Responses to Reforms to Education Expenses

1. In your industry or field, are there studies or courses that are compulsory and must be completed in order to meet licence requirements?

   a) What is the average amount of the expense?

Diabetes education and support is an area of clinical specialty practice and therefore is undertaken as a post-graduate program. For an entry level program the cost varies from $7000 - $9500 for course costs alone. Completing an entry level course provides the health professional with a beginning practitioner knowledge base on which to build towards expert practice.

In order to meet the licence requirements (i.e; becoming a credentialled diabetes educator - CDE) once an entry level post-graduate course is successfully completed, the health professional must then complete relevant practice hours and continue to demonstrate continuing professional development specific to diabetes education and care, as well as maintaining registration in the primary health discipline. These requirements must be maintained to keep CDE status, which is currently renewed every 3 years. This requirement is currently being examined and may become an annual requirement to be consistent with the Australian Health Professional Registration requirements.

The cost for initial CDE application is $275 and maintenance of ongoing CDE is $150 per 3 years.

The cost of maintaining professional development varies according to the specific needs of the learner but would usually include (for example) conference attendance, workshops, professional association memberships, self-directed learning.

In addition to being credentialled as a CDE, health professionals, currently a nurse, dietitian, podiatrist or pharmacist, has to fulfill requirements for their primary discipline, which may overlap with the CDE requirements but can also be in addition to them. There is also separate registration for primary disciplines and by extension, additional costs that vary for each discipline but can be around $150-$200 annually.

   b) What is the highest amount of the expense?

In addition to the major cost of the entry level course, there are many costs associated with clinical placements and study days. The majority of students are studying in their own time, although a small number may have some access to study leave.

Most health professionals who complete the courses report using their annual leave, days off or decreasing their number of shifts to cover the time required 'off work' to attend placements or classes (depending on the study mode). These additional expenses may add thousands to the cost of completing the course. Students travelling from interstate incur more costs for accommodation, travel and time off work.

Should the health professional be aiming for higher level qualifications (for example a Masters level preparation for a Nurse Practitioner in Diabetes), then costs escalate accordingly.

   c) What is the nature of these courses?

To achieve the expert knowledge and skills required health professionals from a range of primary disciplines complete post-graduate education, beginning with a graduate certificate course. The post-graduate certificate course is usually 4 units.

On completion of the course health professionals remain registered and working in their primary discipline and achieve clinical specialization in diabetes education and support.

Immediately post completion of the course they are a beginning practitioner in their area of

specialty, and are expected to continue professional development to move towards expert practice.

2. Is training undertaken in your industry predominantly held in Australia or overseas? Can you provide examples?

Predominately in Australia, however research and advanced practice is world-wide since diabetes is at epidemic proportions globally.

While significant diabetes conferences are run locally, in order to present research, learn the latest techniques or work with experts in diabetes specific fields it is often necessary to travel overseas. Australians present at international conferences and also participate to extend their knowledge and use opportunities to network with colleagues in the field. This is especially an issue for advanced or expert CDEs wanting to keep at the cutting edge of practice.

For example, the 'Advanced Technologies and Treatments in Diabetes' conference in Europe for which there is no equivalent is available in Australia, for CDEs using technologies to improve diabetes care among older people and with 'at risk' communities.

- *REACTION - The aim is to develop an integrated ICT platform that supports improved long term management of diabetes based on wearable, continuous blood glucose monitoring sensors and automated closed-loop delivery of insulin.*
- *inCASA - is an EU funded research project which will develop a system to support the aging population and facilitate them to stay longer and more healthily in their own home. It will combine the use of Telehealth and Habits monitoring.*

One member who attended this conference was able to meet with a nurse practitioner at the clinic to discuss the type of clients, barriers to uptake, issues addressed and review the software used. This will inform practice by improving diabetes care for their client base.

3. In employment relationships, are employees largely obliged to incur work-related education expenses themselves or are they employer provided? Do you anticipate this changing in response to this measure?

In health care the employees may receive some contribution towards costs of work-related education expenses from employers however most of the fees are covered by the employee. Employers may fund if the CDE is presenting at a conference on their behalf, however this level of support is decreasing.

The costs for maintaining specialty practice are in addition to the costs for maintaining a primary discipline registration and professional development requirements.

4. Are you aware of examples where education expense deductions can be claimed under the current arrangements, even where significant private benefits are enjoyed?

There are currently applied constraints to what can be claimed appropriately through the ATO. If a holiday is taken alongside the conference attendance then only a proportion of the cost can be claimed. The private benefit is minimal if annual leave is used to attend the conference and pay own costs. There should remain a balance between the education expense deduction and any private benefit derived (eg; claim the accommodation for the nights of the conference and 1-2 days either side, plus a proportional amount of the airfare and so on.)

5. Are there any lessons for Australia in the experiences of other countries with restrictions on education expenses deductions?

No comment to add

6. Should the $250 no-claim threshold under section 82A of the ITAA 1936 be removed when the $2,000 cap is introduced?

   ADEA does not agree that the cap should be introduced, because of the significant impact on its members and for people with diabetes. Should the cap be introduced the no-claim threshold should be lifted.

7. How should this be prioritised?

   If the threshold is to be lifted it could be prioritised according to community need and the impact of the services to health priorities. Not all CDEs would be in a position to take advantage of the non-deductible expenses.

8. What types of assets that relate to an education activity are placed into a low-value pool or similar small business pool?

   A number of CDEs are in private practice and are sole traders or consult to other health professionals. Many CDEs utilize on-line learning as one form of professional education and development.

9. What are the advantages/disadvantages of the 'reasonable estimation' method proposed above?

   There needs to be flexibility in this approach to accommodate changes and innovations associated with technical educational assets.

10. Are there any unintended consequences from the proposed reforms?

    Diabetes will soon be the largest impost on health care costs in Australia. This reform has the potential to drastically reduce the number of health professionals who choose to study in a specialised area of health care such as diabetes education. Health professionals will be even more financially disadvantaged if unable to claim their legitimate costs. Current educational costs are not anywhere compensated for through the current tax measures and adopting a $2000 cap will potentially have very significant impact on a decision to become specliased in diabetes education.

    Employers in health care currently do not cover most of these costs and with tightening health budgets it is highly likely they will cover even less in the future. Workforce planning is already predicting shortages with additional pressures on health professionals to cover more of their professional development and education costs while simultaneously being asked to do more with less in their work roles.

11. What practical aspects of the proposed reforms need further consideration?

The changes proposed penalise employees who have legitimate professional development and education costs by drastically reducing what can be claimed. This will have far-reaching impacts on service developments and care provision into the future, since the system as it stands now largely relies on health professionals giving up their own time and money to develop new skills and knowledge needed in the health sector to deliver essential care.

If health professionals are unable to claim back the monetary impact on the taxable portion of their income, then why should health professionals continue to support the health sector in this way?

12. Are there any interactions with other areas of the tax law that need to be addressed?

No comment to add

13. Do you consider that further amendments will be required to the tax law outside of those already mentioned in the discussion paper?

No comment to add

14. Are there alternative approaches that you would like to see considered? How would they work in practice and are there any precedents in Australia or other jurisdictions?

UK NHS funds most study costs providing the employee works within that organisation for an agreed period after the qualification has been awarded. Such an arrangement could contribute to health workforce initiatives. Although bonded training has not proven to work, ongoing professional development training and education within a reasonable framework should be considered.