Not-For-Profit Sector Tax Concession Working Group Discussion Paper

Submission from AMA Victoria

Introduction

AMA Victoria advocates for the continuation of the current Fringe Benefits Tax Concessions system. A change to the current arrangements will lead to unintended consequences which could exacerbate the profoundly increasing shortfall of medical services available in the context of aging, more complex chronic illness and obesity.

Should the Working Group consider that a review of the legislation is warranted, a cautious approach ought to be adopted as any legislative amendments that affect remuneration of staff in public hospitals will occur during a time of considerable workplace change. It is almost certain that such a change will have unintended and detrimental consequences.

Background

A healthy supply of quality medical practitioners in Victorian public hospitals is key to ensuring access, the delivery of high quality patient care, developing better treatments for the community, training and supervising the next generation of doctors.

Medical practitioners work in public hospitals for a variety of reasons. For example, Resident Medical staff and hospital Registrars (other than General Practice Registrars) are almost entirely trained in the public hospital system. The work of specialists in Emergency Medicine and some highly specialised disciplines such as liver transplantation are almost entirely carried out in the public sector.

However for many others there is little need for a public hospital appointment. Often quoted reasons for maintaining an appointment include complexity of patient treatment, the opportunity to interrelate with peers and passing on knowledge and skills to the next generation of doctors. However whilst these factors are important, the issue of remuneration is still a critical factor in attracting and retaining medical staff in public hospitals.

Implications of a change in the Fringe Benefits Tax Concessions

A "by product" of working in a Victorian public hospital is that doctors not only treat public patients but also help fund hospitals through the treatment of their private patients in the same hospital. Income from private patients attending public hospitals is difficult to assess but one estimate is that treatment of private patients provides $370 million per annum to public hospitals in Victoria.[1]

[1] See *Austin Health Statement of Priorities of 2011-12*, accessed on 26 November 2012 at: http://docs.health.vic.gov.au/docs/doc/82CE9ADD0E2622C4CA25796D0081DD34/$FILE/Austin%20Signed%20SoP.pdf Part C Activity and Funding pg 9. WIES Private funding is budgeted as $37.275M. The assumption of $370M in private earnings for public hospitals is based on an extrapolation of Private WIES income for Austin Health. Austin Health is representative of approximately 10% of acute health activity in the state of Victoria

This mixture of private and public patients has generally been viewed as a positive characteristic of the Victorian system.[2] A change in the remuneration benefits available to medical staff may jeopardise private practice revenue for hospitals as specialists leave or scale back their work in the public hospital system.

Hospital staff value the benefit of salary packaging. This is another reason why specialist medical staff remain in the public system rather than moving or dedicating more time to the more lucrative private health system.[3]

> *"I want to retain my sessional allocation (of work) with the hospital for the foreseeable future as my patients are interesting and salary packaging makes the income more attractive."*
>
> - Psychiatrist at major metropolitan hospital

This distinguishing point provides an incentive for doctors to participate in public practice. A detrimental change to the fine balance of the supply of hospital staffing with remuneration will mean that a number will lessen their commitment. This decrease in supply of medical staff will affect the ability of hospitals to treat the large number of patients that present for treatment.

The public hospital system is moving through a significant period of change. Governments have agreed to ambitious targets for hospital reform with the introduction of the 4 hour rule. The rule specifies that 90% of patients are to be admitted or treated and discharged within 4 hours of presenting at a hospital emergency department.

National Elective Surgery Targets are in train to provide greater access to those needing specialist care.[4] Both targets require the engagement of significant numbers of senior specialists and registrars, who can make accurate diagnosis, obtain diagnostic tests and develop treatment management plans within a very short period of time.

> *"I have provided expert specialised Orthopaedic service to 2 hospitals in Melbourne for the last 15 years. Whilst the level of remuneration is only a fraction of what I can earn in private, I have been happy to make a public contribution. Salary packaging allows for some offset of this income discrepancy. If it were to be eroded, it would be unlikely that I would continue working in the public sector".*
>
> - Orthopaedic Surgeon at outer metropolitan hospital

If salary packaging benefits are removed, hospitals will struggle to retain senior medical staff, therefore increasing reliance on more junior staff. This will lead to a slowing of throughput as decision times lengthen. It is imperative that during times of change that there is some stability in the system. Changing workload along with a potential drop in benefits will not encourage a culture of support for change.

---

[2] *See Ministerial Review of Victorian Public Health Medical Staff, Report of the Review Panel* 30 November 2007, pg 58, accessed on 14 December 2012 at: http://www.amavic.com.au/content/Document/minreview_vic_pub_health_medstaff_nov07.pdf

[3] Ibid

[4] See *Less Waiting, More Timely Hospital Services for All Australians* accessed on 12 December 2012 at: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhra-lesswaiting-fs

A complexity in the workforce impact assessment is the potential for profound inefficiency if there is a discordant response to loss of effective income. A likely outcome is mismatch so that for example a surgeon leaving in one hospital setting may mean that other staff such as Anaesthetists have less ability to treat patients. Of course the opposite may happen at another hospital but having the same impact.

Many local communities benefit from salary packaging arrangements in public hospitals. Removal of the FBT exemptions for hospital staff will have a significant impact on businesses that provide services, such as restaurants, hotels and caterers.

Under the current system, to receive the FBT benefit, an employee needs to consume services and then claim back the cost as part of their salary package and benefits. The removal of this incentive to spend may have a significant impact on the demand for these services, especially in rural and regional communities.

It is therefore suggested that the Working Group take into consideration the broader implications of any change on local businesses and communities, not just on employers, employees and the public sector.

> *"Salary packaging means that hospital staff spend more in the local economy. To regional centres this can provide much needed assistance during difficult times."*
> - Physician at a regional hospital

Conclusion and answers to specific questions

The above provides a snapshot of the potential consequences of a change to the salary packaging arrangements currently available in Victorian public hospitals.

AMA Victoria supports the continuation of the current system which is seen as manageable, recognises the often discounted rate at which doctors work in the public hospital system and provides a method of incentives which supports local communities.

The following is provided in answer to the specific questions posed by the Working Group.

Question 31: Should salary sacrificed meal and entertainment and entertainment facility leasing benefits be brought within the existing caps on FBT concessions?

The benefits outlined above play a role in attracting and maintaining medical staff in public hospitals. By including these items in the cap, the Working Group is eliminating this type of benefit. The effects would be immediate in terms of a number of specialists making the decision to give up their public hospital appointments. The decrease in the supply of senior doctors in public hospitals will have a downstream affect on teaching, patient throughput and supervision of junior doctors. This has the potential to affect quality, safety and efficiency of care.

Question 34: Should there be a requirement on eligible employers to deny FBT concessions to employees that have claimed a concession from another employer? Would this impose an unacceptable compliance burden on those employers? Are there other ways of restricting multiple caps?

The basis for the current scheme is to provide benefits when working in public hospitals. The current system encourages specialists to work part time in a number of public hospitals. The benefits for the health system of such employment are:

- The opportunity for medical practitioners to contribute their skill and experience to the public hospital systems while maintaining a substantial private practice and its associated income
- Those in major teaching hospitals can pass their skills and knowledge of new treatments to colleagues in smaller hospitals in both public and private
- Part time specialists provide a source of patient referrals which ensure hospitals have access to a range of suitable cases for educational purposes
- It affords hospitals a great degree of workforce flexibility in staffing structure and supply.
- Part time specialists are likely to be productive during their public hospital attendance in order to return to their private practice as soon as practicable.[5]

Providing a disincentive to work at a second public hospital appears to be a tax policy position with not much thought given to the health policy position.

Question 37: Is the provision of FBT concessions to current eligible entities appropriate? Should the concessions be available to more NFP entities?

These concessions should remain available to the current NFP entities. The case for expanding access to the benefit to other bodies must be reviewed on its merits (including to for profit entities carrying out public services).

One obvious extension is the situation where a public hospital service is run by a private operator. At the moment Ramsay Health Care operates The Mildura Base Hospital. There is merit in the operator having the ability to provide these benefits to employees as a way to attract and retain good staff. If Ramsay Health can provide this benefit, the cost of providing public hospital services to the community would more closely align to costs incurred if the facility was state-run. The additional benefit is to the Mildura community with hospital staff expenditure adding to the local economy.

Question 38: Should FBT concessions (that is the exemption and rebate) be phased out?

As discussed in answer to Question 37, the concession should not be phased out.

[5] See *Ministerial Review of Medical Staffing in Victoria's Public Hospital System* Lochtenberg et al, June 1995, pg 27, accessed on 12 December at: http://www.amavic.com.au/content/Document/minreview_vic_pub_health_medstaff_nov07.pdf

Question 39: Should FBT concessions be replaced with direct support for entities that benefit from the application of these concessions?

FBT concessions should not be replaced with direct support for the entities involved. The benefits associated with these exemptions assist in maximising the supply of public sector medical services to the community. The risk is that changing the benefit may upset the supply whilst entities attempt to reconfigure incentives to maintain and grow staffing in highly technical areas. This assumes that the entities attempt to make up the shortfall in remuneration. This assumption may not reflect how entities will react to any changes.

Question 40: Should FBT concessions be replaced with tax based support for entities that are eligible for example, by refundable tax offsets to employers, a direct tax offset to the employees or a tax free allowance for employees?

We do not object to tax free allowances, however, we would note that these should be implemented on a cost neutral basis and their real value be at least equivalent to the benefits available under salary packaging arrangements.