies to show that $2,000 was in fact a reasonable cap point and that there were considerable private benefits for those case studies that exceeded the limit. It seems to us that the case studies in the Discussion Paper were fictional and no particular conclusion can be drawn from the examples used.

In contrast, the AMA has provided real examples of how the cap will affect practising medical practitioners in Australia in various specialties, locations and career progressions. These are outlined below.

**Case study 1**

Dr S B has been a General Practitioner in Cairns for twenty years.

To maintain the standard of service delivery to her community and her Vocational Registration (a requirement for MBS rebates), she needs to participate in self-education for professional development.

Cairns is a regional town. The Far North Queensland Rural Division of General Practice and the Medical Local are in a period of transition. Neither is in a position to provide extensive educational opportunities to General Practitioners.

To deliver good services to a regional community where there is not the full complement of specialists requires good skills, often more skills than in metropolitan or urban locations. General Practitioners in these areas are required to be a generalist. Simply accessing education on one subject alone would approach and often exceed the $2,000 cap that is being proposed by government.

In order to access appropriate education, she needs to travel to capital cities. Cairns has relatively good connections with three state capitals, the best serviced of all Queensland centres except Brisbane and the Gold Coast. Travel from all other regional centres e.g: Mount Isa will involve more time, travel, accommodation and transfers.

To attain the minimum required 130 CPD points, a General Practitioner must attend nine or ten educational events in one three year period, at a direct cost of **$5,000-10,000** per year. The loss in income for the participant is some $5,000 on top of the direct costs.

As an example:

The actual costs for an upcoming one day conference, The Annual Women and Children’s Health Update, on July 27\textsuperscript{th} in Brisbane to be incurred are:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration Fees</td>
<td>$200</td>
</tr>
<tr>
<td>Airfares</td>
<td>$660  (CNS-BNE-CNS)</td>
</tr>
<tr>
<td>Accommodation</td>
<td>$350  (2 nights in hotel/motel)</td>
</tr>
<tr>
<td>Transfers</td>
<td>$240  (Four taxi transfers)</td>
</tr>
<tr>
<td>Food</td>
<td>$150  (2 x B, 2 x D)</td>
</tr>
<tr>
<td><strong>Estimated total</strong></td>
<td><strong>$1,600</strong></td>
</tr>
<tr>
<td>Plus loss of Income (Fri pm &amp; Sat am sessions)</td>
<td>$1,600</td>
</tr>
</tbody>
</table>
This is a full one day conference with 18 speakers, all Brisbane based, earning the participant 16 CPD Category 2 points.

It is becoming increasingly difficult to remain motivated to practice in regional areas. The situation for her colleagues in more remote areas would be even more difficult. All of this is a disincentive and is making her consider ceasing general practice as a self employed contractor in a regional or remote area.

The purpose of self-education is to:
- Maintain professional standards;
- Maintain Vocational Registration, required by RACGP and Medicare;
- Provide patients with the latest, most evidence based therapies available; and
- Consult with colleagues to review current treatments and avoid adverse consequences.

The practice of medicine is not always honed by looking at webinar presentations or completing online learning modules in isolation. There is a great deal that can only be done by an apprenticeship alongside a mentoring practitioner. Often this must be done on a one to one basis.

GPs learn procedural skills from other colleagues who have already mastered those techniques.

Accredited conferences do not consist of morning and afternoon sightseeing, or any sightseeing. Scientific committees take responsibility for selecting and delivering worthwhile programmes. Partner packages during conferences have to be purchased. Pre and Post conference tours are optional, are at the participant’s own cost and are not tax deductible. All of these are easily identified and auditable.

The $2,000 cap for self-education expenses will have a detrimental effect on the quantity of medical practitioners choosing to work in private practice in regional and remote areas. It will fundamentally reduce the quality of their expertise as there will be no incentive for them to incur the costs of self-education.

### Case study 2

Dr C is an Obstetrics and Gynaecology (O&G) trainee. Dr C has to conduct his training through the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). In order to complete his training he has had to complete examinations and compulsory courses, although due to his diligence he has completed these training requirements and paid for them in past financial years. As a result Dr C’s compulsory self-education expenses for 2012-13 are limited to professional memberships:

<table>
<thead>
<tr>
<th>Membership</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>RANZCOG training fees</td>
<td>$2,350</td>
</tr>
<tr>
<td>Society of Obstetric medicine (SOMANZ)</td>
<td>$165</td>
</tr>
<tr>
<td>Medical indemnity</td>
<td>$110</td>
</tr>
</tbody>
</table>

However Dr C is keen to prepare himself so that he can deliver the best possible care to the women of Australia. As a result he has voluntarily attended a number of conferences.

<table>
<thead>
<tr>
<th>Conference</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>RANZCOG ASM</td>
<td>$1,340</td>
</tr>
<tr>
<td>FIGO World Congress of O&amp;G</td>
<td>Complementary</td>
</tr>
<tr>
<td>Travel and living expenses</td>
<td>$6,139</td>
</tr>
</tbody>
</table>

Under current arrangements, Dr C can claim the full $10,104 as education expenses. From 1 July 2014, Dr C can only claim, at most, $2,000 of his self education expenses.
Given that Dr C is a trainee, his salary is significantly less than that of a fully trained doctor. Given his age, he has significant other expenses including a recent mortgage and an impending wedding. The net result will be that Dr C can no longer afford to attend voluntary educational activities such as conferences. While Dr C will miss the stimulation and skills that these conference bring him, the women he cares for will miss Dr C delivering cutting edge, up-to-date health care driven by the most recent of evidence.

**Case study 3**

Dr K is a Surgical Registrar in Orthopaedics. His work related self-education expenses for training are high as Orthopaedics is one of the more expensive specialties with regard to training costs. Nevertheless the expenses listed below are representative of the costs of Orthopaedic training.

The training Dr K undertakes is mandatory if he is to achieve his specialist qualification and absolutely necessary to obtain a Fellowship in Surgery, and to practice competently and safely in that field. In most cases, doctors undertaking Orthopaedic training would complete sub specialist training and may still be training until their mid to late 30s. During this time they are for the most part on public sector salaries and the total cost of training represents a very large slice of their income.

The costs outlined below are the real costs incurred in one year in the course of obtaining the basic requirement for practising as an Orthopaedic Surgeon in Australia. These are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriptions</td>
<td>$2,037</td>
</tr>
<tr>
<td>Examination and training fees</td>
<td>$12,575</td>
</tr>
<tr>
<td>Course/conference fees</td>
<td>$13,209</td>
</tr>
<tr>
<td>Travel/accommodation/books</td>
<td>$11,738</td>
</tr>
<tr>
<td><strong>Estimated total</strong></td>
<td><strong>$39,559</strong></td>
</tr>
</tbody>
</table>

None of the training costs Dr K incurs for the year are for private benefit and none of the costs relate to activities other than examinations, training, courses and conferences. Dr K certainly has no money or time for ‘skiing’ as suggested by some and all of his travel to attend mandatory training is economy class. If this tax measure is introduced as proposed, Dr K will have to find at least $15,000 per annum to cover his training costs and may decide to delay his training. This ultimately will delay access to the specialist care he will eventually provide.

**Case study 4**

Dr Z is a GP Registrar in his final year of training as a GP hoping to practice in a rural or remote part of Australia. This requires training and skills in Obstetrics in addition to rural GP skills. In his final year his work related self-education costs include registration fees, mandatory clinical exam fees, advanced skills training, travel and accommodation to complete training, exams, textbooks and electronic resources.

Rural GPs have to practice without close support from other specialists have to be able to respond to a broader range of clinical situations and emergencies than their metropolitan colleagues. The breakdown is as follows:

Mandatory (essential to practice)

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>RACGP Fee</td>
<td>$369</td>
</tr>
<tr>
<td>ACRRM Fee</td>
<td>$295</td>
</tr>
<tr>
<td>RANZCOG Fee</td>
<td>$315</td>
</tr>
</tbody>
</table>
RACGP Written Exam $3,340  
RACGP OSCE Exam $3,315  
ACRRM MCQ Exam $1,200  
ACRRM Stamps Exam $2,400  
ACRRM Mini CEX $1,900  
RANZCOG Training fee for Advanced Diploma $310  
Radiography Licence $102  
Advanced Obstetric Life Support $1,300  
Introduction to Ultrasound in Obstetrics $1,650  
Textbooks and electronic resources $600  
Flights and Accommodation (Qantas economy) $2,500  
**Estimated total** $19,596

Non mandatory but highly desirable training

Masters of Public Health Tuition fee $10,640 (per annum)  
Monash Student Services Fee $98

This represents the typical costs of a GP Registrar in their final exam year hoping to practice in rural or remote Australia. It does not represent their costs for every year of training.

If the $2,000 cap is introduced, Dr Z will have to fund his training to the tune of between $7,200 – $11,600. Dr Z may decide not to undertake advanced skills training in Obstetrics and may decide to practice in the metropolitan areas. He may defer or cancel his Masters in Public Health. The overall impact would be to diminish access to medical services in rural and remote Australia and reduce the skills and training of the medical workforce.

**Case study 5**

Dr L is one of only 213 neurosurgeons in Australia, even less would identify themselves as paediatric neurosurgeon – perhaps 21. Apart from CPD requirements, Dr L has tried to make a point of attending at least one international conference each year for paediatric neurosurgery. Due to the highly specialised nature of the field, it almost always involves overseas travel. Not only does he benefit from the knowledge gained through the scientific program, but he has also formed relationships with neurosurgeons in Europe and North America that he frequently contacts in relation to difficult or unusual cases.

He attends at least one meeting for general neurosurgery including spinal surgery. Apart from attending these meetings he has maintained a leadership role in the field of hydrocephalus and was appointed to the Board of the International Society for Hydrocephalus and cerebrospinal fluid disorders. This organisation promotes research and education of the condition which is a specialised area – it requires him to attend the an international hydrocephalus meeting each year. In 2012 he was also fortunate to have a meeting in Sydney, the International Society for Pediatric Neurosurgery (ISPN), that he was able to attend.

For each of the meetings Dr L attended, he arranged flights so that he would arrive on the evening before or morning of the conference and leave on the last day. For instance, he attended the European Society for Paediatric Neurosurgery meeting where he had 2 papers presented. This was in Amsterdam. He arrived at 6am on the first day of the conference, stayed for the four days of the conference and flew home on the afternoon of the last day.

He also attended the RACS ASM in Malaysia as it had a substantial neurosurgery component. Again he arrived on the morning of the first day stayed for 2 nights and came home prior to the end of the conference due to clinical commitments. In October he attended the 5th International Hydrocephalus
meeting where he presented a paper and participated in a Board meeting. He arrived the night before
the first session and left on the last afternoon.

On each occasion he flew business class. To do otherwise would mean that he would not be in a useful
condition to attend the meeting on the day he arrived and would otherwise leave earlier. This would
mean more time away from practice during which time he is required to cover substantial practice
costs each day. It also means that he is able to return to work, including surgery, the day after he arrives
home.

In 2012 the costs involved in attending the meetings were as follows:

<table>
<thead>
<tr>
<th>Location</th>
<th>Airfare</th>
<th>Registration</th>
<th>Accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyoto, Japan</td>
<td>$5377</td>
<td>$800</td>
<td>$700</td>
</tr>
<tr>
<td>KL, Malaysia</td>
<td>$3950</td>
<td>$1545</td>
<td>used points</td>
</tr>
<tr>
<td>Amsterdam, Netherlands</td>
<td>$7247</td>
<td>$500</td>
<td>used points</td>
</tr>
<tr>
<td>Sydney, ISPN</td>
<td>$7247</td>
<td>$500</td>
<td>$770</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$20,889</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Equity issues**

The proposed $2,000 cap on deductions for self-education expenses:

- Fails to recognise the mandatory, non-negotiable costs required by vocational trainees as part of attaining their specialist qualification that allows them to go on and serve the Australian community. The Commonwealth and community have already made a significant investment in their education and training and this should not be forfeited at the expense of a policy sham.

- Is counterintuitive to the medical workforce initiatives that the Commonwealth is supporting through Health Workforce Australia. Its report *Health Workforce 2025* identifies a shortfall of medical practitioners and a maldistribution in geographic and specialty distribution. The proposed tax changes would increase this workforce gap and the divide between the services accessible to people living in rural and remote areas who have the poorest health.

- Smashes a fundamental principle of tax law that “*a deduction is allowed for the costs incurred in producing income*” (Discussion Paper page 1). Without any justification or evidence to contradict this principle, it is junked and all individuals are able to claim only $2,000 regardless of the costs incurred. As can be seen earlier from the information the AMA has provided, there are very substantial differences in the costs involved depending on specialty, location, etc.

- Fails to achieve equity between professions with relatively high continuing education costs and those with relatively low costs. Again, this is left totally unexamined by the Discussion Paper. The unstated conclusion drawn by the Discussion Paper is that any expense in excess of $2,000 is for a private benefit or out of step with community standards. Again, as our data shows, this is not the case.

- Fails to achieve equity of treatment between employed professionals (who often get employer support to maintain their professional skills) and those who are self-employed. This inequity will be further amplified by the concurrent proposal to exempt employer-funding for education expenses from fringe benefits tax (paragraph 62). Note, however, the apparent conflict between paragraphs 62 and 68 (the latter raises the prospect of FBT applying to any employer funded education expenses in excess of $2,000 cap);
- Fails to achieve equity of outcomes between the principal of the small business (say, a GP) and any GPs, nurses or other allied health professional employed by that principal (paragraph 56).
- Fails to achieve equity between city and country-based professionals. A city-based GP can drive his/her own car to attend a PD course and live under his/her own roof, while a country GP will incur travel and accommodation expenses to attend the same course. This will work to actively undermine other elements of government expenditure programs which aim to correct the city/country mal-distribution of health professionals.
- Fails to recognise that health professionals are required to undertake continuing education in order to maintain their registration. This is not discretionary expenditure on the part of the health professional. Ability to earn income depends critically on the ability to maintain registration. This affects all the registrable health professions (at least 10 of them from my vague memory).
- The proposed $2,000 cap is extremely low relative to the high costs of CME, especially given the increasing trend of super-specialisation. For example, in some fields of highly specialised surgery, the necessary training can only be achieved in the first place by working overseas and the maintenance of those skills may also require visiting roles overseas or highly specialised international conferences.
- There is no obligation on the Australian Government to follow poor overseas precedents (eg, NZ, Canada, UK). One of the key reasons why Australia achieves excellent health outcomes with a middle-ranking level of expenditure is the very high quality of medical education including CME. Steps which impair that quality of training will have long term adverse effects for the Australian health care system. In addition such comparisons with other countries can be spurious. In the case of NZ, the Government funds medical training through semi-government agencies so the need to claim such expenses through the tax system is avoided.
- The AMA disputes the unsubstantiated assertion in the Discussion Paper (paragraph 34) that CME claims involve “a significant private benefit”. The claim in paragraph 45 is complete nonsense. The cap does not prevent people claiming deductions for costs which involve a significant private benefit. It simply discriminates against any area of economic activity which has relatively high costs of continuing education. The high costs arise in health care because of the rapid rate of technological change and the imperative for health professionals to continually update their skills and knowledge. This updating is not for the private benefit of the health professional, but rather for the benefit of the population at large.
- The proposed arrangements further add to the already extreme complexity of the income tax law increase the risk that well-meaning taxpayers will make errors in their claims. They add to the costs of compliance including the professional costs paid to tax advisers. They will inevitably generate higher levels of patient billing as they increase the effective cost of medical practice as surely as any tax imposed on the provision of health care.
- The proposal will have many unintended, and harmful, implications for the quality of health education in Australia.
- Doesn’t take into account the cost of time off work, leave, locums, etc. Most practitioners are in private practice. When they are undertaking education, there is a big incentive to achieve the educational objectives in the minimum time and at the
least cost. This is because practitioners are not generating practice income from patients while doing education. Nevertheless, the costs of running the practice continue to be met by them. Due to patient demand pressures in General Practice, a Locum would often be needed but there would still be a strong incentive for the normal GP to get back to work.

- Australian medical practitioners need to remain at the cutting edge in order to provide their patients with the best and latest approach to care or the best surgical techniques. Patients expect this also and failure to be at the cutting edge of practice exposes a doctor to the risk of litigation. In many cases, this can only be achieved by tapping the resources and knowledge of Colleagues in the USA or Europe. A $2,000 blanket cap is a higher disincentive for sourcing this educational experience.

What does the AMA want?

The measure has been conceived and announced in a rush without due thought and has enormous potential to damage the Australian economy and medicine in particular. The policy is a crude cost saving measure and would create all sorts of inequities if implemented. There are inequities between professions and within professions, between city and country, between Doctors in Training and senior doctors and between sub specialists and more generalist colleagues.

The Discussion Paper provides no evidence to support the measure and tackles no particular policy failure. It is simply a crude cap which destroys the main principle enunciated at point 1.1.1 on page 1 which states “under Australian income tax law, a deduction is allowed for the costs incurred in producing income. This recognises that people with the same level of income may incur very different costs in earning that income.”

The paper as it stands would be particularly damaging in health.

The paper should be withdrawn in its current form. The AMA would be happy to work with the Government to come up with another proposal which ensures that genuine work related self-education activity is not stifled and that taxation benefits available in relation to them are in accordance with community standards.

As an alternative, the AMA proposes:

1. A tightening of the rules around reasonable benefits for expenses involved in work related self-education activities. This could see the development of pre-determined limits for travel and accommodation. Such an arrangement could be attractive if the Government feels that the issue is that beneficiaries are stretching community tolerance in this regard.

We have no idea whether they are in the case of medical practitioners and there is nothing in the Discussion Paper to help us (This suggestion is outlined in Option B in the Cutcher and Neale memorandum attached to this submission).
2. Another option either instead of, or additional to the Option above, is to tighten the dominant purpose test. This would address the alleged private benefit arising from self-education activities.

Again, such private benefit is alluded to in the Discussion Paper but no evidence is provided. This suggestion is similar to Option C in the Cutcher and Neale memorandum.

It is important to emphasise that the AMA does not believe a higher cap is workable given the very wide disparity that exists between medical practitioners based on their specialty, location or career stage. It is impossible to reconcile a cap with the basic principle underlying this issue as enunciated in Para 1.1.1 in the Discussion Paper.
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