The Network of Establishing GPs Spring Meeting Series, March 2013

"Personal Financial Management"

A *Pot Pouri* of Topics

Slides Accompanying NEGs Presentation

Personal Financial Management

Slide 2 – Meeting Outline

This slide shows a brief overview of what we will cover this evening from personal financial management, contractual entitlements and negotiation, incorporation, FEMPI cuts, HIQA, and potential cost saving measures in practice. It is not intended that we cover any single topic in detail, rather that we give an overview of a *pot pouri* of topics and provide an opportunity for questions and discussion from the floor.

Slide 4 – Personal Financial Management

The first section we will cover is Personal Financial Management. A list of relevant topics is listed and we will briefly go through each of these. From the overview you can see that Income Protection will insure you against both accidents and sickness, whilst Critical Illness Cover will only insurance you against sickness. Life and mortgage cover are both designed to pay out in the event of death only. The last topic we will cover is Retirement Income provision.

Slide 5 – Income Protection

Income Protection, also known as Permanent Health Insurance, PHI, or Salary Protection, is an insurance Policy that after a certain period of time, known as the deferred period, provides you with replacement income if you cannot work as a result of an illness or injury that prevents you from earning an income. You can take out Income Protection if you are in full-time work or are self-employed and earn an income. It protects you only in these circumstances – it will not be paid if you become unemployed.

You may ask, why you need income protection, but just imagine what your standard of living would be if you were unable to work. Your income is probably your most important asset. It funds your whole lifestyle from what's in your fridge to where you go on holidays. Your children depend on it from birth, right through to college and often beyond.

Did you know that if an accident, illness, disability or injury leaves you unable to work for 3 months, your state entitlements are just €10,192 for a single person or €19,661 for a family of four? Just think about those figures. If you do not have an alternative income, could you maintain your lifestyle? Particularly in households in which there is a single earner with multiple non-earning dependents (e.g. wife and 2 children at home), income protection may be very important.

Slide 6 – Income Protection – What is Paid?

If you are unable to work, after the deferred period, Income Protection can pay you an agreed monthly benefit up to 75% of your salary until you are able to return to work or reach retirement age. In effect, anyone taking out an income protection policy insures a proportion of their income – typically the maximum allowed is 50 per cent of your current salary. However because this benefit is paid tax-free, in net terms the amount of benefit paid is roughly equivalent to 75 per cent of a person's take home pay. When you take out a policy you decide on the amount of cover that you would like to be paid in the event of a claim. The maximum level that you can claim is 75% of your income to a maximum of €250,000. Benefits paid are less any State benefits or other income protection plans.

In some policies there is Partial Benefit, i.e. if you return to work but suffer a drop in earnings you may be entitled to a partial benefit payment.

Income Protection Policies usually have deferred periods and there are a range of deferral period available from day 1 cover to 4, 8, 13, 26 or 52 weeks. We will look at deferral periods in more detail in a few slides time. Your payments will activate once you have been unable to work for the specified deferral period.

Slide 7 – Income Protection – Other Things to Note

There are a few other things worth knowing about Income Protection. Tax relief may be claimed on the premium paid. The rate of tax relief will depend on your current tax bracket.

Your cover may continue in the event of you changing employment. If you are made redundant you can keep policy in place, but you cannot claim under the policy if you are unemployed.

You are under full cover if you are working in the EU.

Your policy is designed to support you when you cannot work, but may also help you get back to work. It is clearly in the interest of the Insurance Companies to get you back to work. You may also get access to rehabilitation services and in some cases access to leading edge medical advice and treatment.

Policyholders can also claim more than once on an income protection policy. For example, if you are off for months with a back complaint, the policy will pay out. Provided you keep paying the premiums when you go back to work, you will still be covered and you can claim for the same condition again.

Slide 8 – Cost of Protection and Caveat Emptor

The cost or premium of your Policy will be dependent on many factors including your age, income, health, occupation, the benefit you choose, and very importantly, the deferral period selected. It is possible to reduce the cost of premiums by extending the deferral period – this is a balance that will require careful consideration. We will consider deferral in more detail on the next slide.

It is also important to have “own occupation” cover. This ensures that the policy pays out if you are unable to do your own job. Some cheaper policies offer “any occupation” cover which means they will only pay out if you are too ill to undertake any type of paid work.

If taking out income protection insurance, it is important to select the appropriate level of income required, and review this every few years. Otherwise you could end up in a situation in which you are under- or over-insured. For example, if an individual is earning €25,000 at the time they become sick, their replacement salary will be based on this amount, even if they have insured themselves for €50,000. Clearly this person was vastly over-insured and paying more than was necessary.

It is also important extremely important to understand exactly what is, and isn't, covered under the policy. Some income protection policies cover you only if you become severely disabled and are not able to carry out any job. Such a policy provides very little protection and you would need to become severely and permanently disabled before you could claim any benefit.

Slide 9 – The Deferral Period

One of the most important aspects of Income Protection is the deferral period, the length of time that passes before your policy starts to pay out. Whilst standard Income Protection Policies will pay out after the policyholder has been off work for three months (simply because most employment contracts will provide sick pay during this period), it is possible to take out a Policy which has no deferral period, i.e. day 1 cover, or with a deferral period of 4, 8, 26 or 52 weeks.

Particularly in relation to Doctors it is important to understand the type of employment you are in and what if any sick leave entitlements you may already have.

For doctors who work as Locums and have no contract of employment it may be very appropriate to have day 1 cover. In the event of being sick for even a single day Income Protection would be paid. Considering that there would be no other payment whilst unable to work, this would compensate the loss of earnings even for a single day. This type of Protection might also be very appropriate for other self-employed individuals. If you are self-employed, your income would stop immediately if you become unable to work, as you wouldn't be entitled to social welfare disability benefits or sick pay from an employer. As opposed to employees who would be entitled to €188 p/week, the self-employed are entitled to nothing. In these circumstances, this type of policy could provide an invaluable financial safety net. If on the other hand you have a sufficient nest egg of savings available which you are willing to dip into, you may wish to consider some deferral period. The big disadvantage of day 1 cover is of course that the premiums will be higher.

If you are employed as a sessional GP or Assistant without a GMS number, it is important to know what sick payment arrangements are in place. How long will your employer pay you for

if you are on extended sick leave? Depending upon your contract of employment, you may get sick pay for a short period, a long period, or not at all. In these circumstances you may wish to tailor the deferral period to match the sick leave payments you receive through your contract.

If, on the other hand, you work in the public sector you may be entitled to full pay for six months and half-pay for a further six months. Hospital doctors may well be in this situation, but again they should be aware of the detail in their contract of employment. You could also be eligible for State benefits, and an ill-health retirement pension, which means that you take early retirement with a pension if you become permanently unable to do your job. In such situations, you would have to weigh up whether it's worth paying for extra protection. With 6 months full pay and 6 months half pay, you will likely opt for a deferral period of either 26 or 52 weeks.

The last group are GPs with a GMS contract. The General Medical Services Scheme provides for a payment to be made to General Practitioners via the Primary Care Reimbursement Service in respect of sick leave. The Sick Leave Payment is based on a rolling four year period, meaning that if a GP has taken 12 months sick leave, they will have to wait for 4 years to be entitled to more sick-leave, but also that during any 4 year period a cumulative total of 1 year sick leave can be accrued. Full capitation will be received for the first 6 months, and half capitation for the second 6 months. Locum payments are also made but these varying depending upon the panel size, divided into 2 bands, 100 – 700 patients and 700 or more patients. Clearly, because there is sick pay under the GMS contract, any Income Protection Policy would have a deferral period of at least 26 weeks, if not 52 weeks.

Slide 10 – Critical Illness Cover

Critical illness cover is also known as Serious Illness Cover or Specified Illness Cover. This is a policy which will pay out a once off tax free lump sum if you are diagnosed with one of the illnesses specified in the policy. In theory, this should pay off any outstanding mortgage if the breadwinner is forced to give up work because of cancer or a heart attack. However, remember that the most common reasons for people to be signed off sick are stress, depression and back pain. None of these would trigger a pay-out from a critical illness policy but would on the other hand be covered by an income protection plan. Most serious illness policies will not cover you for many of the most common illnesses that prevent people from working.

Serious illness cover can be a godsend if you fall ill and have no other cover in place, but only if your interpretation of what constitutes a "serious" illness matches the exact definition in your policy. It is all too often the case that people discover that the particular condition they've been diagnosed with is not actually included. Historically there have been problems with certain conditions being tightly defined and customers thinking they're getting broader coverage than they are. For example, most of us would assume that being diagnosed with cancer is about as serious as it gets, but if the disease is caught early, before it has invaded the surrounding tissue, in many cases you won't be able to make a claim under a serious illness policy.

Even if you develop an illness that is serious enough to prevent you from working and earning an income, your policy might not pay out any benefit. It's essential to check not only which illnesses are covered by your policy before signing on the dotted line, but also how these illnesses are defined. And DO NOT confuse Critical Illness Cover with Income Protection! They are very different.
When taking out Critical Illness Cover, avoid being swayed by the price alone. The level of cover and service provided should also be factored in. It is also important to review your

situation on an on-going basis to make sure that the product still matches your circumstances. For example, as people approach retirement, they may well decide that the need for serious illness protection is no longer as pressing, perhaps because their children have flown the nest and they no longer have dependants. It could make more sense at that stage of life to divert the money away from insurance policies and towards a better retirement.

Slide 11 – Life Cover

Life Cover or Life Insurance is an insurance we take out on our own lives or the lives of partners which pays out a predetermined once off tax free lump sum of money to your loved ones if we die within a specified time period. The payment can be used to protect your loved ones financially if you die, or ensure the financial survival of any business.

Various types of life cover are available including single, dual and joint, and life cover. Single Life Cover is taken out by one person and is payable on their death during the term of the Policy. Dual Life Cover is taken out on behalf of two people and is payable on each death during the term of the Policy. Joint life Cover is also taken out on behalf of two people. It can be taken out on a First Death or Second Death basis, i.e. paid on the death of either the First Life or the Second Life during the term of the Policy.

Life Policies can operate for differing terms. Term Life Insurance is life insurance over an agreed term (length of time you choose to be covered for) which pays a cash lump sum if you die during the term of your plan. Life Long Insurance provides the level of life insurance you choose for your whole life, as long as you continue making your regular payments. It can also provide tax efficient inheritance planning cover for your family so as not to impact their inheritance. Life Long Cover offers you guaranteed cover against the following incidents which could affect your family's future income – death, terminal illness (within defined time frame from diagnosis of condition), accidental death and children's death (up to specified age).

The requirements for life cover will vary according to each life stage. It is influenced by the number of children and their ages, and the ideal way to assess how much cover is required is for your partner to decide how much they would need in the event of your death.

Slide 12 – Mortgage Protection

When you get a mortgage, there is a standard legal requirement that you take out a Mortgage Protection Policy or Mortgage Life Cover. This ensures that the mortgage is fully repaid even if you (or your partner) die during the term of the loan. Mortgage protection provides a lump sum payment if you die during the term of your mortgage contract, this lump sum then being used to pay of the remaining outstanding mortgage which will then be cleared. Mortgage Protection should be payable on a joint-life, first death basis (if joint ownership).

In essence it is a bit like Life Cover, however with Mortgage Protection, the amount of cover reduces each year in line with the decreasing capital owed on your mortgage as it is paid off. It is important to be aware that on an interest only mortgage the cover must stay the same and when your mortgage is fully paid off your cover will be reduced to zero.

Mortgage Protection is both the cheapest and most popular type of life insurance on the market. It is the minimum life cover that you are required to take out. It is generally not a

requirement for investment properties, however because the premiums generally are allowable against rental income it is an excellent way of having good life Insurance cover.

If you are taking out a new mortgage or re-mortgaging your home, this type of cover is essential to secure your mortgage with your mortgage provider.

Slide 13 – Retirement Planning - Pensions

A pension is a special type of savings plan, with important tax breaks, in which you can build up money in order to provide yourself with a pension. It is a long-term arrangement, so you can't dip into it before you retire. There are lots of advantages to pensions – in addition to providing replacement income in retirement, a pension will allow you to achieve greater financial security during retirement, there are generous tax reliefs on pension contributions (which are outlined on a later slide), pensions growth is tax free, there is the opportunity to take a generous once off tax free lump sum, and pension can either be professionally or self–managed.

It is important to have a pension as a form of provision for retirement income, because we will have to pay to keep on living during retirement, and the fact that we are living longer means that many of us may have long retirements. The basic state pension is a start, and it may be supplemented by other benefits you may be entitled to, but it's not likely to be enough to give you the standard of living you want. Therefore, it is worthwhile to consider having your own pension. if you retire in your sixties, it is likely that you will live for another 20 to 30 years. So it is important to ensure you have put enough into our pension to provide you with sufficient retirement income. The more you can save during your working years, the better standard of living you will likely be able to afford on retirement. Practically, this means the earlier you start paying into your pension, the better. By saving more money over a longer period of time your pension fund will have longer to grow. Whether that's through your employer, a personal pension or both, is up to you. If you work for the HSE you will be entitled to an HSE pension, and if you have a GMS contract there is a GMS pension scheme which is overseen by a Board of Trustees who are all GPs.

In addition to pensions, there are other investments which you could consider as vehicles to provide for retirement such as property rental income, investments e.g. stocks, shares, bonds, gold, art, and income from other sources. As with any type of investment, pensions including, it is of course always important to remember that the value can go up as well as down.

Slide 14 – Types of Pension

If you are self-employed or working for an employer who does not provide a pension, then you can start contributing to a Personal Pension Plan or PRSA (Personal Retirement Savings Account). You will pay contributions to this plan and will be entitled to claim tax reliefs (which are outlined on a later slide) on the contributions you pay up to certain specified limits. Additionally, your employer can make contributions to your PRSA. These plans are provided by financial institutions with professional fund managers who will invest money on your behalf so that it has the potential to grow in value. When you retire you can normally take up to 25% of your fund as a tax-free lump sum and use the rest to provide a regular income.

A company / occupational pension is a scheme in which you join your employer's trust-based defined contribution. You make regular payments during your working life. Your payments are then invested in your choice of one or more of a range of professionally

managed funds and remain invested until you retire. The investment performance of the fund(s) will determine how much money you may have available when you are ready to retire. Charges and investment performance will affect the fund value. However, as with all investments, the value of your investments can go down as well as up and you are not guaranteed to get back the amount you invested. The money built up is used to buy an annuity or another product which provides you with an income for the rest of your life. Your pension income will be taxed as earned income. You can usually take up to 25% of your pension fund as a tax-free lump sum or an amount equivalent to 1.5 times your salary at retirement (provided you have 20 years' service with your employer), which means you will receive a smaller pension. Usually, your employer also pays into the scheme. If you can join your employer's scheme it's usually a good idea to do so, particularly if the employer pays towards your pension fund – some schemes are very generous. Unfortunately, no one can know how much your fund will be worth when you retire or how much income you will receive each month. A pension scheme lets you invest in a range of funds, giving your money the best chance of growing to give you a decent fund for your retirement. You need to understand more about the funds to make the best choices about where to invest your pension payments and it is very advisable to both talk to an independent financial adviser and also review the performance of your funds from time to time.

Slide 15 – Income Tax Relief

As outlined, one of the big advantages of pensions is that the government provides generous Pensions Income Tax Relief. The maximum pension contribution, in any one year, for which you are entitled to tax relief, is related to your age and is expressed as a percentage of your gross income. The maximum gross income figure for relief purposes in €115,000.00. This table shows the age brackets and percentage of gross income (to maximum of €115,000.00) to which relief will apply.

Slide 16 – What are Funds?

Funds are a way for you to pool your money with other investors so you can take advantage of buying in bulk, spread your money across lots of different investments and get the services of an expert who you wouldn't normally have access to.

You can usually choose which funds to put your money in. There are lots of different types of fund and there are many options to choose from; if you're not sure which one(s) to pick a financial adviser will be able to make recommendations for you. The differences between funds are usually in the way in which they are invested, the way they are managed, the assets they are invested in, and the level of risk they take in relation to the amount of reward they're aiming for.

Most funds are managed on a risk basis, from cautious to aggressive. A cautious fund aims for steady growth over a long period of time with little risk of you losing money. An aggressive fund aims for higher growth but this increases the risk of you losing money. The assets that a fund invests in are also an important factor in the returns you're likely to get. An aggressive fund may invest in companies that have just issued shares and so have the potential to do very well and make a lot of money, but they also have a risk of failure. A cautious fund may invest in Government bonds which provide a guaranteed growth rate. This growth rate may be smaller than you could make on the stock market, but there is less risk to your money.

Once you've paid money into your pension, you will be unable to access it before you retire, apart from in exceptional circumstances. A pension is designed specifically to provide for

your retirement, so you can't draw it out if you're a bit short one month. The government insists on this to balance out the tax savings they give you.
Pensions can be quite confusing and many people find them difficult to understand. It is important to remember that there are two separate elements to a pension. The first is the pot of money you invest into throughout your working life, which is known as your pension fund. The second is the income you take at retirement. When you retire, you can usually take a percentage of your pension fund as a tax-free cash lump sum. You don't have to take a tax-free cash lump sum; you could choose to use your entire fund to provide you with an income during your retirement. The rest of the money in your pension fund is used to buy a product that will provide you with an income during your retirement.

Slide 17 – What Happens if I Move Job?

Pensions are designed to be flexible so that if you change jobs you can bring your pension fund with you. If you had a company pension scheme then moving jobs means that you won't be able to carry on paying into it; your old employer will also stop making payments. If you have been paying into the HSE superannuation scheme this will stop when you cease to be an HSE employee. Instead you can choose to leave the money in your old company pension where it is or to transfer the money in your old company pension scheme into a scheme with your new employer. Another option is to transfer money in your old company pension scheme into a buy-out bond which is a lump sum pension product into which you can pay the proceeds of your old company pension scheme and access the benefits at the retirement age applicable to your old company pension scheme. Alternatively you could transfer the money in your old company pension scheme to a PRSA. Other options may be available depending on your old employer's scheme.

If you decide to leave the money in your old company pension you can still join your new employer's scheme. That way, when you come to retire, you can use the money from both schemes to provide your income. If your new employer doesn't have a company pension scheme you could see if they would pay into a PRSA on your behalf instead.
You should get financial advice before you decide to transfer your old pension to make sure it's the right thing to do.

Slide 18 – General Summary

At this stage of establishing in a career in General Practice, probably with many life commitments, and likely with quite a lot of professional uncertainty, the most appropriate priority is income protection.

After that, it’s never too early to start planning for your retirement. It is easy to take small practical steps to work out what position you're in now and what you need to do next. It is possible that every month of every year that goes by without you sorting out your pension arrangements may make a big difference to your financial security during your retirement. With a pension it is important to ensure as high a percentage as possible of the fund is invested, that charges are minimised, and that you have actively considered what investment strategy is best for your fund.

In relation to a pension there are a number of other things which are worth considering including i) how much your pension is currently worth (contact your pension provider), ii) will your employer match contributions (not an issue with the HSE or GMS), iii) does your partner have a pension, and iv) when do you think you might like to retire. The age you take your benefits will greatly affect how much money you should be saving. The earlier you

intend to retire, the more money you will have to invest now. Don't forget that you will also receive tax relief on your payments into your pension.

Finally, it is worth ensuring that your dependents will be financially secure in the event of your incapacity or death.

Employment in General Practice

Slide 21 – Current Status?

So what is your current situation? As a GP, there are four typical scenarios that could / will present themselves to you. These are outlined above.

Slide 22 – Current Status

We can see clearly, as is illustrated in the table, based on the four given scenarios, that the obligations and so forth relating to self-employed, partnership and company are almost identical whereas the obligations in the case of employees are very different.

Slide 23 – Tax Rates and Credits

Whether you're an employee or self-employed, the following tax rates and tax credits will apply. The company scenario is somewhat different as follows; (see next slide)

Slide 24 - Companies

Directors' salaries which are withdrawn are subject to the rates indicated on the previous slide. However, residual profits are taxed as follows;

Profits are taxable at 12.5% corporation tax rate.

If all profits in a financial year not paid out / distributed, the taxable rate increases to circa 20% (corporation tax rate + professional income surcharge).

Even though the company profits may be subjected to an additional tax charge, namely the professional income surcharge tax, the combined rate of about 20% is still lower than the marginal tax rate of 41% as an employee or self-employed.

The company structure facilitates the retention of cash within the practice and this can help re-investment, cash-flow, and planning in that not all profits are taxable immediately at the higher rates. When the profits or reserves are eventually withdrawn they will be taxed as normal. However, this can be undertaken in a planned manner.

Slide 25 – Taxable Profits (Income MINUS Expenses)

When in practice, be it as self-employed, in partnership or as a company, think business! In this regard, all practice / business expenses should be paid for by the practice – this will ultimately help to reduce taxable profits and lower tax bills!

This gives a list of allowable business expenses for tax purposes.

Slide 26 – Expense Which Are NOT Allowed

Remember, not all expenditure is allowable as a business expense and therefore not allowable for tax purposes. These are some examples of items to be mindful of.

Slide 27 – Practice Management Considerations

On practice management, here are some useful tips.

Slide 28 – Employees – Reducing Your Tax Liability

If you are an employee, you need to do / undertake your own tax planning. This is a list of relevant / useful ways of planning and lowering your annual tax bills.

Understanding & Negotiating Contracts of Employment

Slide 31 – Key Legislation Governing Employment

There are three pieces of legislation that provide protection to an employee. The legislative is clearly defined in respect to what you are entitled to include;

- Written ***Terms and Conditions of Employment*** within 2 months of commencement
- Payslips
- Limit to working hours (generally a max of 48hrs per week, this can be averaged over a period of time for some sectors)
- Daily and weekly rest periods
- This is not an exhaustive list

Slide 32 – Terms for Consideration / Negotiation

Outside of the standards terms of employment set out in a Contract of Employment (as set out in the Term of Information Act 1994) an employee should consider the following when negotiating an offer;

1. Agree working arrangement (employee, consultant etc.).
2. Working Hours - The contract should stipulate the number of hours you will be required to work each week, including the maximum number of hours that can be required. It should also state the on call / weekend arrangement. Some contracts are ambiguous, indicating that call will be arranged on an "appropriate" or "fair" basis. Ensure working hours are clearly defined.

3. Salary – does the base salary agreed cover overtime requirements, additional hours worked. Seek clarification.
4. Bonus / Commission – in addition to the agreed base salary, if possible negotiate in respect to bonus's associated with new patient introductions, feeing and collection) Think commercially.
5. Training – ensure there is a provision to support further education and agree a training budget in line with CPD requirements.
6. Annual Leave (Legislation states 4 working weeks for full time employees). This can be a negotiating point for specialities in high demand. Also important to confirm what the carry over policy is from one year to the next.
7. Benefits – ensure benefits agreed at the offer stage and clearly set out in the Contract of Employment.
8. Expenses – ensure a clear policy is set in respect to expenses that can be claimed.
9. Termination of Employment - Review the contract in respect to the notice the employee is required to provide when terminating the contract of employment. Is it reasonable (i.e. 2 months).
10. Sick Pay Scheme – What is the policy on payment while out sick? There is no legislative entitlement to payment while out sick; a business can define their own policy. Seek clarification. In order to avoid discrimination a business will generally not deviate from Company Policy.
11. Again no legislative entitlement to payment while on maternity leave – defined by the Company.
12. Non Competes - Some contracts will contain restrictive covenants or non-compete clauses. These clauses oblige new employees to agree that they will not go to work for specific competitors during a given period of time. Therefore, if a doctor leaves a practice, he or she may have committed not to practice within a 10-, 20- or 30-mile radius of the employer for a certain period of time. This acts as a barrier to physicians taking patients with them to a new practice.

Slide 33 – Additional Provisions – Seek Clarification

In addition to the Contract of Employment, ensure you receive access to associated policies and procedures which set out the general company rules. These policies provide recourse should an issue arise during the course of your employment.

Slide 34 – Summary

Understand the provisions in a contract which can be negotiated favourably – think commercially and realistically based on the level of position.

It is important to read a contract closely and ensure you understand it. Seek independent advice if required.

You should be happy with the terms of your Contract from the outset; it is generally put aside during the course of your employment and provides a roadmap for resolution if required.

Incorporation for Locums

Slide 37 - Incorporation

Some of you may be familiar with the term incorporation. In this talk we will focus exclusively on the term incorporation as it applies to Locums.

Currently, there are many accountancy firms advising established GPs in relation to incorporating some of their practice. There is good reason why GPs might wish to consider this option. There have been significant curtailments on tax deductible pension contributions which could previously be used to reduce income tax liabilities. A GP might therefore consider operating through a limited company. The transfer of the practice, or part of the practice to the limited company can be completed without tax arising. The profits of the practice would be liable to corporation tax at 12.5% rather than income tax at a composite rate of 52%. The GP would become a director of the company and extract a salary. The level of salary (and therefore the income tax payable on same) can be controlled. The incorporation of a private medical practice can be used to achieve tax savings, provide better planning for pensions, avail of retirement relief and provide for working capital / debt management. The benefits of incorporation are in essence that there is a significantly lower rate of tax for profits retained in the company compared to the top personal rate, and there is a more favourable pension environment for pension investments.

This evening we will NOT be discussing this type of incorporation, rather the type that GPs acting in a Locum capacity have sometimes used.

Slide 38 – Incorporation – Tax Briefing #82

To understand the origins of Incorporation, one must consider a little about taxation, and also how revenue interprets employment status.

Up until 2009 many locums had worked in a self-employed capacity, i.e. they would get paid gross and settle their own tax affairs. GPs for whom they were doing locums would not deduct any tax at source, nor would they pay PRSI.

In December 2009 Revenue issued Tax Briefing #82 to address the issue of locums and self-employment. Despite there being no explicit statement that Locums are employees Revenue referred directly to another revenue document, the "*Code of Practice for Determining Employment or Self-Employment Status of Individuals*" which lays out clearly under what criteria a person carrying out working would be considered an employee or self-employed. They also gave a number of sample answers such as Q6 outlined on the slide. In effect, Revenue indicated very clearly that locum doctors could no longer be paid as self-employed practitioners.

Slide 39 – Criteria Determining Employee Status

It is useful for a second to have a look at these criteria as laid out in the "*Code of Practice for Determining Employment or Self-Employment Status of Individuals*".

Slide 40 – Criteria Determining Employee Status

On any objective measure it would seem quite clear that someone doing a locum is an employee.

Slide 41 – Revenue Position

Just in case anyone has been left in any doubt in relation to the position of Revenue, there really isn't any! The Revenue position that locums are employees has been unambiguously illustrated a number of times.

In 2009 the Appeals Commissioners upheld a decision by Revenue that MIDOC (operating in Longford and Westmeath) must deduct PAYE from doctors provided out-of-hours cover.

It has also been reported that in 2010 Shannondoc made a €350,000 settlement with the Revenue.

Prior to this the Revenue had also won a Circuit Court case in which they contested that a locum pharmacist was an employee.

Additionally, in correspondence with the IMO, Revenue indicated that the PAYE system should routinely be operated by GPs on payments to locum doctors.

Slide 42 – "Incorporation of Private Limited Company"

So what about this term "Incorporation"? What does it mean and what's it all about?

At its most simple, it is when a locum decides that they are not going to work as an employee, and instead, sets up or incorporates a private limited company. The GP for whom they are doing the Locum pays the company directly without deduction of tax, instead of the paying the locum GP. The benefits to working in this way are that expenses can be claimed. The downsides are that there is a substantial amount of legal and taxation paperwork and law to comply with, and this will almost certainly require the employment of an Accountant.

Not forgetting either that tax will have to be paid once a year, and it is essential to set aside a percentage of each salary paid by the private limited company which will go towards your annual tax bill.

Slide 43 – Expenses Which Can be Reclaimed

The list of expenses which can be claimed is quite extensive and necessitates good record and receipt keeping. Ultimately, your accountant will be able to help determine if something can be claimed as an expense.

Slide 44 – Incorporation – How To

From a practical perspective, to actually set up a company there are a number of steps involved including registering or incorporating the company with the Companies Registration Office, registering the Company with Revenue, registering the Directors and Shareholders and setting up a bank account.

On an on-going basis there will also be invoices that need to be prepared and submitted, allowances and expenses that need to be managed, various tax and revenue calculations to be done, and a doctor's tax return to be taken care of.

Slide 45 – Mandatory Requirements

There are also quite a few legal and taxation documents which need to be submitted. In practice, most locums who operate through incorporated companies employ the services of an accountant who deals with the Revenue Commissioners on behalf of his or her company. Ideally it is best if doctors have no dealings with Revenue.

Some of the requirements of having a company are to prepare and submit P30 and P35 returns to the Revenue Commissioners, to prepare annual accounts and financial statements in accordance with applicable Irish law and generally accepted accounting practice in Ireland, to prepare and submit to the Revenue Commissioners a corporation tax return on behalf of the company, to have a Company Secretary who liaises with the Companies Registration Office and maintains a Statutory Minute Book and Register for the company, to prepare and submit to the Companies Registration Office abridged financial statements on behalf of the company, and to prepare and submit 6 monthly and annual returns to CRO on behalf of the company.

Looks like quite a lot!!! However, in practice, all this is usually taken care of by the Accountants.

It is worth considering that there will be extra work involved, and unless you have substantial business and tax experience you will need help in dealing with the administration. Unless your earnings as a locum are substantial, considering the additional compliance costs and time involved in administering the company, the benefits may be marginal.

Slide 46 – Locum vs Company

One distinct disadvantage to doing Locums as an employee is that cash flow can sometimes be difficult – many practice managers end up deducting PAYE / PRSI on an emergency tax basis. It is also often the case that you will have to chase payment, payslips, P45s etc. If you work for more than a few employers during your tenure as a locum, you will not be able to access the Revenue Online personal tax management system – they simply freeze you out.

The big disadvantages to working via an incorporated company are the amount of mandatory legal paperwork, the necessity for rigorous record keeping, and that you will require to set money aside in order to pay Revenue.

Ultimately if you should opt to go down the route of Incorporation, be sure to get a good accountant who is familiar with the law, the workings of Revenue, and who will be able to guide you easily through the entire process. Ask around for a recommendation.

The Dreaded "*FEMPI*"

Slide 48 – Guess Who?

No prizes for guessing who this pair is? Mary Harney and Brian Lenihan, RIP. Why are we showing ancient history? Well, moving on to FEMPI, it was Brian Lenihan as the Minister for Finance who signed it into law, and Mary Harney as the Minister for Health who in 2009 filled in the detail of the first round of cuts under FEMPI. So what is FEMPI?

Slide 49 - FEMPI

FEMPI stands for Financial Emergency Measures in the Public Interest. Since 2009 the government has enacted and signed into law 4 FEMPI Acts and at least 11 Statutory Instruments, 3 of which have directly impacted upon General Practitioners. FEMPI was a direct result of the overwhelming financial crisis which engulfed the Irish State from 2008 onwards. Whilst FEMPI has had a major impact upon GPs with GMS and State Contracts, it has also impacted upon dentists, pharmacists, veterinary practitioners, and state solicitors, as well as a range of state schemes in other areas including farm waste management.

Slide 50 – FEMPI Acts

This slide and following slides show the FEMPI Acts and Statutory Instruments as given on the website www.statutebook.ie, published by the Attorney General. As can be seen there have been 4 FEMPI Acts.

Slide 51 – FEMPI Statutory Instruments for GPs

Following on from the 4 FEMPI Acts, 3 Statutory Instruments directly relating to GPs have been signed into law by the Minister to give effect to the FEMPI Acts. The first of these was in 2009, the second in 2010, and in 2011 a Statutory Instrument was signed in relation to payments for immunisations. In addition, as per the budget in December 2012, it is almost certain that the current Minister for Health, Dr James Reilly, will in 2013 sign a 4th FEMPI Statutory Instrument to give effect to further planned reductions in fee payments to GPs.

Slide 52 – Other FEMPI Statutory Instruments

There have been in addition at least 7 other FEMPI Statutory Instruments signed into law between 2009 and 2012.

Slide 53 – FEMPI Cuts

So what does FEMPI really mean? To understand the impact that FEMPI cuts have had, I will outline briefly the pre 2009 payment structure to GPs.

GPs in Ireland derive income from two principal sources. Firstly, private non State income, e.g. patients who pay the GP directly for Consultations, income from insurance medicals, PMAs, medico-legal reports, occupational health work for companies, etc. Secondly, income from State Contracts which include the General Medical Services Scheme or GMS contract,

i.e. medical and DOVC (doctor only visit cards) and STCs or items of special service, the long term illness scheme, the Hepatitis C scheme, the mother and infant scheme, immunisations, Methadone etc. In 2008 the total fees paid to GPs were €338 million with a further €136 million in allowances.

The contract that exists between the GP (and every GP in the country is now entitled to obtain such a contract) and the HSE for provision of General Medical Services is signed with the HSE, National Shared Services Primary Care Reimbursement Service, the PCRS. This contract provides for a defined list of payments and fees as outlined in a very detailed handbook and accompanying Schedule of Fees and Allowances. This schedule was last updated on 1st September 2008 and can be found at the PCRS website.

What the FEMPI Acts and Statutory Instruments did was to unilaterally, without negotiation, reduce the fees and allowances to GPs that are outlined in the 2008 PCRS Schedule of Fees and Allowances. I will outline some examples of these cuts in a few slides.

Slide 54 – Broader Economic Context

Before we consider some examples of actual cuts that have already taken place under FEMPI, and the potential for further cuts, it is useful to consider the overall economic and health service context.

The number of people with a medical card in Ireland has increased by more than 425,000 between 2008 and 2012, and this has put increased pressure on GP services. According to HSE figures, a total of 1,280,510 people had a medical card in January 2008. By January 2012 this figure had jumped to 1,706,279 – representing an increase of 425,769 people in four years. This also represents as 4.8% increase on the number recorded for January 2010. As we speak the number continues to climb, and we have now reached the magic 40% of the population on medical cards, a percentage that was never envisaged.

The number of people covered by GP visit cards is also on the rise. In January 2012 the figure stood at 126,874, which represents a 6.2 per cent increase on the January 2011 figure.

Coupled with a growing number of increasingly demanding public patients and the accompanying workload, GPs are also struggling with reduced income from fewer private patient visits coupled with FEMPI cuts, at a time when the health service is planning to transfer more services to primary care. At a time of deep recession, GPs – like other healthcare professionals – are expected to do more for less. However, faced with an ageing population, increasing incidence of chronic disease, reduced health spend and increased health costs, perhaps one of the biggest challenges faced by GPs and indeed all healthcare professionals alike is how to how to maintain quality in a time of limited resources. Although an increase in the number of GMS patients brings increased income, this is more than offset by the overall drop in GP remuneration. This is compounded by cuts to hospital services which have meant that more and more work is slowly and insidiously creeping into General Practice from the hospital sector.

The Minister has made no secret of his plans to transfer chronic disease management to the community. The Minister has stated, “For far too long, hospitals and other large institutions in the health system have attracted the lion’s share of resources. Yet we know that certain groups of patients, particularly those with chronic disease, can be treated both more cost-effectively and with better outcomes in the community …. This initiative, which will require the transfer of resources from hospitals to primary care, will be rolled-out in the second half of 2012 and will be fully up and running in 2013.”

The huge concern is that the patient with their chronic disease will end up in primary care with no sign of the resource. We will have to wait and see.

Slide 55 – Increase in GMS Patients

This slide clearly illustrates the increase that has taken place in medical card patients.

Slide 56 – Changes in GMS Income

This slide graphically shows the huge fall that occurred in GMS income during 2009 and 2010. The increase in GMS income since 2010 has occurred because of the significant increases in medical card patients and has NOT offset the even bigger fall in private income.

Slide 57 – Average GMS Income

This slide very clearly illustrates the continuing fall in average income from each GMS patient. Whichever way you dissect the figures the answer is always the same. General Practice has suffered a very substantial reduction in income levels from all sources, and this has been mirrored by a notable increase in workload and demand.

Slide 58 – FEMPI Cuts 2009

So what were the actual FEMPI cuts?

In 2009, Mary Harney introduced an across the board 8% cut in Fees and Allowance paid to GPs. The detail of these cuts is listed above. These cuts were pretty much across the board and produced savings of €34 million in 2010.

Slide 59 – FEMPI Cuts 2011

On 7th December 2010, as part of the 2011 budget, Mary Harney went back to the well of General Practice and announced a much more aggressive range of cuts. Of huge significance to rural general practice was the removal of the distance codes for capitations purposes, and the significance of the 50% reduction in the capitation fee for those patients over 70 years of age residing in nursing homes was not lost on their GPs.

In addition cuts ranged from 22% for out-of-hours services down to 5% for practice staff allowances, with special items of service being cut by 8%. The total savings were €48 million in 2011 which equated to 10% of the fees and allowances paid in 2008 (fees €338 million and allowances €136 million).

Particularly with the reduction in the distance codes, it is difficult to see how the culmination of the FEMPI cuts has not had a disproportionate impact on rural general practice.

Slide 60

Here we can see the fees that applied to items of special service until Mary Harney decided to reduce them from 2011. The next slide will show the current rates. If anyone believes that

it is possible to suture any cut for €31.67 and not make a loss, never mind the current fee of €26.81 as is shown on the next slide.

Slide 62 – The Reality of FEMPI Cuts Bites Hard

The list on this slide gives a further stark outline of some examples of cuts which GPs have endured.

Slide 63 – FEMPI 2012 and 2013

As if enough had not already been taken, on 8th November 2011, Minister Reilly announced a reduction in fees for the flu vaccination from €42 to €28.50. Interestingly, pharmacists receive a fee of €15 for vaccinating the over 65s with medical cards.

Unfortunately, while the financial pressures on General Practice have been ramped up over the last few years, we are not finished yet. In the budget of December 2012, it was announced that a further EUR 70 million will be sought from fees and payments to GPs in 2013. A number of groups have made submission in relation to this, including the IMO which made a detailed submission on 4th January 2013. It was intended that the FEMPI review would be completed by 11th January 2013, but so far this deadline has passed and we await the bad news which is almost certain to arrive.

HIQA – What May Lie Ahead

Slide 65 – HIQA – What May be Coming

HIQA, the **Health Information and Quality Authority**, *An t-Údarás um Fhaisnéis agus Cáilíocht Sláinte,* is an independent statutory, government funded agency in Ireland which monitors the safety and quality of Healthcare in the State and the social care system. It was first suggested as early as 2001 and received its powers and mandate in May 2007 under the Health Act 2007. HIQA also exercises functions under the Child Care Act 1991, and the Children Act 2001.

Amongst other roles, HIQA is responsible for driving quality, safety and accountability in residential services, and also for driving improvements in the quality and safety of healthcare on behalf of patients, including with many other entities health centres and primary care services, i.e. General Practice and General Practice premises. HIQA not only also develops standards, but is also charged with monitoring compliance with standards, and carrying out investigations where there are reasonable grounds to do so.

Of huge significance going forward is that HIQA will almost certainly become a licensing authority for public and private healthcare providers, including primary care services.

Slide 66 – HIQA Publications

Over the last 4 years, HIQA has published a number of high profile documents, some or all of which you may have heard: -

1) National Quality Standards for Residential Care Settings for Older People in Ireland (Feb 2009)
2) Report & Recommendations on Patient Referrals from General Practice to Outpatient and Radiology Services (March 2011)
3) National Standard for Patient Referral Information (March 2011)
4) Standards for Health Information Governance
However, what we all need to be very aware of and will be of huge significance over the coming years to General Practice, particularly when we consider HIQA intervention in nursing homes, is the June 2012 HIQA Publication, "***National Standards for Safer Better Healthcare***". This document, as shown, can be found on the HIQA website, www.hiqa.ie.

The genesis of this document was the **2008 Report of the Commission on Patient Safety and Quality Assurance**, chaired by Dr Deirdre Madden, which investigated a number of serious shortcomings in the health services and called for "***Knowledgeable patients receiving safe and effective care from skilled professionals in appropriate environments with assessed outcomes****".*

Slide 67 – National Standards for Better Safer Healthcare

The first draft of these National Standards was launched for consultation in September 2010 and finally published in June 2012. The 167 page HIQA "National Standards for Safer Better Healthcare" is laid out in 8 sections or themes: -

1) Person Centred Care
2) Leadership, Governance and Management
3) Effective Care
4) Safe Care
5) Workforce
6) Use of Resources
7) Use of Information
8) Promoting Better Health

The document contextualises each of the 8 themes which are then broken down into specified standards. Each of these standards is then expanded upon in more detail to provide concrete detail in relation to practical implementation. For example, within the theme of "Person Centred Care", there are 9 specified standards.

The standards outlined in this document will apply to ALL area of healthcare and in due course guidance documents will be issued for specific relevance to each sub-area. This will include primary care.

In practical terms, what this will mean is not only will there be specific standards laid down for Primary Care and General Practice including the premises, but that HIQA will also licence primary care premises, monitor and enforce implementation of standards, and ultimately should it be necessary (as has proven the case with a number of nursing homes), enforce closure / cessation of business!

Slide 68 – Standard 2.7

To give a real example of what this is likely to mean for General Practice, this is Standard 2.7, under the them Effective Care and Support, one of 8 standards under this theme.

Theme 2 overall revolves around **Effective Care and Support.** HIQA states that "***effective care and support in healthcare means consistently delivering the best achievable outcomes for people using a service. Service providers should aim to deliver the best achievable health outcomes for the resources used through the evaluation and use of best available clinical evidence. Service users' individual healthcare needs are all different and change over time and effective care takes account of this. Services should ensure that each service user receives well-coordinated care and the right care for them at the right time and in the right place***."

Specifically in relation to **Standard 2.7**, HIQA states that "***Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users***."

This slide and the following 2 slides list the detailed points of the HIQA Standard.

Slide 71 – What This Means for Service Users

What does all this mean in practice? Well, what HIQA say it should mean is shown above. Basically that service users receive healthcare in surroundings that are laid out in a way that is easy for service users to enter and get around safely. I remain to be convinced that the HIQA interpretation will be that simple.

It is worth taking note of the fact that in the future HIQA will be able to come into your premises, state they are not fit for purpose based on detailed standards which they will draw up, charge you for a licence, insist upon modifications to your premises (the cost of which you as the GP will have to absorb), and if you do not comply HIQA will be able to revoke your licence and shut you down by taking you to court (which you will probably have the privilege of paying for)! Sounds scary, but this really will be coming. So watch out!

In practice, if we now expand out the entire document which contains a total of 45 standards, each of which is broken down much the same way as Standard 2.7 that we have just considered, I am not sure there will actually be time left to do any doctoring!

Slide 72 - NERA

Going forward, it is not just HIQA that we need to be aware of. General Practice is, no different to other bodies, already subject to inspection by NERA, the National Employment Rights Authority. As can be seen from the list above, NERA inspectors have an extensive list of powers upon entry into a premise of employment. This includes any health care facility in which persons are employed. And believe it or not, there are GPs who have been inspected by NERA.

Slide 73 – Records Required for NERA Inspection

This slide lists the information that a GP as employer must be able to provide during a NERA inspection.

1) Employer registration number with the Revenue Commissioners
2) Full Name, Address and PPS Number for each employee (full-time and part-time)
3) Terms of employment for each employee
4) Payroll details (Gross to Net, Rate per hour, Overtime, Deductions, Shift and other Premiums and Allowances, Commissions and Bonuses, Service Charges, etc.

5) Copies of Payslips
6) Employees' job classification
7) Dates of commencement and where relevant, termination of employment
8) Hours of work for each employee (including starting and finishing times, meal breaks and rest periods). These may be in the form of Form OWT1 (or in a form substantially to like effect).
9) Register of employees under 18 years of age
10) Whether board and/or lodgings are provided and relevant details
11) Holidays and Public Holiday entitlements received by each employee
12) Any documentation necessary to demonstrate compliance with employment rights legislation

This list is pretty extensive and I would guess might frighten many GPs around the country. But the reality is that GPs are already being inspected by NERA.

Slide 74 – HSA

As well as HIQA and NERA there is also the HAS, the Health and Safety authority. The focus of this body is around safety and risk assessment. No different than NERA, there is also an entire raft of documentation that is required for inspection, including those policies listed above and a lot more besides. The bottom line is that no different than with HIQA or NERA, you must be prepared and it is therefore advisable to identify within the practice who the lead clinician and lead governance persons are. This may be a clinician but a practice manager is often well placed to deal with many of the documentary aspects required by these bodies.

Cost Saving Measures

Slide 76 – Money Saving Measures in Practice

We now move on to cost saving measures. This really is just to open the floor to a discussion about innovative cost saving measures that you may have come across or thought of. One example which came from Limerick was the "JobBridge". This is a National Internship Scheme run by FAS under the Department of Social Protection which provides work experience placements for interns for a 6 or 9 month period. Its aim is to assist in breaking the cycle where jobseekers are unable to get a job without experience, either as new entrants to the labour market after education or training or as unemployed workers wishing to learn new skills. The scheme will also give people a real opportunity to gain valuable experience to bridge the gap between study and the beginning of their working lives. Interns will receive an allowance of €50 per week on top of their existing social welfare entitlement. This will be payable for the period of the internship. THAT'S RIGHT …. much cheaper than the alternative! However, the expectation is that at the end of that period the Interns may be offered a job.

Perhaps there may be other suggestions or innovations out there?