Catholic Health Australia

Concessional Tax Benefits to Not-For-Profit Hospitals and Aged Care Services

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Tax
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CHA Report

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1 Executive Summary

Catholic Health Australia ("CHA[1]") has requested KPMG to prepare this report that covers:

- the current tax concessions available to NFP Catholic hospitals and aged care services,
- the likely impact if the concessions are removed, and
- some alternate methods to these concessions.

NFP Catholic hospitals and aged care services have been entitled to a range of current tax concessions. The fringe benefit tax ("FBT") tax concessions have:

- existed since FBT was introduced in 1986[2], and
- become firmly entrenched in the CHA cost and planning structures.

With over half of their employees utilising these concessions, CHA advises that systemising the administration of such fringe benefits has made them simple and cost-effective to provide.

CHA is concerned that the impact of removing the FBT and payroll tax concessions will include:

- CHA would lose staff or find it difficult to recruit staff because:
  - CHA could not afford to increase salaries to ensure staff after-tax remuneration remain unchanged, and/or
  - Staff would look for employment elsewhere to at least maintain current after-tax income, or
- Given existing "tight" margins on which CHA members operate, CHA will be forced to cut back on charitable and community services (including research and currently internally funded training and education activities) that have traditionally not been provided by the 'for-profit sector', in order to accommodate:
  - any compensating salary adjustments to employees arising from FBT concession removal, and
  - imposition of payroll tax liability.

  Would Government accept responsibility for delivering such services?

[1] All references to CHA in this report are to CHA member hospitals and aged care organisations
[2] The concession has existed since 1986 for public hospitals and public benevolent institutions, but only since 1992 for not-for-profit hospitals.

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- CHA is also concerned that, if it increases the gross salary for affected employees, it would also need to increase the gross salaries of all other staff for reasons associated with maintaining staff harmony.

- CHA expects industrial relations issues arising from any adjustments being required to be made to employees' net salary positions,

- Managing any industrial relations issues will require CHA to incur additional costs.

It is submitted that direct government funding model (as proposed by the Productivity Commission) is not a viable alternative to the current tax concessions model. Rather, CHA supports the following option which it considers to be viable:

- extending the current FBT and payroll tax concessions to all types of hospitals and aged care service providers, and

- requiring increased disclosure to the Australian Taxation Office to enable accurate measurement of the extent to which the FBT concession is utilised.

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2 Introduction

The Review of *Australia's Future Tax System*, currently being undertaken by Dr Ken Henry and the Treasury ("the Henry Review"), has raised issues in relation to the complexity and fairness of existing tax concessions available to the not-for-profit ("NFP") sector and, in particular, the impact of these tax concessions on the competitive neutrality between 'for-profit' and NFP organisations.

In this regard, the Productivity Commission has recently released two draft research reports entitled "Contribution of the Not-for-Profit Sector" and "Public and Private Hospitals", which investigate a range of issues concerning the NFP sector and the relative performance of the public and private hospital systems. The draft reports are currently open to public comments through written submissions (due by 24 November 2009 and 9 November 2009 respectively), and the final reports are due to be released on 11 December 2009 before the Henry review (expected in December 2009 / early 2010).

The Productivity Commission report entitled "Contribution of the Not-for-Profit Sector" discusses in detail the efficiency and effectiveness of providing government support by way of tax concessions, in particular, the FBT and payroll tax concessions currently enjoyed by public hospitals and other NFP organisations. The Productivity Commission's view (as outlined in the report) is that competitive neutrality principles should apply and has advocated the abolition of the FBT and payroll tax concessions. In the draft report, the Productivity Commission recommends that government support be provided through direct and transparent government funding, in the form of grants or fees for service, in order to improve equity and simplicity for the long term.

Given the Productivity Commission's recommendation to abolish the FBT and payroll tax concessions currently enjoyed by CHA, this report focuses primarily upon these tax concessions.

By way of background, we understand that:

- CHA's membership comprises of 21 public (2,350 beds) and 54 private (6,125 acute and 525 non-acute beds) hospitals operating across all jurisdictions except the Northern Territory. The 9,000 beds (2,350 public and 6,650 private) represent one in 10 hospital beds across Australia. CHA's not-for-profit private hospitals represent 26% of the private hospital beds in Australia.

- CHA's membership also includes around 12% of Australia's aged and community care services (including 10% of residential beds and 18% of community age care services).

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Disclaimers

This report is has been prepared in accordance the engagement letter between KPMG and CHA dated 21 October 2009.

The comments in this report are made specifically in response to the request of CHA. Accordingly, neither KPMG, nor any entity with which it is associated, nor their employees, undertakes responsibility in any way whatsoever to any person or company other than the CHA for any errors or omissions in the report, however caused.

Our report is based on current taxation and duty law as at the date our report is provided. You will appreciate that the tax and duty law is frequently being changed, both prospectively and retrospectively. A number of key tax reform measures have been implemented, a number of other key reforms have been deferred and the status of some key reforms remains unclear at this stage.

Unless special arrangements are made, this report will not be updated to take account of subsequent changes to the tax legislation, duty legislation, case law, rulings and determinations issued by the Australian Commissioner of Taxation or other practices of taxation authorities. It is your responsibility to take further advice, if you are to rely on our advice at a later date.

We are, of course, unable to give any guarantee that our interpretation will ultimately be sustained in the event of challenge by the Australian Commissioner of Taxation or Commissioners of State or Territory Revenue.

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3 Current tax concessions available to NFP Catholic hospitals and aged care services

CHA qualifies for various tax concessions as a charitable organisation, generally under the 'advancement of religion' head of charity.

FBT exemptions

FBT exemptions are available for Public Benevolent Institutions ("PBIs"), public hospitals, non-profit hospitals and public ambulance services employers.[3]

As such, CHA is exempt from paying FBT on benefits provided to employees subject to a cap on the grossed-up taxable value of fringe benefits provided to each employee per FBT year. The cap amounts are:

- $17,000 for hospital employees;
- $30,000 for PBI (other than hospital) employees.

The capping thresholds were introduced on 1 April 2000 (for hospitals) and 1 April 2001 (for PBIs), are not indexed and have not been increased since their introduction.

FBT on meal entertainment, entertainment facility leasing expenses and car parking is excluded from the above cap thresholds (i.e. a full FBT exemption is available for these benefits).

Payroll tax exemptions

CHA is exempt from payroll tax on wages paid or payable to employees. This includes benefits provided to CHA employees (regardless of whether the benefits are subject to FBT).

Other tax concessions

Although outside the scope of this report, we understand that CHA is entitled to the following tax concessions:

- *Income tax exemptions* – not liable to pay income tax (including capital gains tax) and no requirement to lodge income tax returns.
- *Goods and Services Tax ("GST") concessions* – various grouping, registration threshold and donation concessions – in particular, the GST grouping concession for NFP operators was introduced following submissions by CHA to Treasury;
- *Gift deductibility* – entitled to receive income tax deductible gifts and tax deductible contributions as deductible gift recipients ("DGRs");

[3] Section 57A of the *Fringe Benefits Tax Assessment Act 1986.* Charitable institutions and certain non-profit organisations are also entitled to an FBT rebate.

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- *State tax concessions* - various stamp duty and land tax concessions.

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4 Benefits as a result of the operation of the tax concessions

The primary benefits of the tax concessions to CHA are the ability to:

- attract and retain staff; and
- use operating surpluses (arising from reduced labour costs) to fund charitable (non-profitable) services.

Attract and retain staff

The FBT concessions allow CHA to offer employees an 'after tax' remuneration that CHA could not otherwise afford to pay by including fringe benefits in their remuneration package.

Under these arrangements, a CHA employee may elect to forgo (sacrifice) a part of his or her salary, and take a fringe benefit instead (provided that CHA total employment cost for that employee remains unchanged, i.e. CHA is not worse off).[4] Given that the fringe benefit is not subject to personal income tax (in the employee's hands) or FBT (in the employer's hands), the employee is in a better 'after tax' position (as compared to a normal salary arrangement). In this regard, we understand that the full benefit of the FBT threshold is passed onto employees by CHA[5], who predominately package mortgage and living expenses.

The payroll tax exemption means that CHA's labour costs are lower than if the exemption was not available. This means that CHA has additional funds to either pay its employees' wages or fund charitable services (refer below).

We understand that the tax concessions allow CHA to put salary packages in place that provide employees with an 'after tax' remuneration that is comparable to after-tax incomes of employees in the 'for-profit' sector.

Based on discussions with CHA management, we understand that it is imperative to CHA for it to be able to provide comparable (after tax) salaries in order to attract and retain staff, given the following factors:

- 'for-profit' employers (especially for-profit hospitals) are able to offer working conditions that are seen as more attractive (e.g. given 'for-profit' hospitals generally undertake a higher amount of elective day surgeries, the work is often more predictable and less requirement for overtime);
- 'for-profit' employers are able to offer salary packages that provide prescribed salary increases over a period of time (CHA, being a NFP, is unable to provide such packages given the uncertainty around its funding etc);

[4] Generally, CHA only allow CHA employees to package non-cash benefits up to the relevant capping threshold (such that no FBT liability is incurred by CHA).
[5] This can be contrasted with public hospital employers (such as in NSW) where the benefit arising from the FBT exemption is shared between the public hospital employer and employee (being a 50%/50% arrangement for NSW public hospital employers).

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- high competition for staff, given a workforce shortage (especially nurses) which is expected to exacerbate over the coming years due to an ageing workforce. The workforce shortage in the hospital and aged care sector is widely documented. For example, refer to the following reports for a discussion of this issue:

  - IBISWorld Industry Report "General Hospitals in Australia" dated 5 October 2009;

  - National Health Workforce Taskforce "Health Workforce in Australia and Factors for Current Shortages" dated April 2009;

  - Productivity Commission Research Report "Australia's Health Workforce" dated 22 December 2005, which referred to quantitative work undertaken by the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) that pointed to:

    - an estimated shortage of between 800 to 1300 GPs in 2002 (or between 4 and 6 per cent of the current GP workforce) (AMWAC 2005); and

    - a shortfall of nurses, requiring between 10 000 to 12 000 new graduate nurses in 2006 and between 10 000 and 13 000 in 2010 (which would require at least a doubling of the current graduate completions) (AHWAC 2004a).

Based on discussions with CHA management, we understand that the attraction of salary sacrificing is a key tool for the hiring and retention of certain staff. In this regard, we understand that approximately 55% of CHA's staff utilise CHA's salary packaging to enhance their 'after tax' salary.

Reasons as to why remaining staff do not take up salary packaging are varied, but include:

- salary packaging is not appropriate for all staff, e.g. staff that are not full-time employees or have variable hours,

- some new employees take time to understand the benefit of salary packaging,

- some staff are not motivated by the additional savings,

- some staff are concerned that including fringe benefits in their Reportable Fringes Benefit Amount ("RFBA") will increase their HECS debt repayments, childcare payments etc. because the RFBA will generally be higher than the salary sacrifice made for such fringe benefits.

Fund charitable (non-profitable) services

As outlined above, the tax concessions means that CHA's labour costs are reduced (than would otherwise be the case). The benefit is that any consequential cashflow surplus may be reinvested in service delivery and other (unprofitable) activities that provide community benefit.

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As discussed below, these activities include:

- charitable services (e.g. community based services like drug addiction, indigenous affairs, research institutes, training, etc) which are not undertaken by the 'for-profit' sector, and

- Research programmes and currently internally funded training and education activities.

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5 Potential impact if FBT tax concessions are removed

The direct impact of removing the FBT concession is that CHA will be ultimately forced to "cash-out" the fringe benefits provided to staff. Unless CHA can reduce costs elsewhere or increase revenues, the direct consequence will generally lead to increased employment costs.

However, the extent of any such increase in employment costs will very much depend on the terms of the employment contracts that CHA has with each employee:

- In some contracts, the employer may have a contractual obligation to provide a salary plus defined benefits. In these cases, CHA will have to pay the additional FBT.

- In other cases, the employee may be guaranteed remuneration defined in terms of the "total cost of employment" to the employer. If so, such staff who currently enjoy salary sacrificing arrangements will receive a lower 'after tax' remuneration (given that they will not be entitled to receive tax-free non-cash benefits).

Given these direct impacts, CHA would have the following options available:

- "cash out" benefits without increasing total employment costs; and/or

- increase each employee's gross (before tax) salary to at least return them to the same after-tax remuneration he or she had prior to the removal of the FBT concession (compensating salary adjustments).

5.1 "Cash out" benefits without increasing total employment costs

In this situation, CHA's impacted employees are likely to feel aggrieved and may well consider alternate employment options, whether at 'for-profit' or public operators or outside the health care sector. CHA also would find it difficult to recruit staff given the lower pay conditions.

CHA expect significant industrial relations issues to arise from such aggrieved employees with reduced net salary positions. CHA would need to manage this and would expect to incur additional costs in so doing.

If public hospitals retain the current tax concessions, CHA will not be able to compete with public hospitals in maintaining and attracting staff given public hospitals could offer more attractive salary packages.

Although we understand that employees of NFP organisations (such as CHA) are often prepared to accept a salary lower than market value (e.g. due to the intrinsic value in working for a charitable / religious / good cause), it is not sure how far this 'goodwill' would extend and whether they would be prepared to 'lose' the benefit of the FBT concession.

The loss of staff would have a direct impact on CHA's business and the ability for it to provide services to the community. The inevitable consequence would be for CHA to reduce the level

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of services it offers, if not threaten the financial viability of some of its hospitals and aged care facilities.

5.2 Compensating salary adjustments to employees

Given the potential adverse implications associated with cashing out benefits (i.e. potential exodus of staff), CHA would most likely need to adjust the affected employees' gross (before tax) salary to at least return them to the same after-tax remuneration they had prior to the removal of the FBT concession.

A relevant question is whether CHA would need to adjust the gross salary of the employees that have not taken advantage of the FBT exemptions through salary packaging. CHA is concerned that, if it increases the gross salary for the affected employees, it would also need to increase the gross salaries of all other staff for reasons associated with maintaining staff harmony. If the gross salaries of all other staff are not increased, CHA clearly would anticipate industrial relations issues arising that it must manage very carefully. CHA's increased labour costs would adversely impact its operating cashflows and force CHA to either:

- increase revenue; or

- reduce its costs (by limiting, restricting or potentially ceasing to provide some services, which would clearly have adverse implications to current recipients of these services).

An increase in revenue would be difficult to achieve for CHA aged care operators given that the fees (charged to patients) are generally capped according to Commonwealth Aged Care legislation and regulations.

With respect to CHA hospital operators, an increase in revenue would be difficult to achieve given that the fees (charged to patients) are generally set according to the prescribed amount that patients can claim via Medicare and private health insurance. As such, if CHA hospital operators increase fees charged to patients (in order to attempt to increase revenue), the potential impact is that prospective patients may decide against using CHA hospitals (given the higher out-of-pocket expenses), thereby potentially resulting in lower overall revenue for CHA and putting more strain on resources on other hospitals to meet the increased demand. If private health insurance covers the increase in the patient charges, an adverse impact is that there is likely to be an increase in private health insurance premiums across the sector.

Given the difficulties in CHA increasing revenue, it would need to achieve cost reductions in order to ensure its operating cashflows are not impacted (from the increased labour costs).

To achieve cost reductions, CHA would need to reallocate resources and determine which programmes it will continue to operate. This means that the less profitable services undertaken by CHA may have to be discontinued. Ironically, these are likely to be:

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- charitable services (e.g. community based services like homeless shelters, aged care, drug and alcohol support services, indigenous affairs, community mental health, international health initiatives, etc) which are not undertaken by the 'for-profit' sector, and

- Research programmes and currently internally funded training and education activities.

Examples of some of the non-profitable activities provided by CHA include:

- Mission, Pastoral Care and Social Outreach and Advocacy programs;

- Donations to various emergency relief appeals such as the 2009 bushfire and flood appeals;

- Contributions to projects in developing countries notably Timor Leste, Ache and Nepal;

- Financial assistance to assist individuals and/or families to access health care;

- Discounts for medical procedures for non-insured, low income population groups;

- Discounted bed days available to Queensland Health;

- Donations of food to homeless services;

- Bereavement support through facility support for funerals and remembrance services;

- Free community education and support for chronic disease groups;

- Provision of meeting space for community groups at no cost or with subsidy;

- Various education and training.

These services are generally considered to be very worthwhile and expected to be provided within the community. The question then arises that, if CHA stops providing such services, who will provide them? Unless Government takes on the responsibility for providing such services, there are grave concerns that the needs addressed by these services will not be met.

The knock-on impact of cutting research institutes and research programmes would be that researchers may well have to relocate offshore in order to be adequately remunerated (thereby exacerbating the "brain drain" or "talent drain" from Australia). Ultimately, this may also mean that Australian patients may lose access to some of the leading specialists that operate in Australia now. Whether this will lead to a drop in the quality of care provided in Australia is unclear.

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To achieve cost reductions, CHA would also need to consider whether it is worthwhile continuing to undertake services that are marginally viable. CHA has indicated that its services that produce margin surplus include:

- emergency departments,
- palliative care,
- chemotherapy,
- chronic disease management ,
- some birthing services;
- services in smaller regional areas of the community[6].

The impact of the reduction or cessation of these services would clearly be adverse to current patients who would then deflect their demand for these services on the Government / public hospitals system, thereby exacerbating the strain on its resources.

Illustrative example

The following example illustrates the impact of removing the FBT concessions on the employee's after tax salary position if a compensating adjustment is not made to the employee's salary package ('cash-out' benefit scenario).

	Current package	Revised package (removal of FBT)
Salary	50,905	60,000
Fringe benefit[1]	9,095	0
Gross salary	60,000	60,000
Income tax[2]	(10,035)	(12,900)
Net salary	49,965	47,100
Difference in net salary		2,865

Notes:
1. Assumes employee sacrifices up to full $17K cap (for hospital employees) and FBT Type 1 gross-up rate applies
2. 2009 tax rates used

[6] This may be evidenced by the fact that the large 'for-profit' hospitals and aged care operators are generally located in metropolitan areas.

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Assuming that a full compensating adjustment is made to the employee's salary package, the additional cost to CHA is as follows:

	Current package	Revised package (adjust for FBT)
Salary	50,905	64,182
Fringe benefit[1]	9,095	0
Gross salary	60,000	64,182
Income tax[2]	(10,035)	(14,217)
Net salary	49,965	49,965
Additional gross salary cost		4,182

Notes:
1. Assumes employee sacrifices up to full $17K cap (for hospital employees) and FBT Type 1 gross-up rate applies
2. 2009 tax rates used

Based on a sample of 9 Catholic NFP hospital and aged care operators, 60% of employees salary sacrifice for fringe benefits (i.e. 17,221 out of 29,424 employees). As such, the total costs to these 9 operators of making compensating adjustments to the 17,221 employees who currently salary package is approximately $72M.[7] This equates to approximately $8M per organisation.

[7] This amount is an estimate only. It may be lower if hospital employees do not currently package up to the $17K (for hospital employees) and it may be higher if PBI employees salary package above the $17K cap (i.e. up to the $30K for PBI employees). It also assumes that all employees are taxed at the 30% tax rate. If employees are taxed on a higher tax rate, the cost would be higher.

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6 Potential impact if Payroll tax concessions are removed

The direct impact of removing the payroll tax exemption is that CHA's labour costs would be increased immediately by the relevant amount of payroll tax payable by CHA. Based on information provided by CHA, we understand that the amount of payroll tax payable by CHA would be approximately $120M. There would also be a retrospective effect arising from payroll tax becoming payable on annual and long service leave accrued to date, but not yet taken. When such leave is taken by an employee after removing the payroll tax exemption, payroll tax will be payable on the entire amount of the leave payment. Clearly, this is inequitable.

It is often suggested that payroll tax changes the price of labour relative to capital causing a substitution of capital for labour. In the case of hospitals (acute care facilities), nursing and other staff provide care to patients in need: there is currently no known capital machinery that can replace the individual care required to be provided by nursing and support staff.

Theoretically, introducing a tax like payroll tax will initially increase the cost of employing labour and decrease the demand for it. For industries where wages are flexible and the supply of labour relatively constant, decreased demand for labour should pass the cost of the payroll tax backwards by reducing wages and therefore reducing the cost of labour. In such circumstances, the cost to the employer should not change significantly, but the employee's wage decreases. The impact of the payroll tax would therefore be on the employee's choice of hours worked rather than the company's choice between labour and capital.

CHA is concerned that its employees cannot and will not accept reductions in pay to cover FBT, let alone payroll tax. This means that CHA would expect staff to leave CHA. If this happens, CHA will have no choice but to reduce services (given the difficulties in CHA being able to increase revenue – refer to discussions above).

The further concern is that, unless the "for profit" and public hospital sectors can take up staff leaving CHA, such staff may be forced to consider moving into other higher paid industries. Such a re-distribution of labour out of the healthcare sector would exacerbate the already existing shortage of qualified staff (refer earlier comments) that could have wider ramifications for that sector, especially as the demand for services currently provided is unlikely to decrease. If anything, demand for such services is likely to increase.

Given that many NFP operators (especially aged care providers) already operate on a "tight" margin, the increased payroll tax burden is likely to mean that such NFP operators (like CHA) may incur negative margins unless they reduce services. Continuing to operate for any length of time at negative margins cannot be sustainable without reducing non-profitable activities.

If the dropped services include those that are predominantly benevolent and charitable, each CHA member will then need to closely examine its Charter to determine whether it can satisfy its objects, particularly its charitable objects. CHA is very concerned to ensure that these objects are met given its religious founding.

If the charitable and benevolent objects cannot be satisfied, then the Australian Taxation Office may have little choice but to remove endorsement of such organisations from other federal tax

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concessions such as income tax exemption and deductible gift recipient status. This would add significant further expense to affected CHA members in terms of tax liabilities and management. Moreover, it would force the boards of such members to consider whether that member can continue to operate as a going concern. If the board of such a CHA member cannot satisfy itself about that member's going concern status, there may be little choice except to close down the affected hospital. Even if the board can satisfy that the member can continue to operate as a going concern financially after dropping non-profitable services, it may still consider closing down the hospital to see how that member's resources may be better applied to satisfy its benevolent and charitable objects.

These considerations bring into question the validity of the Productivity Commission's assumption that there should be limited fiscal neutrality (FBT and payroll tax, but not income tax and stamp duty) between the various hospital sectors (NFP, for profit and public). In many ways, the objects of NFP and CHA members are more closely aligned to the public hospital sector, being one of the government's instruments of delivering universal health to Australians, in that:

- The charter of many CHA members includes objects of providing health care to the disadvantaged and those in need, being services not provided by many for-profit hospitals.

- The public and NFP sectors have the added complication of ensuring their activities provide expected financial returns to its shareholders: operating surpluses are used to assist the funding of non-profitable activities which the community expects to be provided.

The bottom line seems to be that, if CHA and other NFP hospitals are forced to reduce services that are not currently provided by the for-profit hospital sector, the community will most likely look to the public sector for delivery of these services rather than cease expecting these services to be delivered. The question then is whether the public sector is equipped to do this and what additional costs are likely to be required by the public sector to ensure continuous delivery of these services.

The other question is whether such reduction of services is an intended consequence of the limited fiscal neutrality proposal. The reason why governments have traditionally provided tax concessions to charities and NFP service providers is to encourage and support the benevolent activities they offer to the community. It follows that removing such concessions will remove the incentive for these activities being carried out. Is that really government's intention?

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7 Alternative methods to the current tax concessions

Outlined below are two alternative methods by which the Government could provide alternate assistance to the current tax concessions. They are:

- replacement of current tax concessions with direct government funding ("grant model");
- Allow FBT and payroll tax concessions for all types of hospitals and aged care service providers.

7.1 Replacement of current tax concessions with a grants model

The alternative method canvassed in the Productivity Commission's draft report is the replacement of the existing FBT and payroll tax concessions enjoyed by NFP and public hospitals with a grants model. There is no information in the draft report as to a suggested methodology or process for such a model.

We have outlined below the arguments advanced by the Productivity Commission (in its draft report) in favour of the grants model and our comments thereon.

- the current tax exemptions are complex and costly to administer and are subject to abuse.[8]

It is submitted that the Productivity Commission's arguments (outlined in the draft report) are not convincing. Although there is complexity in relation to the various exemptions that may be available for different types of organisations (which would be overcome to some extent by the introduction of a national register, as advocated by the Productivity Commission), the same cannot be said of the FBT and payroll tax exemptions.

Payroll tax exemption is a full exemption and therefore has no complexity or administration costs for CHA. Removing the exemption will create new administration costs for CHA.

FBT exemptions for public hospitals and PBI operators have been in place since the introduction of FBT in 1986 (more than 20 years), and since 1992 for NFP operators. The current FBT cap has been in place since 2000/2001. As a result, NFP and PBI operators are very comfortable with the current tax concessions and all have adequate systems in place to administer salary packaging (following 20+ years of practice). Particularly in the NFP sector,

[8] Refer to Key Points at Section 8.1 of the Productivity Commission's report "It would be preferable for NFP hospitals and public hospitals to be fully funded in a transparent fashion and not rely on input tax concessions that are also complex and administratively costly." [emphasis added]
Refer to Section 7.14 of the Productivity Commission's report "There is also complexity involved with administering individual concessions. For example, with regard to FBT arrangements, PeakCare Queensland notes:

> 'Complex analysis and complicated administrative and accounting processes surrounding salary packaging often take the benefit from it. The need for organizations to buy in advice and consultants to ensure they are meeting complex and ever changing regulations is also a consideration worthy of note'."

Refer to Section 7.7 of the Productivity Commission's report "Tax concessions raise the complexity of the tax system overall and may be subject to abuse. Increased complexity can also reduce the efficiency of concession administration."

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we understand that the majority of expenses that are salary sacrificed are mortgage and living expenses, which are relatively straightforward to understand and administer for employees and employers alike.

Introducing a grants model is likely to result in increased costs for the NFP, PBI and public hospital sector, as well as within the Government sector. The increased costs will include:

- likely costs associated with applying for grants each year (e.g. collecting relevant data and reporting to the Government entity),
- the Government establishing a body (be it a new body or part of an existing body) to administer the grants system, including evaluating and approving applications,
- likely costs associated with any system of appealing against decisions to disallow grants, etc.
- to the extent that grants compensate for payroll tax obligations, differential adjustments may be required to the extent different states change their payroll tax rates,
- because annual grant amounts are likely to be determined in advance, CHA may lose flexibility in employing additional staff during a given year as the additional required grant for such employees may not be determined until the following year.

In addition, a grants model may result in a greater funding cost to the Government (as opposed to the current tax model). As outlined above, NFP and public hospital operators would most likely need to adjust the gross salary of all staff (not just employees who salary sacrifice) in the situation where the current FBT tax concessions are removed (and replaced by a grants model). This means that NFP and public hospital operators would rely on a greater amount of grant funding from the Government.

- a grants model will provide a more direct and transparent system of providing government support (than through the tax system), which will improve equity and simplicity in the long term.[9]

Theoretically, a grants model may provide a more direct and transparent government funding model than the current tax concessions. It will also provide a benefit to the Government in being able to administer and control the level of Government assistance in this sector, as compared to the current tax concession model.

However, the introduction of a grants model may also introduce a level of uncertainty in the NFP sector. In this regard, from a NFP operator's perspective, grants are more uncertain than tax concessions given that the level of grants can fluctuate depending on various factors (such as

[9] Refer to Section 8.9 of the Productivity Commission's report "Subsidising a sector through input tax exemptions is less transparent than providing direct and transparent grants or fees for service." And Section 8.12 "Conceptually it would be preferable for governments to provide direct and transparent grants to NFPs rather than payroll tax or FBT exemptions."

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budgetary/policy changes, economic factors, change of government risk) whereas tax concessions are legislated in law.

Moreover, unless the quantum of grants is statutorily guaranteed (being somewhat unusual), the discretionary nature of grants will continue to concern CHA each year. The impact of a greater reliance on grants (rather than tax concessions), means that NFP operators in the hospital and aged care sector (such as CHA) may not be able to make reliable long-term plans given uncertainty surrounding cashflow streams, but rather may look to shorter-term ad-hoc planning. NFP operators may also need to maintain a "buffer" of capital funds in case the level of government grants changes, rather than operating on a "tightrope" and make the most efficient use of funds. This may further contribute to an overall drop in the level of services that the NFP operators could responsibly provide to the community and may discourage investment in new facilities.

- the current tax exemptions means that there is a greater incentive for NFP and public hospitals to allocate more funding to labour (as opposed to capital)[10]

The Productivity Commission's draft report does not provide any evidence to support this assertion. At section 8.16 of the report, it indicates that "evidence presented to the Commission indicates that for-profit hospitals tend to be more capital intensive than NFP and public hospitals".

Into what kind of capital assets would the Commission like to see increased investment? The Report offers no suggestions.

The IBISWorld Industry Report "General Hospitals in Australia" dated 05 October 2009 (the "IBIS report") indicates at (p18-19) labour-related costs in public acute hospitals are higher than in private acute hospitals (for a variety of reasons), including:

- public hospitals attend to a high proportion of non-admitted patients (labour intensive);
- public hospitals incur a higher level of costs in medical training and research (labour intensive);
- private hospital patients directly incur a larger proportion of medical costs (resulting in a reduction in labour costs relative to total costs);
- private hospitals incur other expenses which account for a larger proportion of total expenses (compared to public hospitals) such as food, rent, rates, capital depreciation and administrative expenses associated with billing (resulting in a reduction in labour costs relative to total costs);

[10] Refer to Key Points at Section 8.1 of the Productivity Commission's report "payroll tax and fringe benefits tax (FBT) concessions – provide a significant advantage to eligible organisations by making it less expensive for them to employ labour. Input tax concessions also distort decisions on the allocation of funds between capital and labour."

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- day hospitals (which are principally run by 'for profit' operators) generally concentrate on less invasive surgery, allowing for the rapid discharge of patients and therefore lower staff-related costs (resulting in a reduction in labour costs relative to total costs).

Although the IBIS report only deals with public and private hospitals, given that NFP hospitals provide similar services to public hospitals, it is fair to assume that the same arguments exist as to why NFP hospitals have higher labour costs, as compared to 'for-profit' hospitals. In particular, CHA has indicated that its hospitals undertake more research, community benefit activities and clinical training than 'for-profit' hospitals, which will result in higher labour costs for CHA hospitals (as compared to 'for profit' hospitals).

In any event, we understand that the majority of services provided by the hospital and aged care sector are by their very nature naturally labour intensive given the required high level of personal care. In this regard, the IBIS Report indicates that labour costs account for between 40% and 70% of total recurrent expenditure in hospitals. Given that labour costs are inherently high for hospitals, any skewing by NFP / public hospitals to labour resources (over capital resources) is unlikely to be a significant factor.

- the current tax exemptions means that there is not a level playing field between NFP, public and private hospitals (i.e. there is not competitive neutrality), which thereby inhibits profitability in the sector.[11]

It is submitted that the Productivity Commission's draft report does not adequately address this issue for reasons including:

- Tax Office may collect data and use it to calculate the total level of financial assistance provided via FBT concessions in this sector; such total could be disclosed annually, thereby arguably creating the desired transparency and at a cost likely to be lower than introducing a grants model.

- the introduction of a grants model may create transparency as to the level of financial assistance provided by government, however it will not necessarily create competitive neutrality in the sense that NFP and public hospitals will still obtain benefits (via grants) that 'for profit' operators do not receive. However, there would be a concern if the true intention (albeit unstated) was to introduce a system of grants merely as a transitional measure where the objective was to scale such grants back over time to zero, thereby creating neutrality. If that is the true intention, then that ought to be disclosed and explained in detail in order to not leave the industry with uncertainty.

- seeking neutrality between the NFP/public hospital and the 'for-profit' sector assumes that all operators perform the same services and in similar locations. That assumption may be

[11] Refer to Key Points at Section 8.1 of the Productivity Commission's report "NFP hospitals and public hospitals have a significant competitive advantage over for-profit hospitals." and Section 8.20 "Overall, the Commission concludes that the competitive neutrality principle is violated by the provision of input tax concessions, especially for FBT and payroll tax, to NFPs that compete against for-profit companies in the provision of similar goods and services on a significant scale."

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difficult to sustain in that the 'for profit' operators generally only undertake activities that they consider will be profitable, whereas NFP / public operators seek to undertake all activities that satisfy a wider range of needs in the community. For example, CHA has indicated that NFP hospitals (such as CHA) undertake more research, community benefit activities and clinical training than what 'for-profit' hospitals undertake. If the NFP operators (such as CHA) only undertook profitable activities, the unprofitable or charitable/benevolent services would simply fall back on the Government / public's responsibility.

- Section 8.19 of the Productivity Commission's report states that:

  "In general, it can be expected that those NFPs operating in competition with the for-profit sector will have sufficient revenue to pay market salaries. After all, in these areas, there is a market to attract for-profit companies and therefore sufficient revenue flows."

  It is submitted that this argument is doubtful given that NFP sector provides different services to those provided by the 'for-profit' sector (as outlined above). As outlined above, if the NFP operators paid market salaries (without access to the FBT and payroll tax concessions), the NFP operators would have to cut less profitable services in order to maintain cashflow. This suggests that NFP operators would be reduced to undertaking similar services to those undertaken by 'for-profit' operators, and require the Government / public sector to provide the non-profitable services dropped by NFP operators.

- CHA has suggested that private hospitals and NFP hospitals may not receive the same rates of funding via private health insurance (e.g. it has been suggested to CHA that private health insurers factor in the tax concessions in setting the level of claims permitted). Further work in this area is required to determine whether private hospitals and NFP hospitals receive the same rates of funding in order to form a concluded view on competitive neutrality.

- The 'for-profit' hospital sector has grown at about double the rate of the NFP hospital sector (refer to Figure 8.1 at Section 8.18 of the Productivity Commission's draft report). This suggests that the 'for-profit sector has not been not adversely impacted by the tax concessions available to the NFP sector.

In summary, it is submitted that the grants model is not a viable alternative to the current tax concession model.

In addition, the Productivity Commission's draft report (particularly at Section 8.2) primarily focuses on competitive neutrality concerns for NFPs as against the 'for-profit' sector. Although section 8.3 of the draft report acknowledges that there are competitive neutrality issues in the hospital sector for private versus public hospitals and 'for-profit' versus NFP hospitals, it does not deal with competitive neutrality issues for NFP versus public hospitals.

In this regard, if the current tax concessions enjoyed by the NFP sector are removed, then logically the same tax concessions enjoyed by the public sector should also be removed in order to maintain competitive neutrality between NFP and public hospitals.

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7.2 Allow FBT and payroll tax concessions for all types of hospitals and aged care service providers

Another option is to provide access to the current tax concessions (i.e. FBT and payroll tax exemptions) to all hospital and aged care providers (i.e. to the 'for-profit' sector along with the NFP and public operators).

In this regard, instead of having a blanket exemption, the rules could operate such that the level of exemption is based on the level of prescribed benevolent services being provided by the relevant organisation. For example, factors that may be taken into account may be based on any of the following:

- number of beds available for patients;
- number of patients treated;
- level of certain prescribed 'in need' services.

Overlaying this would be additional disclosure being provided to the ATO (possibly in FBT returns) that permits the value of the concessional benefits to be provided. This should overcome any transparency concerns about understanding the level of government assistance being provided.

The benefits of this option include:

- it would provide a transparent system of providing government support (given that a central model for tax exemptions could be adopted);
- reward operators that undertake services that are needed by the community, which are often not profitable: these may include the prescribed services mentioned above;
- no major change to the current tax concession system,
- obviates the potential industrial relations issues that CHA would have to manage if the exemptions were removed,
- ensures that CHA (and other NFP operators) may continue to maintain its current level of hospital, benevolent and charitable services.

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