Financial Planning for
GENERAL PRACTICE REGISTRARS
# Table of Content

<table>
<thead>
<tr>
<th>PART</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INTRODUCTION AND WELCOME</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>THE BASIC IDEA IN LESS THAN ONE PAGE</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>HOW MUCH DO DOCTORS EARN?</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>BUYING A HOME</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>BUYING YOUR CAR</td>
<td>11</td>
</tr>
<tr>
<td>6</td>
<td>TRAVELLING OVERSEAS</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>[COMMISSION FREE] LIFE INSURANCE</td>
<td>16</td>
</tr>
<tr>
<td>8</td>
<td>[COMMISSION FREE] INCOME CONTINUANCE INSURANCE</td>
<td>20</td>
</tr>
<tr>
<td>9</td>
<td>DO YOU REALLY NEED A WILL?</td>
<td>24</td>
</tr>
<tr>
<td>10</td>
<td>TAX PLANNING FOR EMPLOYEE GPS</td>
<td>28</td>
</tr>
<tr>
<td>11</td>
<td>YOUR EMPLOYMENT AGREEMENT</td>
<td>34</td>
</tr>
<tr>
<td>12</td>
<td>SUPERANNUATION FOR YOUNG GPS</td>
<td>39</td>
</tr>
<tr>
<td>13</td>
<td>WORKING AS A PRIVATE CONTRACTOR</td>
<td>44</td>
</tr>
<tr>
<td>14</td>
<td>ARE YOU LIVING WITH SOMEONE?</td>
<td>50</td>
</tr>
<tr>
<td>15</td>
<td>WORK LIFE BALANCE FOR GPS: THE CONSPIRACY OF SILENCE</td>
<td>53</td>
</tr>
<tr>
<td>16</td>
<td>INVESTING: WHAT YOU WON’T READ ANYWHERE ELSE</td>
<td>56</td>
</tr>
<tr>
<td>17</td>
<td>DEBT AND GPS</td>
<td>60</td>
</tr>
<tr>
<td>18</td>
<td>PROTECT YOUR ASSETS</td>
<td>66</td>
</tr>
<tr>
<td>19</td>
<td>YOUR PRACTICE: THE BEST INVESTMENT</td>
<td>69</td>
</tr>
<tr>
<td>20</td>
<td>WHAT IF THINGS ARE REALLY TIGHT?</td>
<td>79</td>
</tr>
</tbody>
</table>
Part 1  Introduction and welcome

Welcome to Financial Planning for General Practice Registrars. I hope we meet your expectations and our manual is the start of a life-long financial plan that ensures you get the most out of your career and your life.

Congratulations on choosing medicine as a career. It is a good choice. Medicine is the most financially rewarding profession. Doctors, on average, earn more than all other professions. Doctors’ incomes are more stable and secure than all other professions. There are no unemployed doctors. Doctors earn for longer too. There is no pre-determined use by date. A doctor can keep earning a high income, on a part time or full time basis, well past the average retirement age of 50 for women and 58 for men, and well past the “statutory” retirement age of 65. We have many clients well into their seventies working half time and loving it. This may seem a bit remote, even daunting, if you are still in your twenties or early thirties. But it may give some perspective to your contemporary decisions. Medicine is a long-term career.

Medicine can be a family friendly profession if you want it to be. You may not have noticed this yet, but virtually every doctor can choose to work less than full time and still earn a very high income if he or she really wants to. And more and more doctors are doing this. We have hundreds of clients in their mid-thirties who have prioritised their child care years and are happy to work, say, six sessions a week and have plenty of time for their kids and each other. Medicine is the only occupation where this can be done, virtually as of right, and you can still earn $150,000 a year, or three times the national average for a fifty year old male, in just three days a week.

It is interesting, but there is only a low correlation between doctors’ income levels and wealth accumulation. We have doctors earning $1,000,000 a year with no significant assets, and we have doctors earning much less who have invested well and are multi-millionaires. This is because some doctors spend a lot, and other doctors invest a lot and started investing early. Income does not determine wealth. Sure it helps. But you do not have to work seventy hours a week to become wealthy.

Medicine is a career where you can have “It” all. By “It” we mean plenty of time for family, friend and non-work interests, satisfying work and a high sense of personal well being as well as enjoying a safe and secured high income, and a high level of wealth accumulation.

This manual explains how you can have “It”. There is no elusive “Secret”. Financial planning for young GPs is actually quite straightforward. By starting some simple common sense strategies as soon as possible you can make sure the financial side of things is maximised, almost automatically, and you are able to do all the other things you want to do.

Never forget the four basic rules:

✓ keep it simple;
✓ never trust anyone with your money;
✓ never give up control; and
✓ never invest in anything that pays anyone a commission.

Follow these four rules and you will probably end up quite wealthy.
Arrange a meeting

I hope you enjoy this manual and its message. Keep in touch.

To arrange a meeting contact Amy Cropley on 03 9583 6533 or amyk@mcmasters.com.au and make an appointment for a meeting to consider how the ideas in the manual apply to you. The meetings can be in our Cheltenham office, or by Skype or teleconference.

We think it is worth four or five hours of our time to ensure you are on the right track and doing everything you can do to make sure you get the most financially from your career.
Part 2  The basic idea in less than one page

Once or twice a week we sit down with a young GP, pro-bono, and walk them through the things they should be doing to minimize their tax, maximize their wealth and get the most from the financial side of their practice.

In summary, we say:

- salary sacrifice up to $25,000 a year into a low cost commission free industry super fund, such as HESTA. Industry super funds out-perform retail funds because they have lower costs and do not pay commissions. Getting the super snowball rolling as fast as possible as early as possible is step 1 in any doctor’s financial plan. We discuss superannuation in detail in Part 12 (page 39);

- buy a house, almost any house, as long as it is in a capital city, and rent it out as a negative gearing strategy. This will lock you into the market and hedge you against future house prices, making it much easier to buy a real home down the track. We discuss strategies for buying a home in Part 4 (page 6);

- buy a car and carry your laptop, patient notes, brief case, and bulky medical equipment and run a log book for 12 weeks showing home to work travel as deductible business travel;

- arrange at least $60,000 a year of income continuance cover, indexed by inflation, to age 65 with a 90 day waiting period, using the McMasters’ Commission Rebate service so you pay an average of 25% less than everyone else;

- if you have dependants, arrange up to $1,000,000 of cheap, tax effective and commission free life insurance by buying extra life insurance units in your industry superannuation fund;

- sign a simple will leaving your assets to your next of kin, or creating a testamentary trust for your children if you are or soon will be a parent;

- if you can, enjoy a tax-deductible overseas study tour, visiting appropriate medical institutions and learning more about the world of medicine; and

- get as much variety and diversity in your work experience as you can, as your professional skills are your best investment and will drive your financial plan.

Owning your own practice is the best investment, assuming your life circumstances allow you to do this. You can practice medicine until you are in your seventies if you want to, assuming your mind and body are up to it: so take good care of both of them and do not over do the work in the early years. You have worked hard to get where you are now. Make sure you enjoy yourself and get the most out of your career and personal relationships. It’s not all about money.

Never forget the four basic rules:

- keep it simple;
- never trust anyone with your money;
- never give up control; and
- never invest in anything that pays anyone a commission.

Follow these four rules and you will probably end up quite wealthy.
Part 3  How much do doctors earn?

There is a serious shortage of doctors in Australia. The shortage spans all specialities, but is particularly acute for GPs. The shortage is Australia wide: there is a shortage in Double Bay and a shortage in Dubbo, and all places in between. Virtually every practice is short staffed and would take on another doctor tomorrow, if only they could.

There are no unemployed doctors in Australia.

This means there is plenty of work for overseas trained doctors in Australia, and with the Australian population getting bigger and older, this is not going to change for many years. In fact, the shortage of doctors will get worse before it gets better, and the new medical schools will take at least ten years before their first batch of graduates are able to practice unsupervised on their own.

Doctors’ incomes

Doctors’ incomes are high relative to the general population. The Australian Bureau of Statistics estimates the average full time adult to earn about $73,000 a year and many earn significantly less: income statistics tend to be skewed upwards by a relatively small number of (much) higher income earners.

Averages are very deceptive, and exceptions do occur, but a realistic range of average incomes for Australian doctors looks like this:

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Average</th>
<th>Typical Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan GP, non-owner</td>
<td>$A220,000</td>
<td>$A180,000 to $A360,000</td>
</tr>
<tr>
<td>Metropolitan GP, owner</td>
<td>$A275,000</td>
<td>$A220,000 to $A500,000</td>
</tr>
<tr>
<td>Rural GP, non-owner</td>
<td>$A300,000</td>
<td>$A270,000 to $A450,000</td>
</tr>
<tr>
<td>Rural GP, owner</td>
<td>$A400,000</td>
<td>$A350,000 to $A700,000</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>$A450,000</td>
<td>$A400,000 to $A600,000</td>
</tr>
<tr>
<td>Dermatologist</td>
<td>$A400,000</td>
<td>$A400,000 to $A600,000</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>$A350,000</td>
<td>$A300,000 to $A500,000</td>
</tr>
<tr>
<td>Paediatricians</td>
<td>$A300,000</td>
<td>$A250,000 to $A400,000</td>
</tr>
<tr>
<td>Opthomologist</td>
<td>$A400,000</td>
<td>$A350,000 to $A700,000</td>
</tr>
<tr>
<td>Anaesthesist</td>
<td>$A400,000</td>
<td>$A350,000 to $A700,000</td>
</tr>
<tr>
<td>Surgeon</td>
<td>$A400,000</td>
<td>$A300,000 to $A700,000</td>
</tr>
<tr>
<td>Obstetrician</td>
<td>$A400,000</td>
<td>$A300,000 to $A700,000</td>
</tr>
</tbody>
</table>

*The figures shown are based on a 50 year old working a standard 50 hour week.*

These figures are competitive with international income levels, with Australian doctors amongst the highest paid in the world. These figures are also competitive with other professions in Australia, and place doctors amongst the highest, if not the highest, occupational groups in Australia.

Australian doctors enjoy high incomes relative to other Australians and international doctors. But there is more than this to the story. In Australia, doctor’s incomes are much more stable, secure and last longer than any other occupation: there is no mandatory retirement date for doctors and there are many examples of doctors working well into their
seventies and even their eighties on a reduced working week and earning high incomes and enjoying contributing to their community. Many doctors choose to work less than a full working week to accommodate their preferred family lifestyle while many other doctors, often overseas trained doctors who are keen to earn more and set up their financial future, choose to work more than a full working week. The good news is that medicine is flexible and easily accommodates both choices. Doctors can control the number of hours they work each week and there is no minimum or maximum number of hours, or sessions (a session typically running for between three and four hours depending on the practice).

Most GPs see at least 3 patients an hour. But some can see as many as 6 or even 7 patients an hour. Most GPs are paid per service, by the patient, depending on the item number (descriptor) that applies to the service. Medicare provides universal health insurance to Australian citizens, and indemnifies at least part of the cost of most services. Many practices will “bulk bill” the insurer, rather than the individual patients, as this is more convenient for their patients and because this will maximize long term profits and financial viability.

GPs who see more patients per hour, and/or who work longer hours, usually have higher incomes. This explains the wide range of incomes shown in the above table. As a general proposition the less fashionable metropolitan suburbs and rural regions tend to be more profitable. This is due to supply and demand forces and, in some cases, government grants and similar payments to disadvantaged and rural areas to encourage GPs in these locations.
Part 4  Buying a home

The average home price in Melbourne is now more than $640,000. The other capital cities are pretty much the same. The Reserve Bank expects the Melbourne median price will be $1,000,000 by 2020, largely driven by surging population growth, a growing economy and rising incomes. The other states are pretty much the same. The Real Estate Institute of Australia provided the following data as at September 2013:

<table>
<thead>
<tr>
<th>City</th>
<th>September 2013</th>
<th>June 213</th>
<th>% change over quarter</th>
<th>% change over year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sydney</td>
<td>$588,000</td>
<td>$618,600</td>
<td>5.2%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Melbourne</td>
<td>$525,000</td>
<td>$551,300</td>
<td>5.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Brisbane</td>
<td>$420,000</td>
<td>$425,000</td>
<td>1.2%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Adelaide</td>
<td>$375,000</td>
<td>$376,100</td>
<td>0.3%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Perth</td>
<td>$493,500</td>
<td>$499,900</td>
<td>1.3%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Canberra</td>
<td>$495,000</td>
<td>$507,900</td>
<td>2.6%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Hobart</td>
<td>$300,000</td>
<td>$291,000</td>
<td>-3.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Darwin</td>
<td>$510,000</td>
<td>$510,500</td>
<td>0.1%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

Most GPs have to earn between $800,000 and $900,000 of pre-tax income to buy a home costing $500,000 after tax. Most first homebuyers’ home loans take 25 years to pay off. $900,000 is a lot of money and 25 years is a long time.

The position will be more difficult if the Reserve Bank predictions prove correct.

Our advice to young GPs has always been to buy as many homes as the bank will lend you as soon as possible. How can a young GP do this?

Negative gearing

One way of reducing the cost of a home is to get a tenant and the taxman to pay it off for you. This is known as negative gearing. Negative gearing is jargon for borrowing to buy an investment, where the expected assessable income is less than the expected deductible interest, with a resultant net deduction against the GP’s salary income (or other assessable income, as the case may be).

An example may help: A client, Lucy, bought a new $400,000 apartment in early 2012. It was not where she wanted to live, but it was a nice apartment, was secure, and well located with excellent capital gain prospects. It was very rentable.

McMasters’ arranged for Lucy to borrow the purchase price, i.e. $400,000 plus stamp duty, at 6% interest from a medical specialist-lending group.

Lucy received the first homeowners’ grant and lived in the apartment for 6 months. She shared with a friend and received $150 a week board (to cover her friend’s share of costs), tax-free in Lucy’s hands. Lucy eventually took a position in a regional hospital and rented her home to a tenant. They are paying Lucy $270 a week, or $14,000 a year.
The $14,000 is not enough to cover Lucy’s $24,000 yearly interest bill. But Lucy claims the shortfall, i.e. $10,000, as a deduction in her tax return. With overtime Lucy is earning nearly $100,000 a year. Lucy is in the 38.5% marginal tax bracket, and the rental loss generates a $3,850 extra tax refund each year.

Lucy also claims $5,000 building allowance, and $5,000 depreciation each year (including her share of the elevator and other common plant and equipment). These two deductions generate a further $3,850 extra tax refund each year.

Lucy’s total tax refund is $7,700, and this almost covers the $10,000 gap between rent and interest on the loan. Lucy can easily pay the $2,300 shortfall.

Lucy’s apartment is now valued at $500,000, so she is off to a good start. Lucy is glad that she bought her apartment when she did. She will probably never live in her apartment again, and will keep it forever as a core investment. But Lucy can borrow against it for her real home down the track and she is well on her way to financial independence.
Lucy was lucky because her parents were prepared to guarantee the loan for her, meaning she did not have to wait a couple of years, and miss a couple of years of capital gain, while she saved a deposit. Using a medical specialist lender made sense: they understand GPs’ income profiles and are aware that GPs are excellent risks for banks, and almost never default on loans.

But Lucy still did it all herself and has the satisfaction of knowing this.

Sharing with friends

Board received from housemates who live in the house with you is not assessable income.

Looking at Dr Lucy again, in the first six months she lived in her apartment and shared with a friend. Her friend paid $150 a week board. The Australian Taxation Office considers board in these circumstances to be an offset of non-deductible private costs, and not assessable income (i.e. no benefit conferred on Lucy). This means Lucy did not pay tax on this amount. In the 38.5% tax bracket $150 a week tax free is the same as earning $208 a week in taxable income, or the equivalent of nearly $10,800 a year in extra salary.

As it happens Lucy rented the apartment out after about 6 months. But had she stayed there sharing with a friend would have really have taken the sting out of the repayment program. We have another GP who owns a five-bedroom house and receives $200 a week from each of four other housemates. That’s $800 a week cash, the equivalent of nearly $1,400 a week in extra salary, or $70,000 a year. Sharing with four others is a bit extreme for a 35 year old. But he is paying his home loan off at an incredibly fast rate.

Co-ownership with parents

Some doctors buy homes as co-owners with parents. The parents usually pay 100% of the deposit, guarantee the loan and generally make the project work.

This strategy has worked for some doctors, but on balance we are not that happy with it. The reason is simple: our client ends up only owning half a home. And a doctor owning half a home is not that great a result.

We also think owning half your home with mum and dad is a little uncool. If a doctor cannot own all his or her own home something is wrong somewhere.

Co-ownership with friends or siblings

It’s different if you are talking about co-owning a home with friends or siblings. It can make sense to team up with someone and buy say a $1,000,000 home in a great location close to work and all amenities with plenty of living space and privacy, instead of two smaller homes, a distance from work and without the capital gains prospects of the bigger home.

Each case is different, and co-ownership is not for everyone. But it can work beautifully.

A written co-ownership agreement is a must. Even with siblings or best friends. It gives everyone peace of mind and makes sure you will not lose a best friend if circumstances change. And over time your circumstances will change.
Parental guarantees

Anecdotally, more than two thirds of new homes are bought with significant parental assistance, usually in the form of deposit gifts, co-ownership, repayment subsidies, extra security and guarantees. We expect this is lower for doctors, as they have higher incomes and tend to be financially independent.

We confess to not being in favour of significant parental assistance when doctors buy homes. There is usually no need for it and it can create relationship problems in the future. This depends on each family’s individual circumstances and psychologies.

The exception is parental guarantees. Normally there is virtually no risk with a doctor’s parent providing a guarantee. Think about it: the parent is only exposed to the possible drop in value of the property, and this is probably not a great amount. And once a few years have passed the risk usually disappears, as the property increases in value and the equity builds. And doctors virtually never default on loans, and can always earn a bit more by working weekends or nights if they have to.

We think parental loan guarantees for young doctors make a lot of sense. They mean the doctor can buy more properties, sooner, and this usually means more capital gain for less effort. Realistically there is not much risk for the parent.

Common sense is needed but within limits parental guarantees are a great idea.

Positive gearing

Positive gearing is the opposite of negative gearing, and is jargon for borrowing to invest where the expected assessable income exceeds the expected deductible interest cost, with a resultant increase in assessable income. In the context of housing prices, this means buying a property with a rental yield of 6% or more, which is an unusual phenomenon.

Most houses do not generate rents of more than about 3% or maybe 4% of the cost or value of the property. This means it’s very hard to positively gear houses.

Sometimes positive gearing works OK, but it’s usually a sign the house is not that good and either needs a lot of work or is falling in value and not worth buying.

Take great care if you encounter claims of positively geared houses.

Positive gearing of other types of investments is a different proposition. For example, in early 2008, we recommended clients borrow to buy bank shares, which at the time were selling on after tax yields of as much as 13%. This means if a client borrowed, say, $100,000 to buy ANZ shares, they received $13,000 of assessable income, paid $6,000 of interest and made $7,000 of cash profit on the deal; plus capital gains.

It can make a lot of sense for a young GP to adopt a strategy like this as an alternative to buying a home. However, you need to do it to the tune of at least $400,000 before it becomes a comparable strategy.

(It’s interesting, but if you also borrow $400,000 to buy a home, the net dividends from the shares cover more than the interest on the home loan. Plus you do not have to pay rent, plus you enjoy capital gains on both the home and the shares.)
Buying purely for investment purposes

Buying a home hits a psychological sweet spot with most of us. It’s the nesting instinct. The idea of always having a home over our heads intuitively appeals.

But it would be an amazing statistical coincidence if the most suitable home is also the best possible investment option. It almost certainly isn’t, and there is a lot to be said for the idea of buying purely for investment purposes and renting or leasing a house that suits your needs at each stage of your life.

One proponent of this view is Phil Ruthven, CEO of Access Economics, and a well-known and respected commentator on financial matters. Mr Ruthven argues that over time most people will be better off renting, and paying the difference between their rent and the home loan interest payable into superannuation and shares.

Mr Ruthven may be right, if things unfold in line with his assumptions (which seem to ignore the historical out-performance of property over shares) and one has the discipline to invest regularly through shares and superannuation.

But we expect for most GPs, home ownership, and eventually owning your own practice, your own practice premises and your own superannuation fund will be the best way to go.

A word on banks and bankers


We deal with all banks and we are generally of the view that whichever bank you are with now is probably the best bank for you, based on the devil you know theory of selecting a bank. We are often asked “which bank is best?” and our answer is usually that it’s not so much which bank, but which banker within that bank, that makes the difference. Some bankers are marvellous, and understand doctors and have loads of experience dealing with doctors. Some bankers are disasters, and just aren’t worth your time and bother.

We think it makes sense early in your career to link up with a bank lender who has experience and expertise with doctors. This is probably going to save you time and money in the future, and creating a track record and a client history now may pay off in the future.

Each of the big banks, and groups like Experien and Medfin have bankers who we think are pretty good and you should contact us if you need a referral.

Your bank manager is not your friend

You can be friendly with your bank manager, but your bank manager is not your friend. You sit on opposite sides of the table and your interests can be opposite to each other.

Your bank manager loves his children more than he loves you and this means he wants you to pay more if possible. Don’t worry, that the capitalist system. But don’t forget it either.
Part 5  Buying your car

Cars cost a lot of money so it’s not surprising that in virtually every client meeting, the car questions come up. What to buy? How much to spend? Who should own it? And how much can be claimed for tax?

The good news is that it’s all good news. The tax law treats car costs generously and excellent tax results are possible. Standing instructions start with an explanation of the luxury car depreciation limit. Back in the eighties, Treasurer Paul Keating capped the tax benefits on cars at the top end of the price spectrum. The car limit sits at $57,466 for the year ending 30 June 2014. This means there is no tax relief for the capital cost over $57,466.

We prefer our clients buy second hand cars. Bargains abound in the second hand market and excellent cars, often only one or two years old, can be bought at or around this limit. It is a sensible strategy: let some other mugs take the big hit as the car drives out the showroom door and then enjoy years of reliable driving with a car that is, in engineering terms, still virtually brand new.

Once the car is bought, get out that log-book and record all your travel for the next 12 weeks. The key point is that for virtually all GPs, home to work travel is business travel, provided bulky medical equipment is on board, or at least in the boot (see the decision of Mr Pascoe in AAT Case 9235 1994 27 ATR 127, where a doctor’s home to work travel was treated as deductible business travel on account of the need to carry bulky medical equipment). Home to work travel is deductible for GPs if they use their car to carry bulky medical equipment. This is accepted by the ATO.

The log book is essential: there is no deduction without a log book. You can buy a log-book at a newsagency or download one from www.mcmasters.com.au or your AppStore.

Bulky medical equipment need not be heavy. Certainly patient files, your doctor’s bag, laptop, and emergency equipment book comprise bulky equipment for these purposes.

What is bulky medical equipment? It’s a question of fact and differs from case to case. Bear in mind the early court cases involved a rugby player’s sports bag and a musician’s saxophone (and Mr Pascoe decided these cases apply to doctors too). A doctor’s bag, a laptop and some patient files will get most GPs over the line. If there is doubt we suggest you invest in an over-sized fishing boxes used to carry emergency medical equipment about. Then you are home and hosed on the tax side of things; and equipped for an emergency.

Emergency medical kits can be obtained from:

http://www.racgp.org.au/memberbenefits/gpkit;

Making sure you claim a high business percentage means the after tax cost of the car will fall significantly.

An example may help. Dr Joe had recently bought a new black Mazda 3 and it cost him $30,000. Joe followed our advice and kept a logbook for a continuous 12 week period, whereby he recorded each business trip made using that car. He recorded his home to work travel as a business travel on account of the requirement to carry bulky medical equipment.
in his car at all times. At the end of the 12 week log book period, he compared the total business kilometers to the overall total kilometers driven during the logbook period. The professional use percentage for his car turned out to be 90%, which means that he could claim 90% of the running costs of the car including the depreciation on the car.

Joe’s tax benefits from owning the car is nearly $4,800 cash a year, calculated as follows:

| Calculation of tax benefits of the car (1st full financial year) |
|------------------|----------------|
| Depreciation (25% of $30,000) | $7,500 |
| Interest on loan | $2,000 |
| Petrol | $2,000 |
| Other costs (insurance, registration, service, etc) | $2,000 |
| Total costs | $13,500 |
| Business percentage (i.e. 90%) | $12,150 |
| Tax benefit (39.5% tax rate) | $4,799 |

How much should you spend on a car?

Our view is younger GPs should not spend too much on cars. Your money is better spent building up assets and creating a wealth base for later in life. Something safe and reliable, probably costing between $20,000 and $30,000, with maximum tax efficiency, is our standard recommendation.

And if you must get a luxury car, do not spend more than $57,466: anything above this is extremely tax inefficient and pretty much a waste of money. The opportunity cost over the next twenty years will be huge.
Part 6   Travelling overseas

Most young GPs are pretty keen to travel overseas and the good news is overseas travel is very deductible for doctors, and this can significantly reduce the after tax cost of your trip. With appropriate record keeping, the whole of the trip can be treated as deductible even though on a time basis, actual business activities may be a relatively low total percentage.

First, we are talking about real travel, for the purpose of expanding your existing body of medical knowledge and experience. We are not talking about lying on a beach in Bali or wherever. Holidays are great, and we recommend you take them frequently. But it’s not what we are talking about here.

Here we are talking about travelling to, say, the USA, New Zealand, the UK, and Western Europe for the purpose of expanding your existing body of medical knowledge and experience. We are talking about regular planned visits to medical institutions, including clinics, hospitals and universities.

We are often asked when and how overseas travel costs can be deducted against a GP’s assessable income. The answer is simple: overseas travel costs are deductible to the extent they are incurred for the purpose of producing assessable income.

More expansively, and perhaps more helpfully, travel costs are deductible when incurred to increase or maintain an existing body of knowledge currently used to produce income.

Purpose determines deductibility, and paper proves purpose. It’s important to document your professional purposes before, during and after travel. The worst case is usually a part deduction for your travel costs, which is better than no deduction. But with proper planning 100% deduction or close thereto, can usually be achieved.

Purpose determines deductibility, not time. So travel costs are 100% deductible if the GP has meetings for an average of, say, two hours at different locations at average intervals of, say, two days. However, if the intervening hours are spent doing the classic tourist track, an inference may arise that there was a dual purpose, and to that extent the costs will not 100% deductible, but perhaps are just, say, 50% deductible.

Paper proves purpose. Particularly third party paper created before or during the trip. Paper created by the GP, particularly paper created by the GP after the trip, has a low evidentiary value. So it’s important to take care with the paper trail: this includes a properly completed log book, emails and memoranda to and from colleagues before and after the trip, communications with the travel agent and others involved in organising the trip, and, ideally, post-trip correspondence, such as instructions for improving your practice’s service delivery based on your experiences and proof that the improvement occurred.

Third party invoices and an itemised travel diary or itinerary are substantiation musts under the Australian taxation law.

You are allowed to enjoy yourself. And you can spend as much as you think is appropriate. The Commissioner of Taxation cannot unilaterally reduce your costs to a preferred level of frugality: you can fly business class and you can stay at multi-star hotels without fear of upsetting the tax apple cart. The Australian Taxation Office is charged with determining the tax consequences of what you have actually expended, not what he thinks you should have
expended. So business class travel is fully deductible, even though economy class would have worked perfectly well.

What happens if you have two purposes? One purpose may be to learn more about your profession and the other purpose may be to catch up with an old friend? Here the tax law requires apportionment: the costs will only be deductible to the extent they relate to learning about your profession. The apportionment will depend on the facts. A half-day trip to see an old friend may have no impact on deductibility. But staying with the old friend for three weeks, and having, say, one professional meeting each week for each of those three weeks means virtually no costs are deductible: the inference is that the costs are substantially private and the professional part is incidental and minor.

Accompanying spouses can be a problem as they may suggest a secondary or even a primary non-business purpose. But the bottom line is you can probably still claim all your room and car costs, even if your spouse’s airfare is not deductible. It’s perfect if your spouse is also a doctor or involved in your practice as a practice manager or nurse, because here, the second airfare costs will probably be deductible too. But it does depend on the facts.

Each case is different, and if in doubt the best rule is to document, document and then document again, so your tax agent can consider the matter and present the best possible case when preparing your tax return. Remember, you have to be in it to win it, and you are not in it if you do not do the paper work before you go. As always, planning is everything.

Take a look at the following 2013 travel itinerary by Dr Nicole:

<table>
<thead>
<tr>
<th>Day</th>
<th>Itinerary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Travel from Sydney to Orlando</td>
</tr>
<tr>
<td>2</td>
<td>Rest and recovery</td>
</tr>
<tr>
<td>3</td>
<td>Cape Canaveral Hospital and University of Florida</td>
</tr>
<tr>
<td>4</td>
<td>Disneyland</td>
</tr>
<tr>
<td>5</td>
<td>Preparation for seminar</td>
</tr>
<tr>
<td>6 &amp; 7</td>
<td>Weekend</td>
</tr>
<tr>
<td>8 to 12</td>
<td>Seminar</td>
</tr>
<tr>
<td>13 &amp; 14</td>
<td>Weekend: drive down to Miami</td>
</tr>
<tr>
<td>15</td>
<td>Miami Cardiac Assessment Centre</td>
</tr>
<tr>
<td>16</td>
<td>Everglades Cardiac Assessment Centre</td>
</tr>
<tr>
<td>17</td>
<td>Rest</td>
</tr>
<tr>
<td>18</td>
<td>Travel from Miami to Sydney</td>
</tr>
</tbody>
</table>
We concluded that the whole of Dr Nicole’s 2013 travel was tax deductible, being connected to her existing body of knowledge and income earning activities. There was no adjustment for the day at Disneyland, as this was a minor purpose, although obviously the costs of the ticket and similar costs were not deductible.

In summary, here are the rules to enjoy your trip while save on taxes:

✓ must be for the purpose of maintaining or advancing an existing body of knowledge used to produce assessable income
✓ purpose determiners deductibility
✓ paper proves purpose
✓ document, document and document
✓ before, after and during the trip
✓ dual purpose trips = part deductions
Part 7  [Commission free] life insurance

Some young GPs need life insurance. Some do not. Each case is different and the need for insurance is a question of fact, driven by the doctor’s individual circumstances.

For example:

(i) one GP, aged 28, may not need any life insurance, because he or she has no dependants and no one is financially prejudiced by his or her premature death;

(ii) a second GP, aged 28, may need $300,000 of life insurance because her mother is an aged pensioner and there will be no one to look after her mum if the doctor dies prematurely; and

(iii) a third GP, aged 28, may need $1,000,000 of life insurance because he is married with a dependant wife, two young kids and a third on the way.

Be wary of template advice: each case is different and should be thought through on its merit. And remember the agents and brokers are trained to talk you up to a bigger policy. Take what they say with a big grain of salt. It’s a sale pitch not objective advice.

What is life insurance?

Wikipedia answers this question as well as anyone else, and it says:

Life insurance or life assurance is a contract between the policy owner and the insurer, where the insurer agrees to pay a designated beneficiary a sum of money upon the occurrence of the insured individual's or individuals' death or other event, such as terminal illness or critical illness. In return, the policy owner agrees to pay a stipulated amount called a premium at regular intervals or in lump sums. There may be designs in some countries where bills and death expenses plus catering for after funeral expenses should be included in Policy Premium. In the United States, the predominant form simply specifies a lump sum to be paid on the insured's demise.

As with most insurance policies, life insurance is a contract between the insurer and the policy owner whereby a benefit is paid to the designated beneficiaries if an insured event occurs which is covered by the policy.

To be a life policy the insured event must be based upon the lives of the people named in the policy.

Life policies are contracts and their terms describe the limitations of the insured events. Specific exclusions are often written into the contract to limit the liability of the insurer; for example claims relating to suicide, fraud, war, riot and civil commotion.

Life-based contracts tend to fall into two major categories:

- Protection policies - designed to provide a benefit in the event of specified event, typically a lump sum payment. A common form of this design is term insurance.

- Investment policies - where the main objective is to facilitate the growth of capital by regular or single premiums.

This is an American definition but it pretty much sums up the Australian situation too.
Why do young GPs need life insurance?

So if they die their dependants are looked after financially.

The sum insured needs to be relevant to the dependants’ financial circumstances: generally the more vulnerable the dependant, the greater the sum insured. For example, if you are married to another doctor you may not need as much life insurance compared to a friend who is married to say a hairdresser or a social worker.

How much does life insurance cost?

The answer is it depends. The cheapest way to secure life insurance is through industry superannuation funds such as Health Super and HESTA. These funds provide universal life cover to all members, without a medical examination and without medical disclosure.

For example, at age 28, a member automatically receives $166,200 of death cover and $166,200 of total and permanent disability cover for just $3.30 a week. The $3.30 is effectively tax deductible because it is paid out of your deductible contributions. This is remarkably cheap, and the simplest and easiest way to arrange life cover. The $166,200 will be sufficient for many young GPs.

There are no commissions paid to anyone which means we like industry fund insurances.

But once you have kids $166,200 is nowhere near enough cover, if you love them.

Here you can consider:

(i) arranging extra life cover through your existing industry super fund. You can do this online which is cheap and commission free;
(ii) joining another industry fund. Most of the industry superannuation funds provide similar cover. The covers are cumulative. Therefore, if a GP is a member of each of Health Super and HESTA, he or she will have twice this cover. Some clients have as many as five industry fund memberships: a remarkably cheap and easy way to arrange a relatively large amount of life insurance without any medical examinations and without any medical non-disclosures; and/or
(iii) arranging a separate life insurance policy directly with a life insurance company through a life insurance agent or broker.

Once kids come into the equation we believe the total sum insured for a couple should be at least $1,000,000. And possibly a lot more, depending on your spouse’s occupation, your spouse’s insurance, the number of kids and your existing family financial profile including your parents’ financial profile.

Life insurance agents and brokers

Sometimes GPs cannot get an appropriate amount of life insurance through industry superannuation sources. Here the only alternative is a life insurance agent or broker.

The problem is commissions. Insurance agents and brokers are rewarded by commissions; initial commissions, bonus commissions, volume commissions and trailer commissions. This means the agent or broker will almost always try to sell you up. That is, increase the amount of life insurance above what you really need to maximise commission income.
To be forewarned is to be forearmed.

Be careful when dealing with insurance agents and brokers: they are trying to maximise their commission income more than ensuring you have appropriate life insurance and are not over-insured.

**McMasters’ Commission Rebate Scheme**

McMasters’ Commission Rebate Scheme allows us to refund all the commissions paid, including trailer commissions, on life insurance policies. Our fees are strictly time based, quoted in writing and always well below the relevant commissions.

This means young GPs can set up insurance without paying commissions. This reduces the cost of the insurance by more than 25% over the life of the policy.

This also means many doctors end up with a net refund in the first year. The first year commissions are often more than 100% of the premium payable, so the commission refund will be say $2,400, whereas the premium is only $2,000. So you make money (at least in the first year) by arranging extra life insurance.

You can learn more about the McMasters’ Commission Rebate Scheme, and arrange to receive a refund of commissions on any existing life insurance or income continuance insurance policies at www.mcmasterscommissionrebaters.com.au

The following example shows how the McMasters’ Commission Rebate Scheme works.

Dr Tom, a 35 years old GP arranges his life insurance and income continuance insurance with one of Australia’s major insurers through McMasters’ Commission Rebate Scheme.

The premium on his life insurance is about $1,500 p.a. and the premium on his income continuance is about $2,500 per annum. The adviser receives 120% of commission in year 1 and 11% of commissions of each subsequent year’s premium for the life of the policy.

<table>
<thead>
<tr>
<th>Insurance policies</th>
<th>120% of initial commissions</th>
<th>11% of trailing commissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life insurance</td>
<td>$1,800</td>
<td>$165</td>
</tr>
<tr>
<td>Income continuance</td>
<td>$3,000</td>
<td>$275</td>
</tr>
<tr>
<td>Total</td>
<td>$4,800</td>
<td>$440</td>
</tr>
<tr>
<td>Less our handling fee*</td>
<td>$286</td>
<td>$286</td>
</tr>
<tr>
<td>Commissions rebated</td>
<td>$4,514</td>
<td>$154</td>
</tr>
</tbody>
</table>

By nominating us as his adviser, Tom actually receives $4,514 of the commissions in the first year and $154 of the commissions every subsequent year he would have foregone if he had not nominated us as his broker.

The amounts Tom receives are directly proportional to the premiums he pays. The higher the premiums he pays, the higher the commissions are.

*McMasters’ charges handling fees of $160 plus GST for the first existing financial product and $100 plus GST for the second and further existing financial products every time we rebate the commissions. The fee is offset against the total commissions so there is no outgoing from you. Amounts will accrue until there is sufficient for rebate.
Other rules to follow

There are different types of life insurance policy. The only type suitable to a doctor is term insurance which is pure insurance and does not have any investment component.

Whole of life policies and endowment policies include investments run by the life office on your behalf. In summary, you would have to have rocks in your head to have a whole of life policy or an endowment policy. They are expensive, filled with commissions and unlikely to ever perform as an investment. Thankfully we do not see them very often these days.

A simple rule to remember: never own a whole of life policy or an endowment policy.

Your insurance premium is treated as a deductible superannuation contribution if it is structured through a superannuation fund. This happens automatically if your insurance is through HESTA. It can also be arranged by having your SMSF owns your term line insurance policy, or by making sure your term life insurance policy is issued by a superannuation fund owned by the life insurance company.

Do not over-insure

Insurance is essentially a bet. You are betting you are going to die inside the agreed term, and the life office is betting that you will not. The life office will probably win the bet. Many young GPs will need to make the best: the consequences of losing are too high to ignore.

But do not bet too much. Make sure the sum insured is realistic and relevant to your dependants’ future needs. Most young GPs will not need more than $1,000,000. You may wish to have a higher sum insured, but make sure you are aware of what you are doing. And make sure no one is getting paid a commission because of your decision.

<table>
<thead>
<tr>
<th>Age</th>
<th>Commission Free</th>
<th>With Commissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>$291.00</td>
<td>$388.00</td>
</tr>
<tr>
<td>30</td>
<td>$232.50</td>
<td>$310.00</td>
</tr>
<tr>
<td>35</td>
<td>$255.00</td>
<td>$340.00</td>
</tr>
<tr>
<td>40</td>
<td>$330.00</td>
<td>$440.00</td>
</tr>
<tr>
<td>45</td>
<td>$472.50</td>
<td>$630.00</td>
</tr>
<tr>
<td>50</td>
<td>$817.50</td>
<td>$1,090.00</td>
</tr>
<tr>
<td>55</td>
<td>$1,417.50</td>
<td>$1,890.00</td>
</tr>
<tr>
<td>60</td>
<td>$2,572.50</td>
<td>$3,430.00</td>
</tr>
</tbody>
</table>

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McMasters’ owns Dover Financial Dover Financial Advisers Pty Ltd.
Part 8  [Commission free] Income continuance insurance

Income protection/continuance insurance is mandatory for all young doctors.

But you have to make sure its commission free. Insurance commissions are huge: more than 25% of all premiums are paid back to the salesman as a commission, unless you do something about it.

McMasters’ Commission Rebate Scheme allows all doctors to get the commission component of their annual premiums back each year. And McMasters’ Insurance Group arranges income protection insurances (and all other risk insurances) on a no-commission basis. This means McMasters’ clients pay on average 25% less for their risk protection insurance than virtually everyone else.

Learn more about commission rebate scheme: www.mcmasterscommissionrebaters.com.au

What is income protection insurance?

Income continuance or protection insurance involves the GP paying a premium to an insurer in return for the insurer agreeing to pay a set amount to the GP should they be unable to work for more than one month or some other agreed period.

The set amount is usually set as a monthly, fortnightly or weekly amount, and as a maximum tends to be about 70% of the GP’s usual income. Problems can be encountered proving the GP’s income, once superannuation, related party salaries, negative gearing, service trusts and the rest of the tax planner’s armoury is taken into account. Usually communication between the GP’s accountant and the insurer, and an intelligent underwriter, will solve this problem: the larger income can be insured.

So, if a GP damages her back skiing at Perisher, and is laid up and unable to walk unaided for say three months, once one month has passed she can claim a monthly amount of, say, $10,000 per month, or the equivalent of $120,000 a year, under the income protection insurance contract, being 70% of her total reward from the practice, even though her own tax return may only show a taxable income of say $60,000.

But getting by for less than 3 months will not be a big deal for most GPs. It’s getting by for 3 years, or even 3 decades that is our big worry. It’s that bus that does not kill you but which causes mild brain damage that is the real concern here: your life expectancy stays the same but your earnings expectancy falls to nothing. For this reason GPs may prefer policies with a three month waiting period rather than a one month waiting period, as the premiums are significantly lower. A sound case can be made for running the risk that a GP is off for between one month and three months, but insuring the risk that the GP is off for more than three months. But it depends on the GP’s attitude to risk. The GP must be comfortable with the risk they run.

The number of financial dependants, whether they be children, parents or siblings, is relevant to the quantum of the sum insured, just as it is in the case of life insurance. But, unlike life cover, GP without any dependants will still need income protection insurance.

The policy documents need to be read carefully, and there is no substitute for an honest and competent adviser. For example, some policies are cancellable: each year the insurer can elect to cancel/not renew the policy if it wishes to. It can cancel the policy, for example,
if the insured is in poor health! This is remarkable, if you think about it. Do not touch cancellable policies: only non-cancellable policies should be considered. And the payments must last to at least age 65: many of the cheaper policies stop all payments after two years. Not much good at all for a 35 year old GP with a dependant spouse, three young children with BCIBD, i.e. bus crash induced brain damage, or some other condition that means they can never work as a GP again.

Premiums are usually tax deductible, because they relate to the insured GP’s assessable income, which will include any benefits paid under the policy.

**Trauma insurance**

Dr Marcus Barnard developed trauma insurance in South Africa. Dr Barnard noticed his heart attack patients often made a satisfactory recovery health-wise, but were left devastated financially. He encouraged the South African insurance industry to create a new product, which pays benefits on the occurrence of specified health traumas.

Trauma insurance was transplanted to Australia in the eighties and was originally limited to heart attack, cancer, strokes and by-pass surgery. It has grown to comprise a significant percentage of the total insurance market and the average contract extends to more than forty different health conditions, although some include as few as twenty. But nearly 70% of claims still involve heart attack, cancer, strokes or by-pass surgery.

Trauma insurance can be on a stand-alone basis or as part of a life insurance policy.

We are half-hearted about trauma insurance. There is too much devil in the detail. Fourteen years ago, a client suffered a terrible stroke and after five days in hospital the machine was about to be turned off, along with our client. A last minute operation, against the odds, saved the day, and he is thankfully still with us, although there was a huge amount of rehabilitation and he is still under a specialist’s care. He never got his trauma benefits. The policy document was worded so that if he recovered sufficiently, no matter how long it took, the insurer could avoid the payment. It is hard to imagine a more traumatic health event. But it still was not traumatic enough for the insurer.

We have heard of similar problems elsewhere. Trauma is defined in unintelligible terms and different definitions are used in different contracts. Doctors regularly tell us the contract definitions of various medical conditions are significantly narrower and more technical than those accepted by the medical profession. Hence our client had, according to his insurer, a non-traumatic near fatal stroke with permanent side effects, and no benefit payments.

Trauma insurance premiums are not tax deductible. This means they are relatively more expensive than income protection insurance premiums, which are normally tax deductible. Although there is a saving if a trauma occurs, as any benefits are tax-free. But with insurance premiums are certain, and benefits are not. So we prefer doctors to take out appropriate income protection insurance before they consider trauma cover.

Trauma insurance contracts can be held by self-managed superannuation funds. But the preservation rules apply and it is highly likely that, unless the doctor is 55 or older, most of the benefit will stay locked up in the fund. This is not the end of the world, but it is usually not what you would prefer.
On balance, we are not fans of trauma cover and usually counsel GPs against it, while thoroughly checking the life income protection boxes are ticked off.

Once again, if you do have trauma insurance you should make sure its commission free. Insurance commissions are huge: more than 25% of all premiums are paid back to the insurance salesman as a commission, unless you do something about it.

McMasters’ Commission Rebate Scheme allows all doctors whether or not they are McMasters’ clients to get the commission component of their annual premiums back each year. And McMasters’ Insurance Group arranges trauma protection insurances (and all other risk insurances) on a no-commission basis.

This means McMasters’ clients pay on average 25% less for their risk protection insurance than virtually everyone else.

Learn more about commission rebate scheme: www.mcmasterscommissionrebaters.com.au

What does income protection insurance and trauma insurance cost?

The tables below summarise the costs. The good news is premiums do not cost much for a young healthy GP. Income protection insurance premiums are tax deductible, but trauma insurance premiums are not tax deductible.

The tables shows the Increasing annual premium requirements for a female non-smoker under a typical income protection policy for $6,000 per month.

<table>
<thead>
<tr>
<th>Age</th>
<th>Premium for 30 days notice $6,000 pcm</th>
<th>Premium for 90 days notice $6,000 pcm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commission Free</td>
<td>With commissions</td>
</tr>
<tr>
<td>25</td>
<td>$530.61</td>
<td>$707.48</td>
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<td>30</td>
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<td>$2,601.72</td>
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<tr>
<td>60</td>
<td>$3,359.57</td>
<td>$4,229.94</td>
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</table>

Agreed value policies

<table>
<thead>
<tr>
<th>Age</th>
<th>Premium for 30 days notice</th>
<th>Premium for 90 days notice</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Commission Free</td>
<td>With Commissions</td>
</tr>
<tr>
<td>25</td>
<td>$636.54</td>
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<tr>
<td>60</td>
<td>$3,618.00</td>
<td>$4,824.00</td>
</tr>
</tbody>
</table>

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Part 9  Do you really need a will?

If you do not have any dependants and do not have any significant assets, it is quite possible that you do not need a will.

We are not saying you should not have a will. A simple low cost will saying you leave everything to your parents, or other next of kin, cannot hurt. But to be honest, it is no big deal if you die without a will. Sure, the probate process is a bit more complicated but in the scheme of things, this is not really a problem. And it’s not your problem: you are dead. If you die without a will your assets do not go to the government. Your assets go to your next of kin, probably your parents, and in most cases this will not be a problem.

The analysis changes once you start to accumulate assets or dependants. For example, if you are engaged to be married, or are otherwise in a long term relationship, it’s possible, and natural, to prefer your assets to pass to your partner, not, say, your parents. If this is the case, it is strongly recommended that you say so in your will and avoid “complications” should you die prematurely.

Men need to remember that they may be on the road to fatherhood without even knowing it. One of our first client deaths involved a young electrician killed on the job, and he never knew he was going to be a father. So once a man is in a relationship, it makes sense to make sure his will considers any children from that relationship.

A simple will for a young doctor, male or female, is set out in Appendix 1.

Will for a doctor with young children

If you are married or if you have kids you definitely need a will.

The McMasters’ standard will for a couple with young children is a simple will that leaves everything, including the proceeds of any insurance policies, to your family in accordance with a simple formula. If you die prematurely everything is left to your spouse. If you and your spouse both die prematurely your will leaves everything to a testamentary trust for the benefit of your children.

This is a deliberately simple and very natural approach that suits 99% of GPs and dentists who are married and have young children. This approach may not be suited to clients with older children or have divorced or separated from their first spouse. If you are not in this classification (i.e. if you are divorced or separated or have older children or do not have children) this will may not suit you and you should discuss your specific circumstances in meeting or teleconference with Terry McMaster.

Our standard will for a GP with young children uses a formulaic precedent whereby we simply insert your answers to the questions on the next page into a matrix in a schedule placed at the end of your will. Some clients express concerns that it all looks too simple. But that’s the way we like it. Keeping your will simple keeps your costs down. Your will only costs $200 a will or about $400 a couple, plus GST, compared to what can be thousands of dollars for a customised will creating testamentary trusts. And the costs of preparing a will is not tax deductible, which makes the unnecessary extra cost hurt twice as much otherwise.
Our simple approach achieves exactly the same results as more complicated wills, but saved you money and reduces time and trouble connected to the will.

We have also learnt that there is a direct relationship between the degree of complexity and the probability the will is ultimately signed. The more complicated things are the more expensive it is and the less likely you will end up with something for your money.

We have also learnt that the best solution to the question of who should be the trustee of the testamentary trust and who should be the guardian of any children under age 18 is “the will maker’s siblings and the will maker’s spouse siblings.” This is so even if you do not get on with one or two of your siblings. This is because a double premature death is a very low statistical probability, and as a practical matter, your families will determine who cares for your children in any case, no matter what you say in your will.

You can look at a sample will here: Download a sample will for a doctor with young children.

Part 19 (page 69) of the Doctors’ Guide to Financial Planning explains our general approach to the estate planning for doctors and dentists and also describes how a testamentary trust works, and explains the role of the guardian and the trustee in some detail. This document details the advantages of a testamentary trust.

The Doctors’ Guide to Financial Planning can be downloaded here: Download the Doctors' guide to Financial Planning.

We also refer you to an extract from the 2008 Trust Structures Guide prepared by the Taxation Institute of Australia and Harwood and Andrews, a well known firm of solicitors in Victoria. This extract provides further explanations of testamentary trusts work and the advantages that they achieve, including asset protection and income tax savings on distributions to under age children. This extract is included in the Frequently Used Documents section of the client only area of www.mcmasters.com.au and can be downloaded here: Testamentary Trust Materials.
Appendix 1: sample simple will for a young doctor

1. Name
I am the person named as the Testator in the Schedule. This is my last will and testament.

2. Address
My address is as stated in the Schedule.

3. Date
This will is made on the date stated in the Schedule.

4. Revocation
I revoke all my prior wills and testaments.

5. Appointment of executor
I appoint the person named in the Schedule as my Executor.

6. Appointment of alternate executors
If the person appointed under clause 5 is unwilling or unable to act as my Executor, I appoint the person named in the Schedule as the Alternate Executor to be my Executor.

7. Power of Appointment under any other trust
I appoint the Trustee to be the appointor of any other trust in which I hold a power of appointment. I direct the Trustee to exercise the power of appointment under that trust in a manner which is consistent with this Will. I direct the Trustee to treat the assets of the other trust as if they are subject to the terms of this Will and the Trust.

8. Disposition of estate
My estate shall be dealt with as follows:

(i) to pay back all of my debts;

(ii) to pay my funeral costs and related costs;

(iii) and further:

   a. if my mother is alive at the time of my death, I leave the remainder of my estate to my mother absolutely and without any conditions; and

   b. if my mother is not alive at the time of my death, I leave the remainder of my estate to my two brothers, Sim Sample and Som Sample, in equal shares absolutely and without any conditions and if either one of my brothers should die before me leaving children (ie me nephews or nieces) alive at the date of my death then those children (shall receive the share of my estate that otherwise would have been left to their parent (my my brother).

10. Discretionary Power of Sale
My Executor has a discretionary power of sale over all or any part of my estate.
11. **Execution and Attestation**

This will is signed and witnessed as follows:

<table>
<thead>
<tr>
<th>Signature</th>
<th>Full name and address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will-maker</td>
<td></td>
</tr>
<tr>
<td>First witness</td>
<td></td>
</tr>
<tr>
<td>Second witness</td>
<td></td>
</tr>
</tbody>
</table>

**Updated February 2014**
Part 10  Tax planning for employee GPs

Most young doctors will be employees when they first start working. Many will cease being employees and start their own practices as their training programs finish, but others will remain employees whether in hospitals, research organizations or general practice environments for many years. Some doctors, but not many, will remain employees for their entire working lives.

Generally speaking, the tax planning opportunities for employee doctors are narrower and fewer than for doctors running their own practices. For this reason we recommend young doctors cease being employees as soon as possible and instead run their own practices, whether as full equity owners or paying a management fee to a larger practice.

Why is tax planning important?

If you pay less tax, you earn more. It is that simple: you have worked hard to get where you are and you deserve to make the most of your salary on an after tax basis. Tax planning makes sure you do this.

An example may help. John is on the second year of his GP training program and earns about $83,000 plus the mandatory 9.25% superannuation. Overtime takes his total package to $120,000 including 9.25% superannuation. By getting the tax planning right, John is able to legitimately reduce his taxable salary income from $110,912 to $35,550 and save $22,695 tax/cash each year. This means he is $22,695 better off each year, and further on the way to creating a sound financial future for himself and his family.

The savings are summarized here:

<table>
<thead>
<tr>
<th>With no tax planning</th>
<th>With tax planning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount</td>
</tr>
<tr>
<td>Salary</td>
<td>$109,840</td>
</tr>
<tr>
<td>Super %</td>
<td>$10,160</td>
</tr>
<tr>
<td>Super extra</td>
<td>$14,840</td>
</tr>
<tr>
<td>Car deductions</td>
<td>$10,000</td>
</tr>
<tr>
<td>Home office deductions</td>
<td>$1,000</td>
</tr>
<tr>
<td>Telephone and internet (80%)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Negative gearing, depreciation and building allowances</td>
<td>$20,000</td>
</tr>
<tr>
<td>Laundry costs</td>
<td>$150</td>
</tr>
<tr>
<td>Non-slip shoes</td>
<td>$300</td>
</tr>
<tr>
<td>Overseas travel deductions</td>
<td>$8,000</td>
</tr>
<tr>
<td>Pre-paid interest</td>
<td>$10,000</td>
</tr>
<tr>
<td>Exempt fringe benefit: Part time employment with local hospital</td>
<td>$9,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$120,000</td>
</tr>
</tbody>
</table>

Public hospital employees

1This is discussed and diagrammed in more detail in Part 13 “Working as a Private Contractor”
Public hospitals are, for FBT purposes, regarded as “public benevolent institutions”. This means that they can provide their employees with exempt fringe benefits. Once, there was no legal limit on the amount of exempt fringe benefits, but now, due to abuses of these rules, there are limits on the amount of the exempt fringe benefit.

This exemption is limited to a grossed up taxable value of $17,000, which converts to about $9,000 tax free, per employee per employer. The exemption applies per employer, so a GP employed by, say, three different public hospitals is able to receive three tax free amounts, or $27,000 tax free in total. And the exemption is not pro-rated for part time employees.

This can be a great reason to be employed part time by a local hospital for, say, a session or two a week in the emergency area, with most of your reward taken as a fringe benefit. There are examples of groups of GPs re-negotiating the basis of their engagement by the local public hospital so that they are employees for these purposes.

**Deductions for a car**

Getting your car deductions right is step 1 in a young doctor’s tax planning strategy.

In summary, virtually all young GPs are able to claim a significant percentage, probably as high as 90%, of their car costs as deductible costs. This is because they are required to use their car to carry bulky medical equipment, including emergency medicine equipment, and confidential patient information.

Getting the car deductions right will save most young GPs at least $4,000 cash a year, each year, based on a $30,000 car, and more for more expensive cars. This is explained in more detail in [Part 5](#) (page 11) of this manual under the heading “Buying your car”.

**Negative gearing**

Negative gearing is an excellent tax planning strategy for a young GP. Negative gearing is jargon for borrowing to buy an investment, usually a residential property, where the expected assessable income is less than the expected deductible interest, with a resultant net deduction against the GP’s salary income (or other assessable income, as the case may be). Negative gearing is discussed in [Part 4](#) (page 6) in the context of buying a home.

We always recommend young doctors buy residential properties as investments as a stepping stone to owning their own home.

**Superannuation contributions: salary sacrifice arrangements**

We are convinced that the best investment strategy and tax planning strategy for a young GP is to arrange for your employer to reduce your salary, and increase your deductible superannuation contributions.

Young GPs can contribute a maximum of $25,000 a year as concessional contributions to a superannuation fund. For couples this becomes $50,000 per year, and we frequently recommend young doctor couples make sure $50,000 is paid every year to HESTA or a self managed superannuation fund.

Superannuation for young doctors is discussed in more detail in [Part 12](#) (page 39) of this manual under the heading “Superannuation for young GPs”.

**Updated February 2014**
Home office deductions

Most young GPs are able to claim home office deductions in connection with their home office or study. In most cases, these deductions are limited to the running expenses connected to the office and do not include an allocation of rent for a tenanted property or an allocation of mortgage interest for an owned property. For heating/cooling and lighting expenses, the amount that the taxpayer is entitled to claim is the difference between what was actually paid for heating/cooling and lighting and what would have been paid had the taxpayer not worked from home. The appropriate formula for calculating the additional expenses is set out in Taxation Ruling TR 93/30.

Home office deductions include the cost of small items of depreciable property. For example, if you buy a lamp for your study for, say, $200 you can claim the whole cost against your assessable income. Items costing $300 or more cannot be claimed outright in the year they are bought and are instead depreciated over their expected life, i.e. the deduction is spread over, say, five years.

Overseas travel

Overseas travel for the purpose of improving or maintaining an existing body of knowledge currently used to produce assessable income is very tax deductible for young GPs. This is discussed in more detail in Part 6 of this manual under the heading “Travelling overseas”.

Laundry costs

GPs can claim $150 as deductible laundry costs without any substantiation.

Larger costs can be claimed provided they can be substantiated: for example, if you have, say, $300 of dry cleaning costs connected to your work, and you have the receipts, you can claim $300 as a deduction against your assessable income.

Telephone and internet costs

The Australian Taxation Office accepts that 100% of the cost of your mobile telephone can be claimed provided private use is minimal.

The Australian Taxation Office normally accepts up to 80% of the cost of your home telephone and internet costs are deductible. In some cases this can extend to the cost of a home telephone and internet service at a holiday home.

Remote area housing

Employee GPs in remote areas can receive tax exempt housing fringe benefits. These are often used for GPs working with remote aboriginal groups and similar organisations.

Income continuance insurance premiums

Premiums paid on income continuance/protection insurance policies are tax deductible.

Non-slip shoes and other protective clothing
The Australian Taxation Office has released rulings confirming that nurses can claim non-slip shoes. GPs work in the same physical environment and there is no reason why they cannot claim these costs as well (Taxation Rulings TR 95/15, TR 97/12).

Specific purpose protective clothing is also deductible.

**Living away from home allowances**

Employee GPs who have to live away from home (i.e. “the usual place of residence”) can be paid a tax free living away from home allowance to compensate them for the extra costs connected to living away from home.

The Australian Taxation Office guidelines do not specifically mention trainee GPs but they do mention “trainee employers, such as trainee teachers, living away from home in order to undergo training courses of extended duration”. Trainee GPs completing, say, a six to twelve month rural rotation seem to be fairly within the guidelines.

The allowance can be quite generous, sometimes hundreds of dollars a week, and includes reasonable accommodation costs and reasonable food costs.

You can read the ATO guidelines here: [ATO Website: Living away from home allowances](#).

**Reasonable meal allowances**

Overtime meal allowances can also be used to advantage by both employee GPs and the owner GP where paid under an award or a similar arrangement. Overtime meal allowances qualify for special tax treatment. They are:

- tax deductible to the employer;
- exempt from fringe benefits tax for the employer; and
- depending on the method of payment:
  - the allowance is exempt income for the employee; or
  - the employee can claim a tax deduction for the actual cost of the meal, and provided the deduction is not more than the allowance, the employee does not have to substantiate the deduction.

The ATO has advised that a reasonable overtime meal allowance is $27.70. The reasonable meal allowance may be paid either:

- by a cash reimbursement to the employee from petty cash and supported by a petty cash voucher (in which case the reimbursement is exempt income to the employee);
- as an allowance under the usual payroll, with the allowance shown on the employee's annual statement of earnings (in which case the employee claims a deduction for the allowance in its own tax return, with no substantiation up to the amount of the allowance).

For example, if a GP was working back, say, ten nights a month, the employer can pay a monthly allowance to the GP of **$277.00**, or a yearly allowance of **$3,324**. The amount is deductible to the employer, assessable to the employee and deductible to the employee without substantiation up to the amount of the allowance. This means the GP saves about **$1,545** cash each year.

**In-house childcare facilities**
In-house child care facilities are tax free fringe benefits for employees.

We are aware of a number of general practices that have included a staff only in-house child care facility in the design of their building. The results have been startling. Child care is normally expensive and not tax deductible, creating a large outgoing for many GP families. Factor in extra travel time and, to be blunt, guilt and worry, and you can understand why many GPs, typically female, are not keen to do too many sessions during the early child rearing years.

Put a tax free in house child care facility in the premises and these problems disappear. Particularly the travel time, guilt and worry. It makes a big difference to the employer’s prospects of attracting and retaining GPs, and remember that, although the preceding paragraphs seem targeted at female GPs, male GPs are parents as well.

One sticking point in this whole area is what is meant by “in-house”. In summary, the Australian Taxation Office accepts that the facility does not have to be literally in-house, but that an offsite centre can still come within the definition (which makes sense because it is not a good idea to have a child care facility in the shadow of an oil refinery, or a tannery in a heavy industrial area, even if you could get town planning permission.) The Australian Taxation Office accepts that the facility will be “in-house” where the employer bears the rights and risks connected to possession of the premises and is responsible for the conduct engaged in those premises.

**Employee gifts**

Low dollar value and irregular gifts can be provided to employees without a fringe benefits tax charge for the employer or an income tax charge for the employee.

Gifts can be a great way to lift employee morale and show someone that you appreciate them. In the employment context, there is much to be said for the old adage that it is better “to give than receive”! A small after tax cost can add much to the bottom line. It is a HR truism that, beyond a point, people respond more to empathy and appreciation than they do to just money.

For example, a gift of, say, a $100 shopping voucher to each employee before Christmas can be a great way to say thanks. Other shopping ideas include a bottle of spirits, perfume, a food hamper, a CD, a book or a clothes or toy shop voucher. The gift does not have to be consumed on the premises and there is no reason why the gift cannot be something that the employee in turn gives to someone else.

The Australian Taxation Office has some ground rules for the gift to be treated as tax-free: the gift must be “modest in value” and it appears the cut-off point here is $299 per gift. The gift must not specifically relate to the employee’s work performance and there should be no more than four “special occasions”, i.e. gifts per employee per year. There is no reason why gifts cannot be given to related parties (e.g. spouses or children) who are employed in the practice provided, as always, that their engagement is on an arm’s length basis.

**Further reading:** [www.mcmasters.com.au](http://www.mcmasters.com.au)

In the Common Planning Strategies section of [www.mcmasters.com.au](http://www.mcmasters.com.au), we set out a detailed summary including worked examples of the type of tax planning able to be
implemented by an employee doctor. You can access these materials here: Common planning strategies: employee doctors.

These materials include tables setting out what an employee doctor can do to legitimately reduce his or her tax liabilities and linking the reader to other McMasters’ materials and external explanatory materials.

We provide a detailed explanation and resource materials for the deductions able to be claimed by employee doctors at: That’s a good idea: Have you checked all your deductions? We concentrate on claiming deductions for costs which you would incur anyway, but which can be connected back to your practice. In each case, the ATO’s public rulings and established practices are observed, and these sources are sited in our materials.
Part 11  Your employment agreement

Negotiating your employment agreement

The General Practice Registrars Association has negotiated minimum terms and conditions with the National GP Supervisors Association. These terms and conditions are not legally binding, and represent minimums, not mandates, so you are free to negotiate better terms and conditions if you wish to do so.

The current minimum salary rates for GP registrars are:

<table>
<thead>
<tr>
<th>Minimum salary rates for GP registrars 2012 (Source: The Registrar Guide 2013)</th>
<th>Annual salary</th>
<th>Weekly salary</th>
<th>Superannuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPT1 (i.e. first 6 months) or equivalent</td>
<td>The lesser of $72,760 or 45% of gross billings plus 9% super* calculated on a 3 month cycle</td>
<td>$1,399 (or 45% of in hours billings)</td>
<td>Plus 9% super*</td>
</tr>
<tr>
<td>GPT2 (i.e. second six months) or equivalent</td>
<td>The lesser of $87,475 or 45% of gross billings plus 9% super* calculated on a 3 month cycle</td>
<td>$1,682 (or 45% of in hours billings)</td>
<td>Plus 9% super*</td>
</tr>
</tbody>
</table>

(*9.25% from 1 July 2013)

The National Minimum Terms and Conditions are intended to set up a reasonable and fair basis for employing registrars and are very self explanatory and can be accessed here: http://www.gpra.org.au/sites/default/files/NMTC_2013.pdf

These conditions are summarized in a table in the attached appendix.

The Fair Work Act

The Rudd Government’s Fair Work Act 2009 replaces the Howard Government’s Workplace Relations Act 1998 (“Work Choices”). It received Royal Assent on 7 April 2009, and while some sections started on 1 July 2009 the bulk started on 1 January 2010.

The Fair Work Act applies to medical practice employers that are “constitutional corporations” (i.e. run by companies, either in their own name or as trustees of trusts) most Victorian employers, all employers in the ACT and all employers in the Northern Territory.

Other employers continue to be covered by the respective state’s industrial award system. In the NSW, this is the Industrial Relations Act (NSW) 1996.

The AMA NSW Ltd has created an excellent summary of the Fair Work Act, including FAQs, and these materials can be accessed at the website of the Riverina Division of General Practice & Primary Health Ltd. The materials include a collection of primary resources such as the Health Professionals and Support Services Award 2010, Medical Practitioners Award 2010, the Nurses Award 2010 and Fair Work Australia.

More information can be obtained at The Fair Work Australia Website.
What should you do if your employer dismisses you?

If you are dismissed from your employment, you should immediately consult an employment lawyer.

Tips for negotiating your employment contract

It is not all about the money. It is all about the experience. And how much you can learn. A bad experience can be more valuable than good experiences: a lesson in how not to run a practice can be more important than a lesson in how to run a practice. Nothing beats a good mentor; a role model, a person, or a group of persons, upon whom you can base your professional character and personality.

Think about four long days rather than five normal days. Every Friday or Monday off means every weekend is a long weekend, with time to commute home or explore the local area.

If you are short of cash, think about over-time. It pays an extra 50%, plus 9.25% super, which translates to a very generous reward: you can increase your income by 30% by working an extra 20%. Or think about a session or two in an emergency ward, with your reward a tax-exempt fringe benefit, up to the $9,000 limit per employer.

The most profitable practices are not in the fashionable suburbs. Generally speaking, the further away from a capital city GPO, and the less fashionable the suburb or town, the more profitable the practice is. It is all about supply and demand and the competition. Choose a location where there is a low doctor/patient ratio. Dubbo beats Double Bay and Broadmeadows beats Brighton, for practice profitability at least.

Pay attention to the tax planning strategies set out in Part 10 of this manual. Super salary sacrifice, negative gearing, overseas travel, making sure you claim all relevant deductions are safe strategies that maximise your after tax return on your time in the practice.

There is a serious shortage of GPs right around Australia. Most training practices are desperate for registrars. Registrars increase profits, and represent a source of potential new doctors for the practice. Practice profitability is a function of attracting and retaining good doctors, and if you are a good doctor, you should not be shy about asking for something above and beyond the Minimum Terms and Conditions.

Think about where the practice is located: is it proximate to recreation facilities and is it in an aesthetic location. For a surfer, a Victorian west coast town will beat the desert hands down, and for a skier, the Cooma area will appeal more than a city location.

Consider the physical environment you will be working in. Large, modern, purpose built aesthetic premises will make your working experience much more pleasant. If you are going to work long hard hours, you may as well work them in a pleasant environment.

A pleasant environment includes more than the physical: is it a happy team? Some practices are toxic. We have seen practices where the principals literally cannot bear to be in the same room, and only communicate through solicitors. It is a revolving door. New staff picks up on the bad atmosphere and leave as soon as they can. You would not want to be stuck there for a whole year. Check the practice’s references with last year’s trainees and if they don’t sound convincing interview someone else.
<table>
<thead>
<tr>
<th>Matter</th>
<th>Clause number</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work hours</td>
<td>4.1</td>
<td>Defines ordinary hours, including teaching time, consulting time, and educational release time, based on a 38 hour week and a minimum of 27 hours schedule patient contact time. Further conditions are set out for part time work hours: these are essentially pro-rata rules.</td>
</tr>
<tr>
<td>Workload</td>
<td>4.2</td>
<td>Maximum of 4 patients an hour in normal circumstances.</td>
</tr>
<tr>
<td>Personal safety</td>
<td>4.3</td>
<td>Normal rules apply plus special procedures if for on call work and after hours work.</td>
</tr>
<tr>
<td>After hours and on-call</td>
<td>4.4</td>
<td>Required, on the same basis as other doctors at the practice.</td>
</tr>
<tr>
<td>Supervision</td>
<td>5</td>
<td>AGPTP Guidelines cover this issue and emergency procedures are need for after hours and on call work.</td>
</tr>
<tr>
<td>Remuneration</td>
<td>6.1</td>
<td>See above table. Practice salaries are paid fortnightly. Hospital salaries are paid on its normal salary cycle.</td>
</tr>
<tr>
<td>Overtime</td>
<td>6.2</td>
<td>Overtime is paid at 150% plus 9% superannuation, or time off in lieu of payment. Overtime is calculated as the excess over 38 hours over a 4 week cycle.</td>
</tr>
<tr>
<td>After hour and on-call</td>
<td>6.3</td>
<td>55% of gross billings, plus 9% superannuation, plus any hospital on-call allowance.</td>
</tr>
<tr>
<td>Annual leave</td>
<td>7</td>
<td>Two weeks for every 6 months paid out in full if unused at termination. Annual leave is based on average weekly earnings.</td>
</tr>
<tr>
<td>Personal/Carer’s leave</td>
<td>7.2</td>
<td>Up to 5 days paid leave over a 26 week term to care for immediate family members, plus up to 2 days unpaid leave.</td>
</tr>
<tr>
<td>Compassionate leave</td>
<td>7.3</td>
<td>Up to 2 days compassionate leave on the death or serious illness/injury of an immediate family member.</td>
</tr>
<tr>
<td>Parental leave</td>
<td>7.5</td>
<td>As provided for under state and federal law.</td>
</tr>
<tr>
<td>Study leave</td>
<td>7.6</td>
<td>None unless agreed with practice.</td>
</tr>
<tr>
<td>Public holidays</td>
<td>8</td>
<td>Registrars are entitled to public holidays, or time off in lieu for work on public holidays.</td>
</tr>
<tr>
<td>Superannuation and Workcover</td>
<td>9</td>
<td>Normal statutory rules apply.</td>
</tr>
<tr>
<td>Travel costs</td>
<td>10.1</td>
<td>Reimbursement of car costs under normal ATO reimbursement rules and accepted rates.</td>
</tr>
<tr>
<td>Relocation costs</td>
<td>10.2</td>
<td>No reimbursement but RTP subsidies may be available for some rural rotations.</td>
</tr>
<tr>
<td>Accommodation</td>
<td>11</td>
<td>Any accommodation subsidies are to be paid to either the practice or the registrar depending on who pays the initial outlay. The practice must help the registrar fund suitable fully furnished accommodation of an appropriate standard. The registrar pays for electricity and gas, etc.</td>
</tr>
<tr>
<td>Medical registration</td>
<td>12.1</td>
<td>Valid registration required and the Registrar must inform the practice of any changes.</td>
</tr>
<tr>
<td>Medical indemnity insurance</td>
<td>12.2</td>
<td>Required</td>
</tr>
<tr>
<td>Confidential information</td>
<td>12.4</td>
<td>No disclosure of practice or patient information at any time for any purpose unless required by law.</td>
</tr>
<tr>
<td>Termination</td>
<td>13.1</td>
<td>Termination is discouraged and dispute resolution procedures apply to minimise problems.</td>
</tr>
<tr>
<td>Restrictive covenants</td>
<td>14</td>
<td>Restrictions on where and when the Registrar may practice are permitted, but must be reasonable (which means they are not a problem for Registrars)</td>
</tr>
<tr>
<td>Safety and security</td>
<td>15</td>
<td>Normal occupational health and safety rules apply and concerns about unsafe work environments with a particular emphasis on subjective personal concerns about safety</td>
</tr>
<tr>
<td>Dispute resolution</td>
<td>16</td>
<td>RTP dispute resolution processes apply</td>
</tr>
</tbody>
</table>

Updated February 2014
From 1 January 2010, this Fair Work Information Statement is to be provided to all new employees by their employer as soon as possible after the commencement of employment. The Statement provides basic information on matters that will affect your employment. If you require further information, you can contact the Fair Work Infoline on 13 13 94 or visit www.fairwork.gov.au.

The National Employment Standards

The Fair Work Act 2009 provides you with a safety net of minimum terms and conditions of employment through the National Employment Standards (NES).

There are 10 minimum workplace entitlements in the NES:
1. A maximum standard working week of 38 hours for full-time employees, plus reasonable additional hours.
2. A right to request flexible working arrangements to care for a child under school age, or a child (under 18) with a disability.
3. Parental and adoption leave of 12 months (unpaid), with a right to request an additional 12 months.
4. Four weeks paid annual leave each year (pro rata).
5. Ten days paid personal/carer’s leave each year (pro rata), two days paid compassionate leave for each permissible occasion, and two days unpaid carer’s leave for each permissible occasion.
6. Community service leave for jury service or activities dealing with certain emergencies or natural disasters. This leave is unpaid except for jury service.
7. Long service leave.
8. Public holidays and the entitlement to be paid for ordinary hours on those days.
10. The right for new employees to receive the Fair Work Information Statement.

A complete copy of the NES can be accessed at www.fairwork.gov.au. Please note that some conditions or limitations may apply to your entitlement to the NES. For instance, there are some exclusions for casual employees.

If you work for an employer who sells or transfers their business to a new owner, some of your NES entitlements may carry over to the new employer. Some NES entitlements which may carry over include personal/carer’s leave, parental leave, and your right to request flexible working arrangements.

Modern awards

In addition to the NES, you may be covered by a modern award. These awards cover an industry or occupation and provide additional enforceable minimum employment standards. There is also a Miscellaneous Award that covers employees who are not covered by any other modern award.

Modern awards may contain terms about minimum wages, penalty rates, types of employment, flexible working arrangements, hours of work, rest breaks, classifications, allowances, leave and leave loading, superannuation, and procedures for consultation, representation, and dispute settlement. They may also contain terms about industry specific redundancy entitlements.

If you are a manager or a high income employee, the modern award that covers your industry or occupation may not apply to you. For example, where your employer guarantees in writing that you will earn more than $108,300 annually (indexed), a modern award will not apply, but the NES will.

Transitional arrangements to introduce the modern award system may affect your coverage or entitlements under a modern award.

Agreement making

You may be involved in an enterprise bargaining process where your employer, you or your representative (such as a union or other bargaining representative) negotiate for an enterprise agreement. Once approved by Fair Work Australia, an enterprise agreement is enforceable and provides for changes in the terms and conditions of employment that apply at your workplace.

There are specific rules relating to the enterprise bargaining process. These rules are about negotiation, voting, matters that can and cannot be included in an enterprise agreement, and how the agreement can be approved by Fair Work Australia.
You and your employer have the right to be represented by a bargaining representative and must bargain in good faith when negotiating an enterprise agreement. There are also strict rules for taking industrial action. If you have enquiries about making, varying, or terminating enterprise agreements, you should contact Fair Work Australia.

**Individual flexibility arrangements**

Your modern award or enterprise agreement must include a flexibility term. This term allows you and your employer to agree to an Individual Flexibility Arrangement (IFA), which varies the effect of terms of your modern award or enterprise agreement. IFAs are designed to meet the needs of both you and your employer. You cannot be forced to make an IFA, however, if you choose to make an IFA, you must be better off overall. IFAs are to be in writing, and if you are under 18 years of age, your IFA must also be signed by your parent or guardian.

**Freedom of association and workplace rights (general protections)**

The law not only provides you with rights, it ensures you can enforce them. It is unlawful for your employer to take adverse action against you because you have a workplace right. Adverse action could include dismissing you, refusing to employ you, negatively altering your position, or treating you differently for discriminatory reasons. Some of your workplace rights include the right to freedom of association (including the right to become or not to become a member of a union), and the right to be free from unlawful discrimination, undue influence and pressure.

If you have experienced adverse action by your employer, you can seek assistance from the Fair Work Ombudsman or Fair Work Australia (applications relating to general protections where you have been dismissed must be lodged with Fair Work Australia within 60 days).

**Termination of employment**

Termination of employment can occur for a number of reasons, including redundancy, resignation and dismissal. When your employment relationship ends, you are entitled to receive any outstanding employment entitlements. This may include outstanding wages, payment in lieu of notice, payment for accrued annual leave and long service leave, and any applicable redundancy payments.

Your employer should not dismiss you in a manner that is ‘harsh, unjust or unreasonable’. If this occurs, this may constitute unfair dismissal and you may be eligible to make an application to Fair Work Australia for assistance. It is important to note that applications must be lodged within 14 days of dismissal. Special provisions apply to small businesses, including the Small Business Fair Dismissal Code. For further information on this code, please visit www.fairwork.gov.au.

**Right of entry**

Right of entry refers to the rights and obligations of permit holders (generally a union official) to enter work premises. A permit holder must have a valid and current entry permit from Fair Work Australia and, generally, must provide 24 hours notice of their intention to enter the premises. Entry may be for discussion purposes, or to investigate suspected contraventions of workplace laws that affect a member of the permit holder’s organisation or occupational health and safety matters. A permit holder can inspect or copy certain documents, however, strict privacy restrictions apply to the permit holder, their organisation, and your employer.

**The Fair Work Ombudsman and Fair Work Australia**

The Fair Work Ombudsman is an independent statutory agency created under the Fair Work Act 2009, and is responsible for promoting harmonious, productive and cooperative Australian workplaces. The Fair Work Ombudsman educates employers and employees about workplace rights and obligations to ensure compliance with workplace laws. Where appropriate, the Fair Work Ombudsman will commence proceedings against employers, employees, and/or their representatives who breach workplace laws.

If you require further information from the Fair Work Ombudsman, you can contact the Fair Work Infoline on 13 13 94 or visit www.fairwork.gov.au.

Fair Work Australia is the national workplace relations tribunal established under the Fair Work Act 2009. Fair Work Australia is an independent body with the authority to carry out a range of functions relating to the safety net of minimum wages and employment conditions, enterprise bargaining, industrial action, dispute resolution, termination of employment, and other workplace matters.

If you require further information, you can contact Fair Work Australia on 1300 799 676 or visit www.fwa.gov.au.

The Fair Work Information Statement is prepared and published by the Fair Work Ombudsman in accordance with section 124 of the Fair Work Act 2009.

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Part 12  Superannuation for young GPs

McMasters’ recommends young GPs pay the maximum amount of superannuation each year. This is currently $25,000 a year, and in the case of a married doctor, it normally becomes an effective $50,000 a year, per couple, due to the ability to integrate a spouse into the doctor’s superannuation strategies.

For many years, the rules for superannuation just got better each year, particularly for higher income earners. But the Labor Government reversed this trend and has halved the amount able to be paid into superannuation as a deductible contribution each year, from $50,000 to $25,000 for those under age 50, and from $100,000 to $50,000 for those over age 50, falling to just $25,000 in 2012.

It is reasonable to expect this tightening to continue: it does not affect the Labor Government’s traditional power base and is limited to high income earners.

This means young GPs cannot expect to be able to pay large deductible “catch up” contributions down the track. The contributions have to be paid now, i.e. while you are young, if superannuation’s full potential is to be achieved.

A young GP earning $120,000 a year will experience a tax saving of $5,875 a year if $25,000 is paid to super each year [i.e. $25,000 times (38.5% tax less 15% super tax)].

This is a significant benefit. But it gets better. Thereafter, the earnings on the amounts invested in the fund are taxed at 15% for investment earnings and 10% for most capital gains. This lower tax rate means a higher after tax return compared to investing in the GP’s own name. This compounds and over time is a powerful investment advantage.

We strongly recommend young GPs pay the maximum amount of superannuation to get the superannuation snowball rolling as fast as possible as early as possible.

Which superannuation fund?

The TV ads are right. Industry funds are much better than retail funds run by the large fund managers. They all invest pretty much the same, but the industry funds have much lower costs and no commissions, so their net return will almost always be better.

GPs should never use retail superannuation funds.

The only real options are industry funds or self-managed superannuation funds (SMSFs).

What are industry superannuation funds?

Industry superannuation funds are part of the historic Accord achieved by the Government with the unions back in the early 80s. The Government introduced mandatory and near universal superannuation benefits in return for industrial peace and wage restraint. It was a great idea and the benefits are being felt now with workers retiring with significant super benefits for the first time ever.

The union movement set up its own superannuation funds, on the not for profit model. They have been successful, and you can read about them here: Industry Super Funds.
In the medical arena HESTA stands out amongst all the industry superannuation funds. You can read more here: www.hesta.com.au

McMasters’ is very happy with any client being in either of these two funds. They are well run, low cost, and do not pay commissions, and generate reasonable returns for members.

Industry super funds are particularly suited to GPs with:

- less than $100,000 in superannuation benefits; and
- are not interested in running their own investments.

If a young GP has more than $100,000 in superannuation benefits and is interested in running his or her own investments, then a self-managed superannuation fund should be seriously contemplated.

What is a SMSF?

A SMSF is a super fund with less than five members that is managed by its members. SMSFs are also known as DIY funds. The Australian Taxation Office (“the ATO”) is the main SMSF regulator, and has responsibility for overseeing SMSFs in Australia.

The members or a company owned and controlled by the members, act as the trustees. The trustees control the SMSF’s investments and are generally responsible for the SMSF’s administration and its compliance with the law.

A SMSF is controlled by a trust deed. The trust deed sets out the rules the SMSF has to follow. It also sets out the obligations and responsibilities of the people connected to the SMSF, ie the members and the trustees. The rules for paying contributions on retirement or death, investing assets, holding meetings, appointing trustees, paying benefits to members and the other matters affecting the SMSF are also found in the trust deed.

A SMSF is a special type of trust because the trust assets are held and managed by a trustee for the purpose of providing retirement income and other benefits to members. This means it qualifies for special tax concessions under the tax law. The three essential parts of a trust are present in a SMSF. These are a trustee, trust property and beneficiaries, in this case called ”members”. The trust deed must have special rules if the SMSF is to be a complying superannuation fund and be eligible for tax concessions. However, it is the trustee’s year-to-year conduct that ultimately determines the SMSF’s eligibility for tax concessions.

To be a SMSF, the fund must be a superannuation fund and must also satisfy a number of conditions set out in section 17A of the Superannuation Industry Superannuation Act (“the SISA”). These conditions are:

1. the fund must have no more than four members;
2. if the trustees are individual persons, each of them must be a trustee and if the trustee of the fund is a company, each member must be a director;
3. the members are not in an employment relationship unless they are relatives; and
4. no trustee derives any benefit from providing services to the fund or for performing his/her/its duties as a trustee.
What is a member?

A person is said to be a “member” if the trustee holds benefits on trust for them. The role is analogous to a beneficiary of a family trust, and a unit holder of a unit trust. The member is entitled to receive benefits from the SMSF on the occurrence of certain specified events, such as reaching a certain age, or dying (in which case the benefits are paid to the member’s estate or dependants or a nominated person).

Most SMSFs only have two members, i.e. mum and dad. A minority will have children as members too. It usually makes more sense for other people to set up their own SMSF and to keep their financial arrangements separate.

Why the limit on the number of members?

The number of members is limited to four so that the SMSF cannot become too big. This rationale is not perfect, as obviously it is possible for a one member fund to hold more member benefits than a four member fund. But it does make some sense. It also means that individual SMSFs do not become too big, and that the members stay in control. Most of the consumer protection type rules in the law do not apply to SMSFs. The rule that members must be trustees means that members will automatically have access to financial information and other information about the fund, and so a further layer of protective regulation is not necessary. This simplifies the costs of running SMSFs and makes them more accessible and workable. Increasing the number of members beyond four members would run contrary to this policy, making SMSF less workable, more expensive and more difficult to run.

There is some sense in the rule being relaxed so there can be more than four members if they are all part of the same family. This ‘same surname” approach is discussed in the industry from time to time but there is nothing to suggest it will become law at present.

Single member funds

It is not possible for a person to be the trustee for himself or herself. This is because the necessary separation of equitable ownership and legal ownership, which is a fundamental to the concept of a trust, of which a SMSF is a sub-species, is missing.

This posed a problem for the legislature when section 17A of the SISA was being drafted: how can the all members be trustees rule be satisfied in the case of a single member fund? The solution was an exception to the rule, which in effect says in the case of a single member fund:

(i) a sole director/shareholder company can act as trustee, with the member as the sole director and shareholders (since this creates the necessary separation of equitable ownership and legal ownership); or
(ii) another person can be a trustee provided that other person is a relative.

A “relative” is defined widely and goes as far as second cousins, and includes relatives by marriage or adoption, de facto spouses, and ex-spouses. “Spouse” does not cover a same sex partner. There is some contention as to whether a special rule for single member funds is necessary. This is because the member’s dependants may have a contingent interest in the fund, and in that sense may be a beneficiary under the trust deed, and/or because an SMSF is a purpose trust, and may have future members. This contention is, however,
completely academic as the law is very clear regarding who must be the trustee(s) for a single member fund.

Members who are also employees

A person cannot be a member of the same fund as his or her employer, unless they are related. This rule is intended to make sure that self-managed superannuation funds do not become de facto employer sponsored funds, but without the extensive consumer protection type rules afforded to employees in these funds.

What happens if a member/trustee dies?

This is controlled by sub-section 17A (3)(b) of the SISA. If a member dies, the deceased member’s legal personal representative will become the trustee of the SMSF or the director of the company that is the trustee of the SMSF. The legal personal representative will remain a trustee, and hence the fund will remain a SMSF, from the date of death until the death benefits start to be paid. Once the death benefits begin to be paid, the legal personal representative must cease to be a trustee or a director of a corporate trustee.

Who supervises SMSFs?

The Australian Taxation Office (“ATO”) is responsible for enforcing the SISA and other superannuation laws as they apply to SMSFs.

If the SMSF’s deed is drafted properly and the trustees comply with the law, the SMSF will be eligible for tax concessions. These concessions include a deduction for contributions and concessional tax on the SMSF’s income. These tax concessions drive the SMSF’s enhanced investment performance. It is the tax concessions that make superannuation such an attractive investment medium and allows it to outperform alternative investment media.

Although theoretically onerous, trustees are normally able to satisfy these rules without difficulty. The ATO is helpful not obstructive. It is important not to overstate the risk of breaching the law. In most cases SMSFs run smoothly and difficulties are not encountered. Except for cases of extreme culpability, if a SMSF that has inadvertently breached the superannuation law will be deemed to have complied with the law by the Regulator. Where there is a minor breach of these rules, the Regulator generally uses its discretion to deem the SMSF to have complied with the rules.

The Superannuation Industry (Supervision) Act

The SISA, and the regulations made under it, are the major source of SMSF regulation, although other laws, including the Tax Act, have to be considered. The SISA is part of a seven Act parcel of legislation. The SISA is the pivotal Act and is generally referred to the most. In this manual the term “SISA” describes the full parcel of superannuation legislation as well as the SIS Act.

Objects of the SISA

The SISA is intended to increase the security of benefits held for members and ensure the special tax concessions (i.e. tax rates of 15%, 10% and nil %) are only available to SMSFs that are conducted properly. The ATO ensures SMSFs comply with the SISA and other relevant laws. The SISA is a complex piece of legislation. Many of its provisions relate to non-
Who can set up a SMSF?

There is no restriction on who can establish SMSFs. They are set up by people of all ages from all walks of life. Normally people with higher incomes or who have significant wealth set up SMSFs. Older people predominate, since they are able to pay larger contributions and are more aware of their ultimate retirement. Younger people using the SMSF’s to set themselves up for later life are becoming increasingly common.

How much do you need to set up a SMSF?

Some say a person should have $100,000 of super before setting up SMSF. They say below $100,000, the costs of running SMSFs outweigh the benefits. The threshold of $100,000 is often too high. It significantly overstates the cost of setting and running a SMSF and significantly understates the various commissions and fees connected to managed funds.

We believe a more accurate figure is $50,000. This is also the figure quoted by the Australian Society of Certified Practising Accountants as the “break even point” for a SMSF. Some people use SMSFs with less than $50,000, confident that over time the enhanced returns coupled with a robust contributions strategy, will make up for any cost inefficiencies in the early days.

The figure of $50,000 comes with two caveats: these are that the SMSF has a simple investment strategy and does not have a large number of small value transactions. It is the number of transactions that determines the cost of running a SMSF, not its size. One good strategy for a SMSF is to have all of its assets in an investment like an index fund. This is an extremely easy investment to account for and to audit and this means these costs are kept to a bare minimum.

Do you need more for a SMSF paying a pension?

The figure is closer to $200,000 for a SMSF that is paying a pension. This is because most members would be better off taking a tax free lump-sum benefit if they have any less than this. Hence the higher threshold for the SMSF to be economically viable.

How does a SMSF differ from other superannuation funds?

SMSF members do not need the benefit of the consumer protection type rules applying to larger superannuation funds with hundreds or even thousands of members, and no involvement by the members in the operations of the fund. They do not need the benefit of these rules because they are both members and trustees, and therefore are actively involved in the SMSF’s operation and able to access information about it at will.
Part 13  Working as a private contractor

Most GPs, other than hospital GPs, are not employees in Australia.

Most younger GPs will start off working in other practices, while they gain valuable experience and qualify for solo practice under the Australian rules.

The industry standard is for each GP to run his or her medical practice, billing his or her own patients, and paying a management fee to a host practice. The management fee covers all services the GP needs to run his or her practice at the site, such as the use of space, staff, reception and other common areas, gas and electricity, stationery, computers and so on. But it does not cover personal costs, such as professional indemnity insurances, cars, registrations, training, memberships and similar costs.

The management fee normally ranges between 45% and 30% of billings and includes collecting cash from patients and insurers. The host practice collects the cash, deducts its agreed management fee, plus 10% GST, and then hands the balance to the GP. This sometimes looks like the host practice is paying the GP. But they are not: the GP is technically paying the host practice, and the host practice is not paying the GP.

This is an important point and means:

(i)  the host practice is (probably) not liable for any negligent error or omission by the GP;
(ii)  the host practice does not have to insure the GP, under the Workcover rules or the professional indemnity insurance rules;
(iii) the host practice does not have to deduct pay as you go withholdings from the net payments to the GP;
(iv)  the host practice does not have to pay mandatory superannuation contributions for the GP; and
(v)  the host practice does not have to pay payroll tax on the net payments to the GP.

A picture is worth a thousand words.

The following diagrams help explain the method of engaging. All diagrams are from the www.mcmasters.com.au website.

Diagram 3.1 (next page)

Diagram 3.1 shows all practice income being received by the doctor, who then pays a management fee to the host practice.
This is the ideal legal structure and cash flow pattern.

However, in many practices, in particular larger practices with a large number of GPs, it is too hard to have each doctor banking his or her own billings. In these cases, it may make sense to instead have the host practice bank all billings, pay them intact to the GP, and then have the GP pay the agreed management fee plus GST to the host practice.

This is shown in diagram 3.2 as follows:
In other cases, the host practice banks billings and pays the net amount on, deducting its agreed fee and paying the net amount only to the GP.

In each case the tax results are the same. That is:

(i) the GP includes all billings in his or her own tax return (or the tax return of a company or trust set up for these purposes);
(ii) the GP claims a deduction for the management fee paid to the host practice;
(iii) the GP claims a GST credit in the quarterly Business Activity Statement;
(iv) the host practice includes the management fee in its tax return and shows it as a creditable supply in its quarterly Business Activity Statement.

Are there any exceptions to the industry standard?

There can be exceptions to the industry standard.

Some GPs are engaged as employees, and paid a salary for their work. Government employees (e.g. military GPs), hospital GPs and locums are commonly engaged as employees. The employee GP’s salary is usually calculated as a percentage of their billings, or it may be a set hourly or sessional rate (a session normally runs for between three and four hours). Sometimes the salary is calculated as an annual amount, although this is unusual outside hospitals or government institutions, such as the defence force.

Sample engagement contract

Some practices use complex legal documents to engage non-owner GPs and to record the understanding between the parties regarding matters, such as:
(i) the range of services provided;
(ii) the calculation of the service fee;
(iii) the minimum hours each week and the minimum weeks each year;
(iv) common professional standards;
(v) notice period for termination by either party;
(vi) ownership of, and access to, medical records;
(vii) contact with staff and patients post termination, and any other restrictions.

A simpler, cheaper and more doctor friendly alternative is a letter from the practice setting out the terms of the engagement. This letter is just as effective from a legal point of view, and has the advantage of being unilateral (i.e. it does not require a counter-signature to be effective). It is less likely to damage the relationship: it is interesting how the tabling of a draft legal contract, and the implied or actual presence of a solicitor, can ruin what was a happy, friendly, effective and professional relationship, of mutual benefit and advantage.

A sample engagement letter looks like this:

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**GREENSLEEVE MEDICAL CLINIC**

1 April 2019

Dr Ali Ashmali
17 Greensleeves Road
Warrandyte Victoria

Dear Ali

Your engagement

I am writing to confirm the terms of your engagement at the Greensleeves Medical Clinic ("the Clinic").

You (or your practice entity) are engaged as an associate. You are not an employee. You are responsible for all aspects of your patients' care and treatment and are entitled to bill your patients in your own account. Obviously common standards apply for all doctors at the Clinic, but within these boundaries you are entitled to practice as you see fit and have all normal professional discretions and powers regarding the treatment of your patients.

The Clinic is not responsible in any way for the treatment of your patients.

The Clinic provides the full complement of services required to run your practice and attend to your patients. This includes consulting rooms, medical equipment, nursing staff, reception staff, electricity, stationary, medical supplies, patient billing services and all other reasonable services required to run your practice.

You will pay the Clinic a management fee equal to [describe entitlements]. You are primarily entitled to the gross amount of these fees and these should be included in your income tax return. However, for administrative purposes your fees may be paid directly to the Clinic as your accounts and then paid on to you less the Clinic’s management fee, or as otherwise agreed from time to time.

I confirm that the Clinic is not your employer; this is accepted by all relevant revenue authorities. This is because you are paying us and we are not paying you. Therefore the Clinic is not required to deduct group tax from any payments due to you or to pay work cover or superannuation for you. These costs are your responsibility. The Clinic is not required to pay annual leave, sick leave or holiday pay. You should discuss these matters with your accountant or solicitor if this is not clear.

Your hours will be as agreed by us in writing from time to time.

All medical records connected to your patients remain the property of the Clinic at all times but you have a right to access them and copy them at all times.

This agreement may be terminated at any time by either of us giving four weeks written notice, or such shorter period of notice as we may agree is reasonable at the time.

Thank you for your good service and companionship. I look forward to working with you in the future and please do not hesitate to contact me should you wish to discuss the matter in any way.

Yours faithfully

Name of doctor

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Draft tax invoices

Australian tax law requires a service provider to provide the doctor with a tax invoice showing the service provider’s name, Australian Business Number, the pre-GST value of the services, the GST and the post GST amount payable.

One of the best tax invoices, and explanatory notes, we have seen was provided by Healthscope, a large corporate service provider, to its doctors, and these materials are reproduced here:
Financial Planning For General Practice Registrars

Updated February 2014
Part 14  Are you living with someone?

It’s common for young doctors to live with a partner without being married.

For years the laws regarding de facto couples, including same sex couples were confusing, complicated and different in each state and territory. This changed on 1 March 2009 when new Commonwealth laws for the division of property for people in de facto relationships came into operation for the first time.

De facto couples are now within the Family Law Act 1975 rules for dividing property and paying spousal maintenance. The new laws allow de facto couples access to the Family Court of Australia and the Federal Magistrates Court (the Family Law Courts) for property and spousal maintenance matters. Cases concerning their children have been with the Family Law Courts since 1988.

What are the new laws?

The new laws provide for separating de facto to obtain property settlements on the same principles applying to separating married couples under the Family Law Act 1975.

The new laws allow the Family Law Courts to divide any property the couple own, either individually or jointly. Superannuation benefits can be split and spousal maintenance can be ordered. Before 1 March 2009 this was not possible in Queensland and was only recently possible in Victoria.

The Family Law Court has jurisdiction if:

- the period (or the total of the periods) of the relationship is at least 2 years;
- there is a child from the relationship;
- one of the partners made a contribution to their property, financial or non-financial, or as a homemaker or parent, and serious injustice to that partner would result if the order was not made; or
- the relationship has been registered in a State or Territory with laws for the registration of relationships.

What relationships are covered?

A de facto relationship is a relationship that two people who are not married or related by family have as a couple living together on a ‘genuine domestic basis’. A de facto relationship can exist between 2 people of the opposite sex, or between 2 people of the same sex.

Whether a de facto relationship exists is a question of fact including:

- the duration of the relationship;
- the nature and extent of their common residence;
- whether a sexual relationship exists;
- the degree of financial dependence or interdependence, and any arrangements for financial support, between them;
- the ownership, use and acquisition of their property;
• their degree of mutual commitment to a shared life;
• whether the relationship has been registered, in a State or Territory with laws for the registration of relationships;
• the care and support of children; and
• the reputation and public aspects of their relationship.

In which States and Territories do the new laws apply?

The new laws apply in New South Wales, Victoria, Queensland, Tasmania, the Australian Capital Territory, the Northern Territory or Norfolk Island.

The new laws do not apply to Western Australia.

If a couple has lived in Western Australia and another state the concept of ordinary residence, i.e. whether the relationship is geographically connected, determines whether the new laws apply.

Alternatively, the new laws will also apply where court orders are sought if:

• the couple were ordinarily resident in one or more of those States or Territories during at least one third of their de facto relationship; or
• the party applying for the order made substantial financial or non-financial contributions to property or as a homemaker or parent in one or more of those States or Territories.

provided that one of the parties is ordinarily resident in one of the States or Territories when the application to the court is made.

What sort of issues do the Family Law Courts consider?

The Family Law Courts look for a fair and just division of property. Each case depends on the specific facts, and the courts consider matters like:

• the length of the relationship;
• the contribution, financial and otherwise, made by each person during the relationship;
• what each partner owned before the relationship;
• the value of your assets, less any debts;
• direct financial contributions;
• indirect financial contributions;
• non-financial contributions; and
• the future needs of each partner.

Once the Family Law Courts decide what proportions of the assets belong to each party, they can order how these assets are to be divided, including ordering transfers between partners, sales to third parties, superannuation splits (i.e. transfers) and so on.

A relationship broke down before 1 March 2009. Do the new laws apply?
The new laws apply to relationships that break down after 1 March 2009.

State or Territory laws continue to apply to couples whose relationship broke down before 1 March 2009.

If the relationship broke down before 1 March 2009, the parties may choose for the new laws to apply to them. Their choice must be in writing and signed by both of them after each has obtained independent legal advice and received a signed statement from their lawyer that the advice was given.

Couples who have obtained final court orders about their property or for payment of spouse maintenance under a State or Territory law cannot choose to apply the new laws. Neither can couples who have made a written agreement binding courts on those matters under State or Territory law, except where the agreement has ceased to have effect without property being distributed or maintenance paid.

**What if a couple don’t want to be covered by these laws?**

A couple may decide they do not want the new laws to apply to their relationship. Couples can agree in writing about how they will distribute their property and maintain each other if their relationships break down. These agreements are called “binding financial agreements”. They must be in writing and are only enforceable if both parties have received independent legal advice.

Binding financial agreements are not enforceable if they start after the relationship breaks down. That is, they are only enforceable if entered into before or during a relationship.

Written agreements made about their property or spouse maintenance under State or Territory law before 1 March 2009 continue to apply.

**Can I make an agreement with my partner outside these new rules?**

Yes you can. Both of you may agree as to how your assets are to be divided without asking a court to decide. If you do this, it is a good idea to speak to a family law solicitor beforehand, and also as to whether you should register your agreement with the Family Law courts (i.e. obtain a consent order). A consent order means neither of you can change your mind down the track and also ensures certain stamp duty and income tax exemptions are available.

**Can an ex-de facto partner apply for maintenance?**

The new laws allow a partner to apply for maintenance in certain circumstances, depending on the relative financial position of each partner. A court will order maintenance be paid to a partner if:

- that partner cannot adequately support himself or herself, whether because of health, child care responsibilities or other reason; and
- the other partner is able to support that partner.

In most cases, maintenance orders are for a limited period of time.
Part 15  Work life balance for GPs: the conspiracy of silence

Certain personal characteristics are needed to get you into medical school, through a gruelling course, and through rigorous post-graduate training to finally qualify as a fully fledged GP. These characteristics may not be those typically associated with a happy, relaxed, work life balance later in life.

Being self-employed does not help in the stress management stakes.

And the essential, intrinsic nature of medicine, whereby a health emergency can occur at any time, adds incredibly to the stress equation.

It is not surprising many GPs are dangerously over-stressed.

It’s not surprising many GPs need to change the way they view their world, and re-assess their personal values, if they want to be happy, relaxed, healthy and to get the most, personally and financially, from their medical career.

The Medical Journal of Australia 1998 carried an article by Peter L Schattner and Greg J Coman titled “The stress of metropolitan general practice”. You can read this article here: The stress of general practice. It is an excellent article, and it identifies and discusses a number of stressors including:

(i)  workload, and a perception that workloads are excessive;
(ii)  a perceived threat of litigation;
(iii)  financial concerns;
(iv)  clinical duties;
(v)  effects of work on outside life;
(vi)  physical working environment; and
(vii)  the endless quest for personal achievement or excellence.

In July 2004, the Royal Australian College of General Practitioners commissioned Dr Danielle Clode, a psychologist, to review the literature on the physical and emotional health of doctors. Dr Clode’s review affirms that doctors “enjoy somewhat better physical health on average than the general population” but significantly lower levels of mental health, manifesting in high levels of work dissatisfaction, marital difficulties, substance abuse and “compelling evidence” of increased suicide risk, particularly for female doctors.

Our professional experiences, while obviously only anecdotal and well short of a formal scientific study, are consistent with these conclusions.

Dr Clode’s detailed review can be read here: The Conspiracy of Silence.

There is a positive correlation between good financial planning and better work life balance. We have seen many GPs limit their working week to say no more than 45 hours, say 8.30 to 5.30 Monday to Friday, as a result of improving the tax efficiency of their practice. The improved tax efficiency means you can cut back your hours and maintain the overall cash return from your practice. Similarly, growing your wealth reduces concerns about your financial future and your overall stress level.
Getting your financial plan going early in your career, maximising your after tax income through legitimate tax planning and implementing sensible and safe investment strategies through superannuation and trust based structures allows you more family time and more time for your personal interest.

If you are worried about your work life balance, we recommend you do something about it. Speak to someone who understands medical practice. Be a little wary of some older doctors: they may have the attitude that if they did it tough you should too.

You are not much use to your patients if you are unhealthy. You are no use at all if you are dead. Being off work for health related reasons is not much use either. You owe it to your patients and colleagues to get the work life balance right.

**Tips for improving your work life balance**

Look after yourself. Your health is most important. GPs can work into their seventies, and sometimes even their eighties. So you lose a lot of money if you lose your health!

Make time for yourself. Regularly have your own time, even if it is just a short walk with the dog in the evening, or a quiet cup of tea in the morning before the chaos starts.

Time management is critical. Doctors are usually good time managers. So improvements are usually connected to leading how to say now, and learning how to delegate. One rule we have is a doctor should only do the things a doctors has to do and everyone else can do the rest. You should use your practice manager, your practice nurse and your colleagues as much as possible. If a task can be done by someone else it should be done by someone else and you only do clinical tasks that have to be done by a doctor.

Find a practice that suits you. We know practices where the owners are ogres. And we know practices where the owners are angels. The angels create less stress. And normally more profit: relaxed practices are normally efficient practices with good sustainable habits and this maximises long term profits as well as minimising short term stress.

Part of finding a practice that suits you is making sure the physical environment is good. New purpose built surgeries are the best. A building designed as an efficient medical centre with all mod cons easily beats a converted 1970s triple fronted brick veneer. Realistically you will work for long hours, so make sure those long hours are spent in a pleasant and functional work environment.

Find colleagues you like. They do not have to be your best friends forever, but a working day is far more pleasant if you like your colleagues, enjoy their camaraderie and respect them professionally. It is not just the other doctors. It is the nurses, allied health professionals and support staff as well.

Take lots of holidays. Long ones and short ones. The nature of medicine is that it is hard to tune out unless you are physically distant and detached from the practice. This is particularly the case for owner GPs and GPs in rural areas. And holidays are particularly important if you have young family. Your spouse may be going quietly crazy while you are spending long hours at the surgery, and he or she needs a break too. And your kids will not want to take holidays with you for much longer, so make sure you do it now.

Who knows, a 3 month sabbatical may be the best career move you ever make.
Younger doctors appear smarter than older doctors when it comes to work habits. As far as we can tell, it seems they are working less than previous generations, and are more inclined to share home duties and parental responsibilities. But old habits can die hard and the work life balance needs to be explored by all young doctors if future happiness is to be optimised.
Part 16  Investing: what you won’t read anywhere else

There is a huge amount of investment information available for young GPs, either free on the internet or in the media, or cheap at your local bookstore. A summary of the main options open to GPs, and everyone for that matter, is set out in the Doctor’s Guide to Financial Planning, which can be downloaded for free from www.mcmasters.com.au. E-mail terry@dover.com.au if you need a temporary password to access this website.

We have no mind to replicate or reproduce all of it here. Rather we focus on the specifics of what a young GP should invest in, and should not invest in, and why.

Never, ever touch a tax scheme

We have a 35 year-old GP client who borrowed $500,000 to “invest” in shonky tax schemes put up by shonky accountants.

Guess what? The trees are gone. But the debt still stands.

Our client will be paying off the $500,000 for the next ten years. He has to earn nearly $1,000,000 to get enough cash after tax to pay the $500,000 back. And he has to feed, cloth, house and educate his three kids. It is put his financial development back ten years: just think of the lost opportunities.

In my view his accountant’s betrayal was criminal.

Never, ever touch a tax scheme.

The four basic investment rules

Never forget the four basic investment rules:

✔ keep it simple. If you do not understand it then you should not invest in it. Complex derivative investments are one example: just don’t touch them, no matter how glossy the brochure is, and be particularly alert if the salesman says you cannot lose if the market goes up or down;

✔ never trust anyone with your money. Almost every time we see lost money, we see a betrayal of trust. If you trust someone long enough it is virtually certain you will be betrayed (at least as far as money is concerned). Just don’t do it ;

✔ never give up control. You may find it hard to believe but once or twice a month we will sit down with a new client to discover they have signed over decision making authority to their advisor. That’s as dumb as it gets: guess what the advisor does. You guessed it, anything and everything that will increase his commission income irrespective of what is good or bad for the client ; and

✔ never invest in anything that pays anyone a commission. This means you may miss one or two good investments. But you will definitely miss a lot of bad ones and overall the maths will come out in your favour.
How to invest

So, what are the options for young GPs? Happily there are heaps. Property, shares, businesses, certain managed funds, the list goes on and on. It is too long to cover here, instead we focus on things you should know that you will not be told elsewhere?

Your home: the million dollar median

First, buy a home. This is discussed separately in part 4, which shows how important we think it is. Residential property is now the highest performing asset class in history and it is likely to stay that way over the next ten years: the Reserve Bank says Melbourne housing prices will double from a median of $500,000 to a median of $1,000,000.

That is an average capital gain of about 7% a year compounding. And you save rent. Or if you rent the property, you receive rent (allow 3%) and you get tax advantages. In fact, a rental property will pretty much pay for itself if it is done properly.

We believe young GPs should buy as many home as the bank will lend them, as soon as possible.

Berivan Yilmaz, a McMasters’ director, is a registered real estate agent in NSW and Victoria (March 2010) and she can help you buy a home that suits your needs. Contact Bez on berivan@mcmasters.com.au.

Your practice: your best investment

The best investment is your practice. This is so whether you own your own practice or work in someone else’s practice. This is discussed extensively in Part 18.

Your practice generates the cash flow that drives everything else. So it makes sense to get its legal structure right and to implement all possible legitimate tax strategies to maximise after tax cash flow.

Maximising your after tax cash flow means you have more cash to invest, and the wealth accumulation process becomes so much more efficient.

Home or practice?

We are sometimes asked what should come first: my home or my practice?

The answer is your practice. This is because your practice drives the cash flow that makes everything else possible. Maximise the cash flow from your practice and everything else flows on automatically.

For example, if a $100,000 investment gets you a one third interest in a busy and well established general practice, with an “owners’ reward” of say $100,000 per owner (i.e. each of the three owners gets $100,000 a year profit on top of his or her time reward) then the extra $100,000 a year easily pays for the new home, and more.

So your practice should come first.
Sue Torwick, an experienced practice manager on the McMasters’ consulting team, and the brains behind our training division, can help you set up your practice. You can contact Sue on sue@mcmasters.com.au.

**Pay off non-deductible debt as fast as possible**

Step 1 in your asset accumulation program is the elimination of expensive non-deductible debt. You have to earn nearly $2.00 for every $1.00 of interest you pay on a non-deductible debt, so you can see why this is so important.

Credit card debt is toxic: a nominal rate of 13% becomes a pre-tax equivalent rate of about 20%. So avoid credit card debt and, if you have it, pay it off as fast as possible.

Home loan debt is not so bad: the nominal interest rate is about 7% and at least you have a property to show for it. But it still makes sense to pay it off as fast as possible.

(While we are talking about non-deductible debts, it makes sense to borrow to pay your deductible practice costs and to use the enhanced cash flow to pay off your expensive non-deductible debts. Care is needed but this can be a very good strategy. Speak to us if you need more expansive or more specific advice about these strategies.)

**Surgery premises**

Surgeries are usually good investments for GPs.

Provided a number of conditions are met, they are usually capital gains tax free investments too, which makes them ever better.

You have to buy at the right price. And the surgery has to be in the right place. But normally they are great investments that increase your profits by much more than the market rent. Let me explain. A GP is stuck for space, but can extend his surgery by one consulting room. The builder quotes $250,000 (which includes a makeover of the exterior and an update for the reception area, as well as new patient wash rooms and a disabled wash room. The GP believes he can recruit a new assistant GP once the works are completed.

We calculated that the new GP will generate $400,000 in extra patient fees (plus PIP and other incidentals) and our client’s management fee will be $140,000 (i.e. 35% of $400,000: it is not rocket science, isn’t it?).

This means the extra investment in the surgery will earn 56% per annum, being $140,000/$250,000 each year. If you know of something, better keep it to yourself.

Yes, there is a risk that the assistant GP may leave. That is one of the reasons our client updated the building: he is trying to make the workspace as pleasant as possible to help attract and retain good team members.

Not to mention the extra patients attracted by the better service and amenities.
Superannuation

Superannuation is actually not an investment. It is a way of making an investment.

We strongly recommend all GPs including young GPs contribute the maximum amount possible each year, which is currently $25,000 (and is effectively $50,000 for married doctors as a couple).

In the early years, we recommend industry superannuation funds, such as HESTA. They are commission free, low cost and have excellent corporate governance and internal controls. Your money is as safe as it can be.

Getting the super snowball as big as possible and rolling as fast as possible as early as possible is a major theme of our doctors’ financial plans.

Young GPs should usually tick the “maximum growth” box on the application form: this means your money will be invested mostly in Australian shares and in the long run, on average, this is where the best returns are likely to be. This also provide a neat diversification: ideally you are simultaneously investing in residential property and your practice, meaning all bases are covered and you are exposed, in a tax efficient way, to each of the major asset classes.

You can read more about superannuation for young GPs at Part 12 of this manual.
Part 17 Debt and GPs

We have never seen a self-made millionaire become wealthy without using debt. We have also never seen a self-made bankrupt go broke without using debt. Debt is a two edged sword: it can create wealth or it can destroy wealth. Most people, especially GPs, use debt intelligently and enjoy the wealth it creates. Whether it is increasing equity in the family home or a rental property or a geared investment in shares, unit trusts or other securities, most GPs over the last ten or so years have enjoyed an increase in their wealth and much of this has sprung from the judicious and sensible application of debt.

The high cost of living and high tax rates make it hard to accumulate wealth from personal income alone. Superannuation, mandatory and voluntary, helps. But even double-digit contribution rates are insufficient to accumulate wealth, except over a very long time. Most are not prepared to wait that long, i.e. until retirement, to enjoy the benefits of wealth.

Borrowing to acquire appreciating and income producing assets is the solution.

Tax deductible debt: the GP’s friend

Debt is the GP’s friend. Most GPs who borrowed money to acquire investment assets have ended up much better off as a result. This is because, historically, each of the major asset classes has produced average annual returns significantly greater than the cost of borrowing to acquire and hold them, i.e. the interest rate. Most GPs who borrowed money over the last twenty years to buy good quality diversified assets have done well. This is even before the tax benefits are factored into the equation.

Our basic thesis is that GPs should take on more debt than their non-medical age peers. This is because the height, stability, security and longevity of the GP’s income means they are capable of servicing a relatively greater amount of debt than most people.

In the long term, which we define as being twenty years or more, it is very probable that the rate of return on each of the major asset classes will exceed the interest rate. And this means GP who have borrowed to invest will become wealthy.

The basic benefit of a geared investment, that is, that the return on investment is greater than the cost of investing, is enhanced by a number of features. These include:

(i) most geared investments have some owner’s equity in them. Therefore, not only is the rate of return greater than the cost of funds, but that greater rate of return is earned on a larger capital base;

(ii) most geared investments produce at least some un-realized capital gains. Un-realized gains are not taxed until they are realized. And when they are finally realized are only 50% taxed provided they are held for more than one year. Warren Buffet calls this tax deferral an interest free government loan;

(iii) tax benefits will exist if the assessable income (which does not include un-realized capital gains or half of any realized capital gains on assets held for more than a year) is less than the allowable deductions, i.e. if the investment is negatively geared; and

(iv) sometimes, tax benefits can be enhanced by intelligent use of depreciation, repairs and pre-paid interest arrangements.
Investing in a diverse range of assets is a good idea when gearing. Diversification reduces risk. Do not have all your eggs in one basket. By investing in a number of different assets and a number of different asset classes one can reduce the risk of specific asset values falling, and, in particular, reduce the risk of them falling below the debt, so that owner’s equity is wiped out. How much, or how little, diversification there is depends on the doctor’s own expectations of performance and attitude to risk.

Despite the need for these cautions and comments, it is clear that those who borrowed money to gear sound investments over the last ten years or more have by now mostly done very well. Many wish they had geared more investments. Those who lost money on geared investments tended to sell too quickly. They did not fully appreciate that property and shares investments are long term, (i.e. at least ten years,) and a year or two of poor performance does not mean that they should be sold. Others just made poor investment decisions. Thankfully, these tend to be the minority, and it is rare for all investments to perform poorly. Normally it is just one or two. Diversification is the key here, reducing the prospects of being left with just one or two poor performing assets.

It is hard for anyone, GPs included, to accumulate significant wealth without taking on at least some debt for some time. The amount of debt is a matter of choice, and reflects an underlying attitude towards risk. But as a general proposition, over the last ten years, GPs who borrowed to acquire sound investments did a lot better than those who did not. This general proposition applies to young GPs in their early years of practice, say up to age 35, middle aged GPs in their “peak-cost years”, say between age 35 and age 55, and to older GPs who were starting to wind back their professional commitments.

Looking to the future, then, it is likely, therefore, that GPs who take on debt to acquire more investments will accumulate more wealth than those who do not. And those that take on more debt than most will accumulate more wealth than most. Sadly there are no guarantees that this will be the case, and each person has to make their own decisions. What is good for one person may not be good for another. But as a general proposition, doctors who borrow to invest will probably do quite well.

**Borrowing to Invest**

If you need more encouragement, or perhaps convincing, that GPs should be borrowing more, shout yourself a copy of Noel Whittaker and Paul Resnik’s book “Borrowing to invest: the fast way to wealth: a user’s guide for borrowers”. No one could ever accuse either of the two authors of lacking conservativism, and they each have elder statesman standing in the financial advising community.

Published by Simon and Schuster in July 2002, paragraph 1 of chapter 1 reads:

“Are you prepared to use other people’s money to build a better life for yourself. Have you stopped to think about what will happen if you don’t? Chances are you would never own your own home. Every mortgage is, after all, built on someone else’s money. And, unless you are heir to a fortune, it’s just as likely that your years in retirement will be years of watching the dollars.”

This paragraph, and the title of the book “Borrowing to invest: the fast way to wealth”, gives you a good idea of their basic thesis. But we recommend you read the rest of the book to find out what else they have to say.
In her book “Personal Finance for Dummies” Barbara Drury writes:

“Many people still feel uncomfortable about borrowing money to invest, a practice referred to as gearing. Yet the same people cheerfully borrow to the gills to buy their own home because they understand that the only way to own such an expensive asset is to use other people’s money.

Borrowing to buy growth assets, such as shares or property, and using your own cash or equity in your home as a down payment, helps you increase your returns. You make a profit as long as the investment returns (income plus capital gains) are greater than your interest payments. Say you have $10,000 and borrow another $10,000 at 8% interest to buy shares with a dividend yield of 4%. The dividends of $400 cover your interest payments but you stand to make double the profit when you sell the shares because you bought twice as many shares as you could have done with your own money.

Gearing can substantially increase long-term investment returns, but it magnifies the potential risks as well as the potential rewards. If you choose to gear into shares or investment property, invest in a diversified portfolio of high quality assets that have the best chance of producing solid capital growth over the long term. Never gear to invest in speculative investments, or to avoid tax.”

An investment is “negatively geared” if its income is less than the interest incurred on any amounts borrowed to acquire it. An investment is neutrally geared if the income derived from it is (roughly) equal to the interest incurred on any amounts borrowed to acquire it. And, similarly, an investment is positively geared if the income derived from it is greater than the interest incurred on any amounts borrowed to acquire it.

The investment may be property, whether residential, retail, commercial or industrial, shares or similar securities in listed or unlisted companies, or managed funds or indexed funds. Each of the major asset classes is suited to geared investment strategies.

The word “geared” is chosen because of its engineering connotations: the idea is that with correct gearing or leverage a result can be obtained that is better than that obtained without gearing. This is usually achieved by expanding the practitioner’s asset base and allowing time to run, and capital gains to accrue, which more than compensate for the deficiency in cash flow caused by the interest being greater than the income.

This technique usually works. But there is no guarantee that it will. It depends on the quality of the underlying investment. A word of caution is appropriate: gearing works in reverse to. The effect of any drop in value will be greater too, and it is possible that the practitioner’s equity in an investment can be wiped out as a result of this phenomena.

A rational investor will be prepared to negatively gear an investment if the expected after tax return, including capital gains, is greater than the expected after tax cost of holding the investment. The after tax return will usually be made up of two things; one, the income from the investment (i.e. rents, dividends, or distributions, depending on the investment), and two, the increase in value, or capital gain, over time. The income can usually be predicted with reasonable certainty. The capital gain is the wild card. No one knows the future, so the best one can do is expect a capital gain. This is where investing becomes an art rather than a science; expectations will be the critical issue.
We have never seen a wealthy person who at some stage has not taken on at least some debt for business or investment purposes. We have also never seen a bankrupt person who has not taken on at least some debt as well. It is clear that debt is a two edged sword: it can increase investment returns and it can reduce investment returns.

It is best to keep to sensible debt levels, manage interest costs and to favor higher income yielding investments if the downside of debt is to be avoided.

The Australian Master Financial Planning Guide says that:

“An investor should only make a negatively geared investment if:

• the investor has secure and permanent income from other sources sufficient to cover living expenses and all other requirements as well as the shortfall under the negative gearing;

• where the gearing arrangement or borrowing includes a liability to make margin calls in certain circumstances, the investor can satisfy the margin calls by supplying further security or by payment from other sources to avoid the possibility of a forced sale (keep in mind that the economic conditions that lead to the need for a margin call will, almost certainly, mean that any forced sale will be at depressed prices and will lead to a significant loss to the investor;

• the investment is made on the understanding that it will be retained for at least five, preferably, ten years or longer;

• the investment and borrowing have sufficient flexibility to cover events such as death, disablement; major illness or redundancy. The first three of these would normally be covered by insurance or superannuation benefits and redundancy could be covered by an employer pay out. However, even in these circumstances the negative gearing arrangement ... may need to be terminated. Check whether this can be done without incurring penalties and with the flexibility to avoid suffering loss through a forced sale of the asset;

• there is flexibility to cover changes in circumstances, such as a transfer overseas (where the tax advantages may not apply) or divorce; and

• the taxpayer can take full advantage of the tax deduction. Negative gearing normally works best for investors on the highest marginal tax rate but may be of less value to low tax rate or non-tax-paying investors.”

The author then warns of the danger of negatively gearing into an already geared investment, such as a listed company or a property trust. This increases both the up-side risk and the downside risk even further.

Handy hints for getting the money

Research costs before you sign the contract. Make sure you know the interest rate, the principal repayment rate, the administration costs and the early repayment penalties.

Shop around. The first offer is unlikely to be the best offer. Remember that GPs are good risks so make sure you get an offer that reflects this. Look for a bank that offers special deals for GPs. Most do. The AMA has done a great job negotiating a special deal with the CBA and most of the other banks will match it or more if pushed to do so. The banks know
that GPs have virtually a nil delinquency rate on debts, and this means more money can be
lent at lower rates while still maintaining overall profitability.

Some finance brokers specialize in doctors. We generally find them quite good. Their rates
are as competitive as the banks and their service exemplary: perhaps they are more aware
of their exposure to bad word of mouth advertising!

Make sure that your finance application is clear and to the point. Support it with recent
accounts, company searches, business plans and similar documents where necessary. These
materials are best included as appendices to the main application as they may cloud the
message you are trying to deliver. If the loan is for business or investment purposes, stress
this, as it may be relevant if the ATO questions the deductibility of any interest claimed on
the loans down the track.

Ensure that your application shows all repayments can be met out of existing and expected
business cash flows. If asset sales are contemplated in the short or medium term then say
so, as this is very relevant to your capacity to service the debt. Financiers may not be
impressed if the repayment of principal depends solely on the sale of the object investment.

Do not borrow too much. Most banks work on a debt to equity ratio of about 70:30. But in
working out the value of your equity, they discount historical cost by factors representing
their expected resale experiences. Take account of these discount factors before you
commit yourself to a transaction. Ensure that your finance application includes all relevant
materials. This should include all financial information that does not favor your application.
If something goes wrong later on and the bank finds out that you withheld certain
information then, to say the least, tempers could rise.

Keep the communication channels clear. If something does go wrong, tell the bank straight
away. This is important because banks base their recovery actions on how they perceive the
borrower to have behaved. Trust is very important with banks. If your word is your bond
then you will get much better treatment if an unexpected situation arises. For example,
time and time again we have seen banks extend an existing facility over the ‘phone without
any extra security when a GP has asked for it, whether it be to use as a deposit for a new
property or whatever. Because trust has been established the banks will come to the party
and help you out where needed. Open and honest communication is the key to building this
sort of a relationship, and once it is created, don’t waste it!

The banks will be extremely reasonable if you are reasonable with them. It is therefore
important to play with a straight bat at all times.

McMasters’ Finance

McMasters’ arranges finance for our clients every day. Our approach is explained in detail
on www.mcmasters.com.au in the section dealing with “McMasters’ Finance”.

We do not accept commissions and only charge on a time spent basis.

We work with your preferred lender, and only suggest another lender if it is in your interest
to do so. We generally recommend:
(i) GPs do not use margin lending because the interest cost is too high, and this significantly reduces the after tax return from a geared investment (most other advisors do not like this advice as it means they do not get commissions);

(ii) GPs do not use personal finance contracts such as leases, commercial hire purchase and chattel mortgages, as the interest rate is too high (most other advisors do not like this advice either, because again it means they do not get commissions);

(iii) GPs do not pay mortgage protection insurance: and this is no big deal because all the big banks will automatically waive mortgage protection insurance for doctors; and

(iv) GPs use “equity access” type loan facilities whereby they have a right to draw down an agreed amount, secured against their home and at home loan rates, for deductible costs such as employer super contributions, practice management fees, personal deductible costs and deductible interest expenses.
Part 18  Protect your assets

Google “protect your assets” and you will get plenty of hits showing strategies and marketing advisors who say they can protect your assets.

Fair enough. But our view is in the context of medical practices their concerns are overstated and out of all proportion to the risks actually faced by GPs. Patient litigation risk is real, but is very manageable and as a practical matter not an issue for most GPs.

No GP has lost his or her home in a patient litigation. It just has not happened.

Professional indemnity insurance is real, and the insurers stand by GPs when litigation occurs. Australian insurers are solvent, and in the one or two past cases when there has been solvency concerns various state and federal governments have supported the insurers back to solvency and no GP has been left exposed to risk.

GPs are well trained and systematic. As long as you follow normal procedures and protocols, and pay your insurance premiums on time, it is unlikely you will have experience any problems in practice.

Having said this, we are conservative by nature and like to minimise and even eliminate risk wherever possible. So, subject to tax planning issues we normally recommend GPs do not acquire significant assets in their personal name (unless it is covered by an equal or greater amount of secured debt, with priority over any litigious patient) and instead own assets in the name of safe haven related persons.

These “safe haven related persons” include:

(i) your spouse, assuming he or her does not face similar occupational risks;
(ii) a family trust (where the essential nature of a discretionary trust means no one person has an interest in the property that can be attacked by a trustee in bankruptcy unless a specific liability, mortgage or charge is created); or
(iii) a superannuation fund, subject to certain limits.

Happily, these safe haven persons are usually optimal for tax purposes too. So there is no conflict between asset protection strategies and income tax strategies. An exception arises with residential property, whether it is:

(i) the GP’s home, where the capital gains tax principal residence exemption normally demands it be owned by individuals;\(^2\) or
(ii) a negatively geared property, where the tax benefit may be less than otherwise if the property is owned in family trust or a residential property, assuming the GP is in the 46.5% or 39.5% tax bracket.\(^3\)

\(^2\) In Victoria an existing home can be transferred to a spouse without stamp duty, but in other states a spousal stamp duty exemption is not available.

\(^3\) In Victoria rental property home can be transferred to a spouse without stamp duty, but in other states this spousal stamp duty exemption is not available. In each state a transfer of a rental property will have CGT implications.
We are generally comfortable with GPs owning their existing homes or rental properties in their own names. The continuing tax benefits, and/or the stamp duty and CGT costs of changing, mean this is normally the best option.

New acquisitions should be thought through on a case-by-case basis, with each case being a little different. Contact Terry on 03 9583 6533 or terry@dover.com.au if you need any specific advice.

Be careful about transferring existing assets to a safe haven. The transfer may be subject to stamp duty and or capital gains tax. Often these costs will make the transfer irrational, and prohibitively expensive.

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<td>Rental property in Victoria</td>
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<td>Home other than in Victoria</td>
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<tr>
<td>Rental property in Victoria</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Rental property other than in Victoria</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Listed shares and securities</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Unlisted shares and securities</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The specific stamp duty and capital gains tax implications and complications should be considered in detail before any transfer is completed. The above tables are guides and are not to be relied on without specific legal advice.

Generally assets cannot be transferred to a superannuation fund by a member unless the asset is business real property (e.g. a medical surgery) or listed shares and securities and a limited class of unlisted shares and securities.

What if a writ is served on you?

It is quite possible, even probably that a writ will be served on you at some time in your professional practice. Don’t panic. Pass the writ to your insurer as soon as possible and get legal advice from a solicitor who is experienced in medical negligence cases. This is not McMasters’: we do not handle this sort of work but we can recommend appropriate solicitors if you wish us to do so.

Friendly debt
One strategy for protecting existing assets is to mortgage them in favour of third party lenders, such as banks, and even in favour of related parties such as spouses and family trusts. The idea is in any litigation the asset will be sold and the secured creditor will be paid in priority to the litigant. At least that is the idea: you should get specific legal advice before implementing a strategy like this.
Part 19   Your practice: the best investment

Owning a practice is the best possible investment for a young GP.

Goodwill values are very low, and this is great news for buyers. It is not unusual for a practice to generate extra profits each year greater than the amount paid to acquire it. For example, it is quite probable that spending say $150,000 to buy say a half share of a well located, profitable, stable and well resourced general practice, with a reliable team of GPs, will generate more than $150,000 a year in extra profits. That is a reliable and low risk return on investment of more than 100%. Few alternative investments will get you anywhere near this.

Goodwill values are definitely down at present. This is bad news for vendors but good news for buyers. We have not seen many examples of goodwill above about $100,000 over the last few years, except for sales to corporate practices.

In one recent sale the value of the employee liabilities (i.e. sick leave, annual leave and long service leave) was more than the goodwill of $50,000. This led to the unusual situation of the vendor paying the purchaser on settlement date (at least the vendor got a small tax break: the $30,000 goodwill was CGT free but the $35,000 payment was 100% deductible).

The valuation process

We are often asked to comment on the value of a client’s medical practice. The question can be asked for a variety of reasons: the client may be interested in selling all or part of his practice, the client may be interested in buying all or part of a practice, a divorce might be imminent or the client simply wants to know what his practice is worth.

The question is asked more frequently for a partnership than a sole proprietorship. For obvious reasons there are more changes in partnerships than there are in a sole proprietorship. Value needs to be calculated each time a partner leaves or joins or the fractional shares of the partners change.

Whatever the motivation behind the question, it is one that is frequently on the minds of clients. The question of how to value a practice is closely related to the question of goodwill, which is often the most valuable asset in a practice. The theoretical concept of goodwill is looked at in the preceding part of this manual. In this part of the manual, we look at the mechanics of valuing goodwill and put forward a sample valuation to give you some idea of what to look for in a practice and, perhaps, some idea of what your advisors are talking about when this topic comes up.

A real life example of valuing a medical practice

A real life example may help explain the valuation process. The example used in the following paragraphs is based on a real client situation and the figures involved are realistic. They have been altered to simplify the presentation and to preserve client confidentiality.

About the practice

The practice is well located in an upper-middle class area in Melbourne. It has five owners, with a history of getting on well and resolving issues fairly. It owns its own building, is a training practice, has a team of four full time practice nurses, has five full time equivalent
non-owner doctors, ranging from part time male doctors in their seventies to part time female doctors in their early thirties, and covering the full range of practice sub-specialties.

The owners work four days a week, including rostered evenings and Saturday mornings.

The practice is a business for tax purposes and is run via a practice trust, with all the owner doctors’ rewards derived through their family trusts and paid to superannuation funds, relatives and company beneficiaries in tax efficient manner.

The practice is regarded by other local doctors as excellent, the best in the area. It is well regarded by patients too: so well regarded it no longer accepts new patients unless they are family members of existing patients.

The practice’s finances are well resourced, and it privately bills (some exceptions) with a strict pay on the day policy. The practice has a very competent practice manager, who runs a small team of staff and the owner doctors have little to do with the day-to-day management of the practice. They meet once a fortnight as owners to discuss clinical matters and once a month to discuss administrative matters. The practice manager attends the management meeting (unless they are talking about her).

One of the owner doctors wants to leave to re-join her family interstate. It is very amicable, and regretted by the remaining owner doctors. We were asked to value her interest in the practice to obtain a sale price for an incoming owner doctor. The prospective new owner doctor has worked at the practice (run his own practice and paid a management fee of 35% of billings) for the last five years and has a lot of energy and time invested in the practice. She likes the practice and wants to make her career there.

**Step 1: Calculate future maintainable earnings**

The first step is quite straightforward. The task is to calculate how much profit each owner is making from the practice. Historical accounting reports prepared by accountants and used for things such as income tax returns are used to estimate the "real earnings" of the practice. "Real earnings" is the actual reward from all sources accruing to the owners from the practice. These historical “real earnings” are used as a basis for predicting future earnings, and will need to be adjusted for the effect of any known changes in the practice or the general medical environment. For example, the increase in Medicare rebates in 2005 generally increased future earnings above what they had been over the previous three years. Any calculations of future real earnings would have needed to be adjusted for the increased rebate payments at that time.

To compute future maintainable earnings per doctor one normally uses an average of at least three years and adjusts profit for the effect of:

(i) transactions with the owners and related persons; and
(ii) transactions that will not be experienced by the new owners.

The average full time non-owner doctor at the practice is earning about $200,000 a year, net of costs. So we subtracted $200,000 from the departing owner doctor’s share of net income to determine the return on her investment. The $200,000 was taken as a measure of reward for her actual time in 2009, with a small discount for the two prior years.
The figures looked like this:

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of net income</td>
<td>$346,000</td>
<td>$320,000</td>
<td>$415,000</td>
</tr>
<tr>
<td>Reward for time in the practice</td>
<td>$180,000</td>
<td>$190,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Reward on equity</td>
<td>$166,000</td>
<td>$130,000</td>
<td>$215,000</td>
</tr>
</tbody>
</table>

The average is then computed (this bit is straight forward):

2007  $166,000  
2008  $130,000  
2009  $215,000  
Total $511,000  

Average  $170,333  

The amount of $170,333, represents the average return on investment for the three prior years, and was accepted by all concerned as a reasonable estimate of future maintainable earnings. This is thought to be the best measure of renewable profit connected to the practice. This amount is then used as a basis for all subsequent calculations.

Step 2: Determine the value of the multiple

The second step is less mechanical and more subjective than the first step. It requires the valuer to determine an appropriate multiple to apply to true earnings in order to estimate value. The determination of the multiple requires the valuer to apply logic, business experience and intuition. It is more art than science. Any two valuers will probably come to a different multiple and this is quite acceptable: the difference reflects their differing perceptions of the strength of each component in the determination of the multiple.

The higher the multiple, the lower the valuer's assessment of the risk attached to the business and the greater the value of the business.

One method of determining the appropriate multiple for a medical practice is to identify each of the factors that are believed to be critical to a practice’s success and to then allocate to each of these factors an optimum score reflecting the relative importance of that factor in the valuation process. Each factor is then scored and the sum of the scores compared to the sum of the optimum score to determine the strength of the multiple.

This approach is very flexible. It allows the doctor to weight each factor according to the doctor’s own view of their relative importance to a practice, and to add or delete factors as they think appropriate. This calculation might have looked like this:

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Optimum</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loyalty</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>New Patients</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Activity</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Number</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Premises</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>
A perfect score of 300 gives a multiple of three, which we believe is a maximum for a medical practice like this. So a score of 208 gives a multiple of 2.08.

There is no reason why you should not create your own list of factors to be considered and give them an optimum score that reflects the relative importance of each factor to you. This is actually what we ask our valuation clients to do: this makes the valuation their valuation. We just guide them through the formal thought processes underpinning the valuation. There is every reason why different prospective purchasers would attach different relative importance on each factor and then score them differently. In fact, one would expect this to happen. This is the advantage of this approach: it is very flexible and can be adjusted to meet different circumstances.

Step 3: Determine value

This multiple is then applied to the estimate of future maintainable earnings of $170,333 obtained earlier to calculate goodwill of $354,292.

<table>
<thead>
<tr>
<th>Maintainable future earnings</th>
<th>$170,333</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple</td>
<td>2.08</td>
</tr>
<tr>
<td>Goodwill value</td>
<td>$354,292</td>
</tr>
</tbody>
</table>

In other words, in the valuer's opinion a willing but not anxious buyer and a willing but not anxious seller would agree to a price of about $354,292 to acquire the goodwill of a practice with the above characteristics and that has produced an average earnings for its owner on a four day week over each of the previous three years of $170,333.

This is a high valuation, based on observed market results. But the purchaser was prepared to pay because she had already invested five years of her life in this practice and realistically was not able to re-create the practice elsewhere herself. The emotional and financial cost of starting again elsewhere was significant, and it was important to her sense of self-esteem that she be seen as a member of a leading general practice.
What about plant and equipment?

This value includes a share of the plant and equipment.

Second hand plant and equipment values and furniture and fittings values are generally very low and are rarely significant components of a practice sale.

Alternative valuation methods

There are alternative methods of valuation. For example, we understand some valuers suggest practices can be valued by obtained by multiplying a factor of between 15% and 35% of gross fees generated. A typical factor for these valuations appears to be about 30%. This approach, as simple as it is, seems to be historically entrenched in the minds of doctors and is often used in valueing medical practices without any real attempt to analyze the practice’s profile in a more scientific way.

The difficulty is it is too mechanical and does not deal with issues other than gross fees. These issues may well have an overwhelming influence on the valuation. For example:

(i) it does not consider costs. Some practices will have a much more favorable costs profile than other practices. It seems sensible to take this into account by basing the valuation methodology on net earnings rather than gross fees. If you do not do so, different practices will be valued similarly just because they happen to have similar gross fees, for example, taking on an associate who bills what he costs will increase value but will not increase net earnings. This is not sensible; and

(ii) it does not consider non-financial matters. For example, it does not consider expected future competition. A potential purchaser may well be cognizant of this but the valuation process will not highlight the problem.

If this approach had been used in the above example, the client would have paid too much for the practice as average gross revenue (and revenues for 2008) was more than $360,000 a year. Based on a factor of 30% this would have valued the practice at $108,000. In our view that would have been too little. We believe this valuation approach is too simplistic, too rigid and fails to take into account all relevant matters that may affect value. We do not recommend it to our clients.

Capital gains tax and goodwill

The Government has created special concessions to reduce what would otherwise be the tax charge on capital gains that are connected to the sale of a small or medium sized business. The rationale is that small and medium sized business are the engine room of the Australian economy, employing more staff than each of the big business sector and the government sectors, and generating more wealth for the economy.

Small and medium sized business operators need incentives to encourage their efforts, and exempting capital gains on the sale of a business (provided certain conditions are met) is one way of encouraging entrepreneurial energies.

Small and medium sized business operators are also required to invest in the businesses, and this often means cash is short for superannuation and similar investment strategies. The CGT concessions are seen compensating small and medium sized businesses for not being able to use these other tax concessions to build up wealth for retirement.
Whole books have been written on the question of capital gains tax and goodwill. It is a very complex area, and doctors selling goodwill as part of a practice sale should make sure they access experienced tax solicitors to confirm that the receipt is a tax free capital gain and is not taxed either as ordinary income or under the general CGT rules.

Suffice it to say here that:

(i) the CGT concessions are one reason why we recommend GPs invest in their own practices. It is nice to see doctors get a large tax free cheque on the sale of all or part of their practice;
(ii) most GPs who sell practices for capital gains can treat the capital gain as a tax free capital, under a combination of CGT concessions; and
(iii) GPs who sell their practices to large corporate service providers and then enter into a long term service agreement with the corporate service provider may not be able to treat the receipt as a tax free capital receipt. The Australian Taxation Office has issued a ruling indicating in some circumstances these payments may be taxed as ordinary income. This means almost half the payment may end up being lost in tax. The ruling is private ruling 25443 and a copy of it can be downloaded directly from the ATO’s website here: Private Ruling IT 25443.

The need for expert tax advice

We stress that there is no such thing as off the shelf tax advice and each case must be considered on its merits and any GP contemplating selling their practice or any similar rights should seek specific legal advice from McMasters’ Solicitors as to the capital gains tax consequences before proceeding with the transaction.

This is particularly the case for any GP contemplating a sale to a corporate service provider.

Why are goodwill values so low?

There is no doubt that general practice goodwill values are very low at present.

In many cases, the sort of value agreed by the GPs in the above example just is not achieved. There are many reasons for this phenomenon and they boil down to supply and demand imbalances, particularly between:

(i) the number of GPs interested in selling their practices and the number of GPs interested in buying those practices. There just aren’t any buyers. The reasons for this are complex but most analysis includes:
   • the increasing feminization of the medical workforce, and the fact that traditional age entry points for general practice ownership conflict with the motherhood years;
   • an increasing preparedness for younger GPs to prefer lifestyle over extra work, and a perception that owner GPs work harder and longer than non-owner GPs. Many younger GPs do not see proprietor status as being relevant to their professional status as a GP, and many see it as a negative, reducing future location options and lifestyle flexibility;
   • a tendency for younger doctors to partner other doctors, or other high income earners, thereby reducing the need to work harder and longer hours; and
• the shortage of non-owner GPs, the engagement of whom is the key to increasing maintainable practice profits and hence creating goodwill value; and

(ii) the number of patients and the number of GPs, which means virtually any GP will have an instantly busy practice if he or she decides to set up a practice, so the cost of setting up a solo practice, which can be as low as $80,000, provides a natural cap on the value of an established practice.

Goodwill values are virtually nil in under-doctored areas including most rural locations and the less fashionable metropolitan suburbs. Doctors just do not want to work in these locations. Normally these practices cannot even be given away (although, perhaps paradoxically this makes them excellent options for younger doctors setting up their own practices, particularly if the older vendor stays on as a part time assistant). This creates a substitution effect across the market and reduces the goodwill values in alternative areas.

The shortage of GPs creates almost a bidding process to attract and retain good quality GPs to the practice. If you are tired, facing family pressures, and sick of working 12 hour days why not sell a half interest in your practice for just $50,000, if this means you can go home at 5.00 pm most nights of the week and share your fixed costs with another GP. And have peer/professional support in your practice.

We have many examples of excellent practices changing hands for virtually token goodwill values. Some of these are summarized below.

We do not think this will change until the first generation, or two, of alumni from the new medical schools matures and enters this phase of their medical careers.

Results of recent sales of medical practices

The following sales are selected because of their relevance to this valuation. This appendix is not a complete list of the sales we have been engaged in. We can provide further evidence of the market for goodwill if asked to do so.

Details are changed too but all examples are indicative of actual transactions.

Sale 1 2006

5 GP busy practices established for more than 30 years in a fashionable location.

This practice was owned by the one GP and was making more than $250,000 a year profit. The practice was sold for $90,000 plus plant and equipment to a country GP coming back to the city. It was offered for sale to the GPs engaged in the practice over the preceding two years but none were interested. Health was a big factor in the decision to sell, even though he was very disappointed with the final sale price. The vendor also received the benefit of a “good” lease of the premises, which are owned by his superannuation fund.

$90,000 was a very low price for this practice, and we cannot understand why none of the assistant GPs was prepared to buy it.

Sale 2 2006

This was the sale of a one quarter interest of a South East suburban practice. One of the 4 owners wished to leave. He was initially offered a nil exit price by his ex-colleagues, on the basis that their profits would fall if he left. This was despite having paid $80,000 to join the
practice five years earlier. Eventually, a sale price of about $40,000 was agreed to, including plant and equipment. The practice was not a happy practice and I can understand why the GP wished to leave.

Sale 3  2006

A busy 5 GP practice that was part of a larger group was bought by the lead GP. His consideration was a nominal fee only, as he was required to give up a minority holding of shares in the larger group. It was considered that these shares had nil value because there was no realistic expectation of a dividend for many years due to operating losses.

The larger group was prepared to do this deal because it realized the practice would fall apart if the buyer left the practice. This would have left the larger group liable for staff costs and the remaining lease on the building and the plant and equipment. The buyer took over these obligations as part of the practice.

Sale 4  2007

A GP bought a 1/3 share of an outer eastern suburban practice for $50,000. This was after an initial asking price of $100,000 plus plant and equipment. The GP has worked in the practice for a few years, and brought his own patient base to the practice when he joined from a nearby community medicine practice.

We expect the GP to make an extra $30,000 a year as a result of buying in.

Sale 5  2007

A profitable 5 GP practice located in semi-rural location was sold to the landlord pharmacist for $180,000. The vendor GP has agreed to stay working there and to pay a 50% management fee for five years, along the lines of corporate sales.

The pharmacist kept the premises occupied, which adds to value, and retained a close source of prescriptions by buying the service trust and then agreeing to provide services to the GPs. The pharmacy is located in the same building.

Sale 6  2007

I expect this is the last sale to a corporate health provider that I will see.

A corporate vendor paid $200,000 for the service entity of a large female health practice located in a fashionable inner eastern suburb. The vendor is a fifty year old female GP who has practiced from the site for more than twenty years. The vendor signed a five year service agreement.

The vendor owns the premises and she will also receive the benefit of a good lease from a public company tenant. This will increase the premises value should she wish to sell them.

Sale 7  2007

A one GP practice in a country town sold for $50,000 all up after the untimely death of original GP. The practice is easy commuting distance from Melbourne and was bought lock stock and barrel as a going concern: a friendly larger local practice staffed it with a GP until a purchaser could be found.
Sale 8 2007

A foreign trained GP bought a 20% interest in a rural practice for $90,000. She will make at least an extra $60,000 a year profit from being an owner. She trained at the practice and had a high regard for the other GPs and was not interested in working at another practice in the region, or moving to another practice.

Sale 9 2008

A five GP practice was for sale in Geelong for $100,000, deferred for one year. The buyer will almost certainly make $100,000 a year from the service trust. No buyer can be found. Apart from the general reasons explained earlier, the particular reason appears to be a concern regarding signing a new lease and what would happen if the GPs left the practice.

Sale 10 2008

A half share of a Mornington Peninsula practice was for sale for $40,000. It appears that an assistant in the practice will buy the half share for this amount.

Sale 11 2008

A married couple, both GPs, bought a two and half GP practice for $50,000 in Melbourne’s South Eastern suburbs. The vendor GP sold on a walk in walk out basis and immediately returned to the UK. The purchaser has also bought the building for $450,000. The practice is well located on a main road and is quite profitable.

Sale 12 2008

A GP in Queensland bought a 1/4 share in a practice semi-rural practice for $10,000. The vendor GP left the area six months earlier and the remaining 3 owners invited the purchaser to join the practice after working there as an employee for 12 months.

Sale 13 2008

A large practice in Eastern Melbourne bought a local three doctor practice for $30,000. The vendor doctors are in their sixties and will continue to practice at the site indefinitely. The adjustment for employee’s long service leave and similar entitlements was more than $30,000, meaning the vendors paid money to the purchaser on settlement date.

Sale 14 2008

A very large medical centre (20 consulting rooms) in an outer Eastern suburb in Melbourne sold for $1,400,000. The sale price was made up of $1,200,000 for the building and $200,000 for the practice. The vendor is not a GP and was earning $200,000 a year from running the service entity.

Sale 15 2009

An established one GP practice in Melbourne’s South Eastern suburbs closed its doors and moved in with a larger local practice after a failed sales program. The owner was not able to sell the practice to another GP.

Sale 16 2009
A 35 year old one doctor practice in Southern NSW with total patient fees of $600,000 and low costs sold for $450,000, including all plant and equipment and the surgery premises. The vendor believes the goodwill component is about $60,000. The practice is very profitable and the purchaser is expected to make more than $400,000 a year profit.

**Sale 17 2010**

A half share of a well established outer suburban practice owned by a female GP was sold for $140,000. The vendor was making more than $400,000 profit.

**Recent formal valuations by McMasters’**

**January 2009**

The goodwill of a 6 GP practice in Melbourne’s outer north western suburbs was valued at between $100,000 and $150,000. Plant and equipment was valued separately.

The valuation was required to assist in a legal action between the unit-holders.

**February 2009**

The goodwill of a 10 GP practice on the NSW central was valued at between $150,000 and $200,000. Plant and equipment was valued separately.

The valuation was required to assist the practice in admitting a new owner.

**May 2009**

A Queensland GP bought a practice on the Gold Coast for $30,000, including all plant and equipment, patient files, computer systems and staff, including a full time assistant GP, with another full time assistant GP (FTD) expected to arrive soon.

**May 2009**

A Melbourne outer Eastern practice was offered for sale to a client for $10,000. We advised against purchasing the practice on the grounds that there was insufficient room for growth, with just two consulting rooms and one procedures room.
Part 20  What if things are really tight?

GPs are generally well paid. Most young GPs do not have significant cash flow problems: salaries range from around $80,000 to $150,000, depending on the amount of overtime (and some young GPs do a lot of over time).

Long hours may mean consumption is lower than usual, and many young GPs have significant cash surpluses. Following the tax and investment strategies in “Financial Planning for Registrars” just makes it better.

But some young GPs are not in this position. For example, we often encounter young GPs with dependant spouses and kids, and that $80,000 plus just does not cover the day-to-day costs of living. Unless you are really into frugality, and we recommend you should not be.

Here, we say be patient. The higher income will come. If necessary, borrow to subsidise family living costs for a few years until the higher income kicks in. Ideally, the loan will be at home loan rates from your preferred bank, and banker, but if necessary take a small unsecured loan from a medical specialist lender such as Experien or Medfin.

Think of it as an investment loan. The best investment is your training and education. It makes sense to take on sensible levels of debt if necessary to achieve this training and education. You will be able to pay it back very quickly once the training years are ended.

For example, a recent meeting involved a specialist on a low income while he completed a few more years training. The training will increase his annual income by more than $100,000 a year, once completed. The problem is living on $80,000 a year now, with a dependant wife, one young child, another on the way and three dogs plus a cat.

The specialist and his wife own a home and it has $200,000 of equity. The plan is to arrange a $60,000 facility and draw it down by $400 each week for the next few years. This will allow a better standard of living during the training years and the loan will be quickly cleared once the training is completed.

We expect the home will increase in value by more than $60,000 over the next three years, so this is a much better strategy than selling the home and going back to renting. And it is much better than working extra weekends and never seeing the family.

Debt can be an important part of the work life balance.

In ten years time, our client will have forgotten about the loan, but will remember the family time and the holidays. And so will his family.