This technical query paper was submitted to Revenue via the TALC Direct/Capital Taxes Sub-committee. The matter was discussed at the June 2022 and September 2022 TALC Direct/Capital Taxes Sub-committee meetings and the discussions are reflected in the Minutes.

Submission to Revenue seeking clarification regarding the tax treatment of GMS income assigned by employed GPs to GP practices

31 May 2022

Revenue's 2010 Review of GP Practices

During 2010, Revenue conducted a review of the tax treatment of doctors engaged by GPs on a part-time, temporary or non-permanent basis (referred to as "locums"). Following the review, Revenue's position was clear that locums were to be treated as employees subject to tax under Schedule E. Prior to this, it was normal practice for locums to be subject to tax under Schedule D.

Revenue eBrief 08/2011 noted that:

> *"A reminder has issued to most general practitioners of the forthcoming deadline of 15 February 2011 to regularise their 2009 position, if appropriate, without the imposition of penalties. (General Practitioners in the South West Region and in the Kildare District were not included in this reminder letter as they have already been contacted locally).*
>
> *In summary, where doctors were engaged by a practice in 2009 and the PAYE system was not applied to the payments, this must be rectified by submitting a supplementary Form P35 to the Office of the Collector General using the self-correction rules as set out in Chapter 2.2 of the Code of Practice for Revenue Audit. The form must include a computation of the correct tax, PRSI, levies and statutory interest payable together with the payment due. For 2010, any additional tax, PRSI and levies accrued on foot of payments to doctors engaged must also be remitted to Revenue through the 2010 Form P35."*

Post 2010: Typical Structure of a GP Practice

Subsequent to Revenue's review in 2010, many GP practices restructured their businesses to ensure that locum GPs were engaged as employees (employed GPs). Consequently, the current position for many practices is that the entire GMS and private income of a GP practice is subject to tax under Schedule D in the hands of the partnership/sole trader irrespective of whether the income is generated by a partner as a self-employed GP or by a GP employed by the practice. This approach means that all the expenses of running the

practice (including rent, overheads, salaries etc) are attributable to a single trade. As there is a single trade, the possibility of any tax leakage is minimised as payments to employed GPs are subject to PAYE.

We understand from practitioners that as part of their contract of employment with the GP practice, it is common practice for employed GPs to agree with their employer that they will enter into a GMS contract and assign the income generated under the GMS contract to the practice. We understand that the following are typical clauses that would appear in the employment contract:

- The employed GP is paid an annual salary of €[X] based on [X] clinical sessions.
- The employed GP is entitled to [X%] of practice / partnership superannuation entitlements.
- The employed GP agrees that any GMS income attached to their GMS panel forms part of practice/partnership income.
- The employed GP agrees that any PSWT allocation relating to GMS income is allocated to the practice / partnership.
- The employed GP agrees that any GMS benefits relating to annual leave, study leave and practice support subsidies form part of the practice/ partnership income and the employed GP's leave entitlements are captured in the main body of the employment contract.
- The employed GP is indemnified against expenses, liabilities and losses of the practice/ partnership.
- On exiting the practice, the employed GP agrees to use all best endeavours to ensure the smooth transfer of patients, including their GMS list, to a partner or another nominated GP in the practice/ partnership.
- On exiting the practice, the employed GP agrees not to work within a 10km radius of the practice within 2 years of exiting (ad-hoc locum work and out-of-hours exempt).

While the GMS contract is between the HSE and the individual GP, it is noteworthy that the HSE takes into account the number of GMS lists held by the practice in certain instances. For example, the Practice Support Subsidy (PSS) is a contribution from the HSE towards a practice nurse and secretary in respect of GP practices with GMS listings. The HSE acknowledges the existence of partnerships and recognises that a HSE partnership can exist between a self-employed GP and employed GPs with GMS contracts working in those practices, when considering the amount the PSS for which the GP practice (as a whole) will qualify.

For instance, a GP operating as a sole trader may have a GMS list with 1,800 patients. However, the PSS that the GP can receive from the HSE based on their GMS list is maximised when the list reaches 1,200 patients. Any additional patients over 1,200 patients will not increase the level of the PSS. However, if that GP hires a GMS eligible employed GP and transfers just 100 of the GMS patients over to the employed GP's GMS list, the practice can amalgamate both lists for PSS purposes and will qualify for an increased PSS.

Therefore, to ensure that a GP practice has the supports necessary to deal with the large number of patients which it serves, it is preferable to split the GMS list between the two GPs. The increased PSS is paid to the practice, despite the fact that one of the GMS lists is in the name of the employee rather than a partner in the practice.

A GP practice may also qualify for a PSS towards a practice manager where there is more than one GMS list in a practice. This can include a situation where a sole trader or partnership employs a GP who holds a GMS list. The PSS for a Practice Manager is not available to single handed GPs.

Tax Appeals Commission Determination 01TACD2022

Arising from the Tax Appeals Commission (TAC) Determination 01TACD2022, we understand that Revenue is examining the tax treatment of GMS income assigned by employed GPs to GP practices and that one possibility which is under consideration is whether such income should be taxable as Case II income in the hands of the employed GP.

We understand the basis for Revenue considering such an approach is based on the comments made by the Appeal Commissioner at paragraph 255 of that determination, i.e., *"simply mandating or directing a payment, to which the holder is personally entitled by contract to another person or entity, does not in any way alter the taxability of the payment in the hands of the person contractually entitled to such income."*

The comments at paragraph 255 were made in reference to the use of profits after they have been earned by that person. The quote from the *Mersey Docks and Harbour Board v Lucas*[1] case at paragraph 254 of the TAC determination (i.e. the one immediately preceding the comments in para 255) was made in reference to the profits of the Harbour Board being taxable notwithstanding that it had been compelled by statute to own and maintain docks and there was a restriction on the use of the profits so earned, so that they were to be applied to repay the moneys borrowed to construct the docks. It is understandable in that context for such a conclusion to have been reached by the House of Lords as there was no question of the entitlement to the income being assigned, transferred or otherwise foregone in that case. In our view, the statement by the Appeal Commissioner at paragraph 255 was made in light of the particular view taken of the facts of the *Mersey Docks and Harbour Board v Lucas* case as to what was done with the income by the taxpayer in that case.

However, more generally, it is the case that rights to income can be and often are assigned without a transfer of the underlying asset from which the income derives. The provisions of the TCA 1997 recognise that where such an assignment occurs then, on first principles, the income is not taxable on the assignor of the right to the income stream thereafter. One such provision which recognises this within the TCA 1997, which would be superfluous if this was not the case, is section 813(5), which applies in certain lending situations. This provision seeks to overrule the first principles position by causing income which passes by way of assignment of entitlement to same without a sale or transfer of the underlying property from which the income derives to be taxable on the assignor. Therefore, statute already

[1] *Mersey Docks and Harbour Board v Lucas* 8 AC 891

recognises the fact that where the right to income is assigned, surrendered, forgone or waived that the transferor may not be taxable on the income from same for the duration of that assignment.

The two cases mentioned in the paragraphs immediately preceding the comments at paragraph 255, *Dolan v K*[2] and *Mersey Docks and Harbour Board v Lucas,* were cases involving the use of income after it had been earned. Neither case involved the contractual assignment of entitlement of income. The contractual assignment of entitlement of income is more than the mere *"mandating or directing"* of a payment after it has been earned. In our view, the Appeal Commissioner's comments at paragraph 255 should not be read as being relevant where entitlement to an income stream is properly assigned and not merely mandated or directed to be paid to another person. Statute recognises that where entitlement to an income stream is properly assigned, then the income is not that of the assignor for the period of the assignment.

The practical implications of GMS income of an employed GP being treated as Case II income in the hands of the employed GP

If it is the position that all employed GPs with GMS contracts must be treated as self-employed in relation to this portion of their income, in our view this will undermine the current structure of many GP practices and may have a far reaching and detrimental impact on the profession.

GPs do not generally split their time so that they see GMS patients during one session and private patients during another session. An employed GP may see several GMS patients and private patients during one session. Indeed, it is likely that during any one session, an employed GP would have consultations with GMS patients which are on their GMS list and also see patients on the GMS lists of the partners in the practice. Similarly, the other partners in the practice frequently have consultations with patients that are on the employed GP's GMS list.

Accordingly, it would be extremely difficult to accurately determine the correct allocation of the overheads of a practice to the GMS income of the employed GP. The creation of multiple trades within one practice will increase the compliance burden and the risk of errors occurring. It would also result in a loss of employer's PRSI to the Exchequer arising from the employed GP's salary (or part thereof) being treated as Case II income.

If the GMS income arising from GMS contracts held by employed GPs is treated as personal to the employed GP, this will impact on the manner in which GPs operate their practices going forward. The current approach whereby a GMS patient may visit any GP in the practice, irrespective of whether they are their allocated GP would have to be reconsidered and this could have a knock-on impact for patients. Feedback which the Institute has received indicates that this approach is also likely deter the uptake by newly qualified GPs of GMS contracts in circumstances where, we understand there is already a shortage of GPs availing of such contracts.

[2] *Dolan v K* [1944] IR 470

By treating employed GPs with GMS lists as self-employed, will also reduce the ability of GP practices to maximise the PSS available for the practice, which will potentially undermine the financial viability of their practices.

There is now an urgent need for clarity from Revenue on the correct tax treatment, as it will impact filings for the tax year for 2022 and the quantum of income that is required to be declared on those returns. Indeed, for certain taxpayers, it may mean that they will have a filing obligation for the first time.

PSWT

As the profits of the practice are split on a profit share basis between the partners, prior to the introduction of ePSWT, the PSWT for the entire practice (including employed GPs, some with a GMS contract and others with PSWT derived from other Government sectors, such as the Department of Social Protection or the HSE) was split on the same basis, linking the PSWT to the income from which is it derived (i.e., only the partners of the practice claimed the credit for the PSWT). This was a straightforward process requiring no interaction with Revenue regarding the reallocation of PSWT between taxpayers, which at the same time, could easily be reviewed by Revenue. All PSWT and associated income was captured within the accounts of the practice and accounted for in the tax return of the partners.

With the introduction of ePSWT, tax agents must make an application to Revenue to ensure that the PSWT is allocated in accordance with the profit-sharing basis of the partnership, as set out in paragraph 5.2 of Revenue's Tax & Duty Manual Part 18-01-04. This application must be accompanied by a letter of undertaking signed by all the partners in the practice. Given practices are commonly splitting the PSWT on a profit-sharing basis, this process has added a considerable administrative burden. We believe that a simplified approach which could be considered would be to extend the duration for which the letter of undertaking applies to a number of years.

In respect of PSWT that has been allocated to employed GPs, the approach which has been adopted by agents since the introduction of ePSWT is to file a Form 11 for the employed GP, so that the PSWT allocated to them can be reclaimed and then refunded to the practice (in accordance with their contract of employment). Again, this approach is administratively burdensome and it also gives rise to cash flow implications for GP practices. Arising from the TAC Determination 01TACD2022, clarification is now needed from Revenue as to whether this is the correct approach.

Conclusion

The commercial reality on the ground, and the understanding between the GP practice and employed GPs with GMS income, is that the GMS income of the employed GP is the income of the practice and it should continue to be treated as such, as it has been to date.

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If Revenue's position is that GMS income received by an employed GP is taxable as Case II income in the hands of the employed GP, irrespective of the contractual arrangements between the employed GP and their employer, this will have far reaching consequences for many GP practices. It is imperative to ensure that all income, expenses and tax liabilities are captured comprehensively and accounted for by the taxpayer who takes the risks and liabilities of running the business and generating the income like they have been to date. Therefore, in our view, it would be important that Revenue consults with all the stakeholders involved, including the HSE, the Irish Medical Organisation and tax practitioners who specialise in medical practices, regarding the potential practical consequences of such an approach for GP practices.

In addition, the process of reallocating PSWT between partners needs to be reviewed and simplified in view of the changes brought about by the introduction of ePSWT.