I would like to comment on an aspect of the Contribution of the Not-for-Profit Sector Draft Productivity Commission Report. I should declare that I am an employee of a state public hospital, and that my views do not necessarily correspond with those of my employer, and indeed do not reflect anything other than a personal perspective. I also declare that I do not participate in salary packaging. I will be happy to elaborate on any of my comments, if required.

> "– input tax concessions do not reflect potential benefits, and some, notably the payroll tax and fringe benefits tax concessions, are costly and complex to implement and administer, and raise valid competitive neutrality concerns in some areas, for example, hospitals"

The notion and consequences of competitive neutrality in hospitals (an area singled out for attention) has not been adequately described, and some of the examples of application of salary packaging are inaccurate and little more than sensationalism. The statement about the effect on competitive neutrality in Box 1 (Overview, page XXXI) is immediately followed by one that substantially reduces the FBT benefits for hospitals, yet this is not explored.

Under the heading "**Improving arrangements for more effective sector development —workforce, skills and access to capital",** the Draft Report states in the first paragraph that part-funding of NFPs has effects on service delivery. While that statement is undoubtedly true, it overlooks the analogous consequences of the "For-profit" organisations which must return a dividend to shareholders and investors.

In addition, it is not necessarily universally true that NFPs must offer less competitive wages. In the sector with which I have the greatest familiarity, the pathology services sector, private sector wages are substantially poorer than those offered by NFPs. Private pathology laboratories maximise investment returns by choosing to pay lower wages. The nexus between the for-profit private laboratories and the investors, to the disadvantage of the pathology worker, is worsened by the influence that the College of Pathologists has on the Medicare schedule fee for pathology tests, and by the number of Pathologists who invest in ownership of private healthcare providers. However, because the Medicare fee applies to both NFPs and for-profit pathology, the quantity of profit, or return on investment, has an inverse relationship to the costs of employee related expenses.

Under the heading "**Strengthening relationships — government, business and community"**, paragraph 4 on page XLIV refers to fully funding services which would be required to be provided by government. Great suggestion, but this does not examine the situation for hospitals, where funding is obtained from a variety of sources, typically including at least two different levels of government.

In the body of the report, Section 1.3 discusses definitions of NFPs, and quite properly recognises that sector-wide regulation is probably not appropriate. The section, however, does not appear to take into account the community "flow-on effects" of the activities of NFPs. For example, active Church groups presumably have a positive effect on the welfare of members and clients, but probably also benefit the local community through the visibility of their activities (possibly by reducing the environment for crime) and on the broader community through reduced welfare costs. Similarly, in the case of trade unions and professional associations, many benefits won through the industrial activities of trade unions or the professional activities of professional associations have flow on to non-members and sometimes clients. However, this omission appears to be partly corrected in Section 3 of the report "Measurement"

Discussion in this part of the Draft Report about what is an NFP probably confirms, contrary to submissions relating to the FBT benefits, that public hospitals are actually a government-sector organisation, rather than an NFP, and are therefore technically outside the scope of this report.

Chapter 8, under Key Points, repeats the erroneous statement that public hospitals have a significant competitive advantage over for-profit hospitals in the area of input taxes. Logically, this cannot be true, or at best considers only one aspect of funding services, because public hospitals are not obliged to provide returns to investors, and private hospitals are not bound by government-determined fees for their services, being able to charge "market rates". In addition, services provided by private hospitals may not have the same scope as those provided by public hospitals. Further, the contribution of private hospitals to education and research is substantially less than that of public hospitals. Let's have a level playing field, by all means, but to do so requires taking into account all factors, not merely those which suit the owners of and investors in private hospitals.

The description of Deloitte's submission on behalf of ACL in regard to the Adult Migrant English program, on page 8.7 refers to a competitive advantage resulting from tax concessions to NFPs, but fails to refer to the profit advantage of ACL over the NFPs, such profits being made <u>after</u> paying the cost of these taxes.

The suggestion on Page 8.14 that "most hospitals have a subsidised staff canteen" may have been true in the distant past, but is no longer the case. Indeed, food sources within hospitals now tend to be more expensive than in the community, because the market is more captive. It is also not generally true that salary packaging can legitimately be used for holidays, other than the meal component. In relation to the salary packaging benefits applicable to NSW Health employees, and in direct contradiction of the "Marketing information from Salary Options (2009, p. 1):", accommodation costs could not be legitimately claimed in the example given.

There are further errors and omissions in the information recorded in Box 8.4, at least in regard to NSW Health employees (refer to NSW Health PD2007_076 for accurate details). The first two examples refer to PBI or NFP hospital staff, not public hospital staff, but the distinction may not be apparent to the general public. In a NSW public hospital setting, in the first example, Dr Peter would be entitled to legitimately claim only the cost of his own meal, $200, through salary packaging, and in the second, Jane could claim only the food costs of her wedding. This is made quite clear in literature distributed to NSW public hospital staff interested in salary packaging. The information provided by McMillan Shakespeare is probably accurate, but the information from EPAC is wrong in part, as far as it applies to NSW public hospital staff.

Further, while it may be partly true that "For PBI hospitals, with labour being relatively less expensive, there is a greater incentive to purchase more labour at the expense of capital." Healthcare, surely, is a service industry - is it a bad thing that more labour is employed ?

The next paragraph in the Draft Report describes a distortion "between employees at PBI hospitals". This distortion certainly exists, but is not restricted to PBI hospitals or NFP institutions, but is widespread throughout the community !

The submission by Yooralla, that low paid employees do not really benefit from salary packaging, is demonstrably incorrect, except possibly for those on the very lowest tax rates. This is easily shown, and the position taken by Yooralla appears to be paternalism at its worst.

The assertion in the penultimate paragraph of page 8.16, that "NFP hospitals operate in the market sector, in full competition with for-profit hospitals" is simply not true, and must not go unchallenged.

In the example that follows, which compares two hospitals in Brisbane, the report clearly identifies two potential means by which private hospitals could compete for staff with a public hospital, but fails to indicate the many other ways by which staff can receive non-salary financial and non-financial benefits that make their site of employment attractive. If private hospitals are unwilling to use these options, and are also unwilling to accept the market forces that they are overtly calling for, then their position is one of hypocrisy.

In arguing for the removal of the FBT benefits from public hospitals, the Commercial Hospital Operators Australia (CHOA) argues that it would add a cost of some $45.4 million for nursing. However, the CHOA does not put this into context by also reporting its profits in comparison to the profits of public hospitals.

The CHOA has also failed to indicate that an option not available to public hospitals (at least in NSW) is to offer over-award wages.

The operating motivations for public hospitals and for private hospitals are clearly quite different : public hospitals are predominantly client focussed, while a large driver for private hospitals is the return on private investments. As well as having different philosophies, the two have a different range of services, and different social benefits, and for the CHOA to suggest that the FBT benefit has a significant effect on competitive neutrality is to vastly oversimplify the issues, for self-serving reasons.

If the CHOA (and indeed the private pathology businesses) were to accept a reduction in the substantial net profits made by that sector, it would find that it could easily compete with public hospitals for staff.

In summary, the Draft Report appears to have given great credence to submissions made by private hospital operators without adequately investigating the validity of claims made. I would suggest that such submissions are highly partisan, and motivated purely by profit-making aspirations. Further, the information provided in the Report does not make the case that public hospitals should be considered with NFP institutions, rather than being treated as government operations. That is, public hospitals should not be considered in this report. However, if they are to be included, then the principle of a level playing field should be rigorously applied, and all relevant factors, including the profit-taking of private health providers, should be considered.

I trust the format of this comment will be satisfactory,

With kind regards,

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