A submission of operators of not for profit private hospitals to the Productivity Commission in response to Chapter 8 of the draft report on the *Contribution of the not for profit sector.*

We the undersigned are the operators or representatives of the majority of not for profit hospital beds in Australia.

Not for profit private hospitals are a practical expression of their owners' (in most instances faith based or community based organisations) focus on fulfilling a community good, as well as maintaining a balanced and vital healthcare system in Australia.

Not for profit operators apply all of their resources (including any surpluses) to improving their healthcare facilities or meeting community needs, and expanding their service provision, with many undertaking clinical research as well as education and training for the general benefit of the Australian community. This distinguishes them significantly from for profit hospital providers who must by definition provide a financial return to their shareholders.

We oppose the removal of payroll tax exemptions, employee fringe benefits tax concessions, and meal entertainment tax concessions for employees. We oppose these possible changes because to do so would bring a pressure to not for profit hospital service delivery that would significantly disrupt the delivery of ALL hospital services, both public and private, across Australia.

Many of our organisations have made individual and detailed submissions in response to the Commission's Chapter 8 of the draft report on the *Contribution of the not for profit sector*. This submission does not seek to go into the detail outlined in these separate submissions. Rather, this submission seeks to make it clear to the Commission and to the Federal Government that there is no basis for the removal of tax concessions from not for profit private hospitals, and that we the not for profit private hospital sector are united in our determination to ensure removal of tax concessions is not pursued.

Our opposition to the removal of these concessions is based on our view that the draft report of the Commission:

1. Overlooks the **charitable public benevolent nature** of not for profit hospitals and seeks to classify not for profit charitable hospitals as incorrectly having the same purpose as for profit hospitals;
2. **Questionably applies competitive neutrality** policy to the private hospital sector;
3. Ignores and makes **no attempt to quantify the consequences** of the proposal to remove tax concessions from not for profit hospitals;
4. Would create a new **advantage for government owned hospitals** in attracting staff at a time when a new disadvantage would be created for not for profit hospitals;
5. Fails to outline **what adverse consequence is currently being imposed on for profit hospitals** as a result of current taxation arrangements.

1. Charitable public benevolent nature of not for profit hospitals

Our not for profit hospitals are recognised as charitable public benevolent institutions in that they comply with one or more of the common law requirements for classification as a charity because they exist for one or more of the following reasons:

- The relief of poverty,
- The promotion of religion,
- The promotion of education,
- Purposes beneficial to the community.

Classification as a charitable public benevolent institution is one of the key reasons that our hospitals and our employees currently receive certain tax concessions. Chapter 8 of the Commission's draft report has made no argument to suggest our hospitals are not charitable public benevolent institutions, and nor has it proposed any change to this definition. Chapter 8 does, however, seek to suggest that there are no real distinctions between not for profit and for profit hospitals. This proposition is flawed, in that for profit hospitals exist to fulfill a profit motive and not for profit hospitals exist to fulfill a community good, and, or to advance religion.

To this end, a number of not for profit private hospitals provide a range of services that are either not done at all or very rarely occur in for profit hospitals. This is due to the poor financial returns gained from providing some hospital services. However, the provision of these services by not for profit hospitals takes pressure off the burdened public hospital system, which is already struggling to manage the demand currently imposed on public health services. Such clinical services include bone marrow transplantation, treatment of highly complex medical oncology patients, and fully integrated palliative care services.

This analysis is supported by the Australian Bureau of Statistics catalogue 4390.0-2006/07 which notes that:

- Not for profit private hospitals are generally larger than for profit hospitals.

- The average cost per patient day grows as hospital size increases, which in turn means that the opportunity to profit decreases. This is a reflection of the greater complexity of procedures undertaken at the larger private hospitals.
- There are also considerable differences in the average recurrent expenditure per patient day in not for profit as opposed to for profit hospitals. Religious or charitable hospitals had the highest average costs per patient day ($1,054) in 2006/07. This does not mean religious or charitable hospitals are more expensive or less efficient, rather it suggests the nature of the work they carry out does not create the same opportunity to profit that for profit private hospitals have.

2. Questionable application of competitive neutrality principles

The draft report of the Commission questionably applies the principle of competitive neutrality to private hospitals. The term competitive neutrality was originally limited to the context of National Competition Policy:

> "Australia's governments have taken the logical view that the disciplines imposed by the effective competition, being the greatest drivers for improving productivity and encouraging innovation, need to be extended throughout all sectors of the economy for Australia's standard of living to rise…The removal of advantages available to government businesses because of their public ownership will enhance the ability of private businesses to compete with those owned by governments."[1]

The National Competition Policy, in defining the public policy use of competitive neutrality, states that the principle is to be applied in the creation of a level playing field between government owned enterprises and other owned enterprises across the Australian community. The National Competition Policy has not previously applied principles of competitive neutrality to commercially owned for profit enterprises and not for profit owned enterprises. We question if the Productivity Commission should be taking such an approach.

3. Quantification the consequences

Chapter 8 of the Commission's report proposes the removal of tax concessions from not for profit hospitals, yet it makes no analysis as to what impact this would result in.

As operators and representatives of most not for profit hospitals in Australia, we are in no doubt as to the consequences of removing payroll tax and fringe benefits tax for not for profit private hospitals and their employees, and in turn, their patients.

For some of us, hospital operations would move from being viable to unviable if payroll tax concessions were removed. Margins are mostly slim in private not for profit hospitals, and many not for profit hospital operators already struggle to maintain operational

[1] National Competition Council, *Competitive neutrality reform: Issues in implementing clause 3 of the Competition Principles Agreement.* January 1997, pp.1, 3.

viability whilst at the same time pursuing the constant demand for capital reinvestment that consumers require.

Our staff would suffer a loss in take home pay if their fringe benefit tax concessions were removed. For many, this would give them no choice but to seek work in government owned hospitals where the benefit may still apply, or in other parts of the health system.

For our operations to remain financially viable if payroll tax exemption is removed, and for us to be able to retain staff if fringe benefit tax concessions are removed, we would need to incur new costs. These new costs, attributable to the proposed recommendations of the Commission in its draft report, could be met from a combination of 3 sources:

- The passing on of these costs to our funders, who are either individual consumers or private health funds. In the case of private health funds, increased costs would need to take the form of an increase in the cost of health insurance premiums, an outcome which is clearly contrary to current Federal Government policy.
- Hospital surpluses or reserves, which in most of our cases is either not possible or unsustainable. If the cost increases attributable to the proposed recommendations of the Commission in its draft report had to be met from surpluses or reserves, in time all of our hospitals would eventually become unsustainable in their current form. This would result in major disruption in access to health care across the entire Australian population as some not for profit private hospital services would be cut or closed as a result of the Commission's recommendations.
- Cancellation of mission or community focused services which currently assist in relieving the pressures on the public hospitals. Cancellation of community benefit activities would lead to the question as to why not for profit hospitals would seek to continue their hospital operations at all. Closure or sale of hospitals by not for profit operators would inevitably lead to less choice for the Australian community and possibly restricted access to certain services currently provided predominately by the not for profit private hospitals.

The final report of the Commission should quantify the risk to hospital care that arises from the recommendation to remove tax concessions from not for profit private hospitals. If the Commission can not quantify the risk, it should recommend that more detailed risk quantification occur prior to the development of any future proposals to remove existing tax concessions.

4. Advantage for government owned hospitals

The draft report of the Commission does not propose to remove fringe benefits tax concessions from employees of government owned public hospitals. In the event that these concessions were removed from employees of not for profit private hospital but they were retained by employees of government owned public hospitals, our organisations would be significantly disadvantaged in attracting staff in comparison to government owned public hospitals.

Perversely, the disadvantage the Commission incorrectly sees as existing between for profit and not or profit hospitals today would shift to existing between non government and government owned hospitals. It would be not for profit hospitals that would be most disadvantaged by this policy outcome, a policy outcome that would clearly be in breach of the original intent of the National Competition Policy; to avoid government owned enterprises from enjoying financial advantages over non government owned enterprises.

5. What adverse consequence is currently being imposed on for profit hospitals?

The argument for similar tax treatment of for profit and not for profit hospitals as outlined in the Commission's draft report is inherently flawed. The Commission has overlooked the advantages that for profit private hospitals already have over not for profit private hospitals in the fundamental area of the ability to attract capital resources. For profit hospitals attract capital investment because they can offer investors a return on that investment. Not for profit hospitals do not offer any such return to contributors.

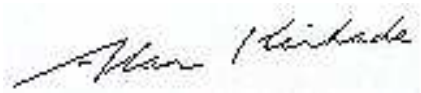
Figure 8.1 on page 8.18 of the Commission's draft report shows that both for profit and not for profit private hospitals have grown rapidly over the past 15 years, as measured by the number of patient days. The Commission cites data that in the period 2002-03 to 2006-07, not for profit hospitals recorded a growth in the number of patient days of 16 percent, compared with an essentially stable number of patient days in the for-profit private hospitals. This data is cited as proof not for profit hospitals have access to capital. Not for profit hospitals generate funds in the form of patient fees, loans and donations. They do not have access to shareholder equity. This means that they rely on loans and donations to finance capital works. Debt for not for profit hospitals is generally more expensive than the debt available to for profit hospitals because there is no equity to act as a buffer for lenders during lean times.

However, assessing the entirety of the data presented at figure 8.1, it is starkly evident that since 1992 when there was an almost equal amount of bed day capacity in both the for profit and not for profit sectors, the for profit hospital sector has enjoyed extraordinary growth that has outstripped that of the not for profit sector. With the for profit sector having been able to strengthen and grow its bed day capacity so rapidly, it is evident that the for profit sector has not suffered a particular disadvantage through the operation of tax concessions for not for profit hospitals.

Conclusion

The draft report of the Productivity Commission suggests that not for profit hospitals are no longer entitled to enjoy their tax concessions. We disagree. To remove the concessions would result in significant disruption to ALL hospital services in Australia.

We seek that the Commission addresses the potential consequences of removing the tax concessions in it final report prior to the report's submission to the Federal Government.



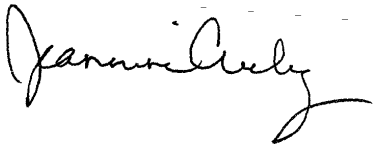
Alan R Kinkade
Group Chief Executive
Epworth HealthCare

Nick Warden
Chief Executive
The Burnside War Memorial Hospital Inc

Stephen Walker
Chief Executive Officer
St Andrew's Hospital

Ray Fairweather
Chief Executive Officer
St Andrew's Toowoomba Hospital

Marcia Everett
Chief Executive Officer/Director of Nursing
South Perth Hospital



Jeannine Creely
Chief Executive Officer
Cobden District Health Services Inc

Alan Cooper
Chief Executive Officer
Friendly Society Private Hospital

Andrew Mitchell
Group Manager, Mental Health/Counseling
Wesley Mission - Carlingford

Richard Royle
Chief Executive Officer
UnitingCare Health
Representing Uniting hospitals:
The Wesley Hospital
St Andrew's War Memorial Hospital
The Sunshine Coast Private Hospital
St Stephen's Hospital, Maryborough
St Stephen's Hospital, Hervey Bay

Martin Laverty
Chief Executive Officer
Catholic Health Australia
Representing Catholic groups of hospitals:
St Vincent's Health Australia (Nat)
St John of God Healthcare (Nat)
Little Company of Mary Healthcare (Nat)
Cabrini Health Australia (Vic)
Mater Hospitals (Qld)
Mercy Health (Vic and NSW)
MercyCare (WA)
St Vincents and Mercy Private (Vic)
St Vincent's Private Hospital (Lismore)
Catholic Health Care Ltd (NSW)