19 November 2009

Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Attention: Tracey Horsfall

Productivity Commission Draft Report on the Contribution of the Not-for-Profit Sector

I refer to the Commission's draft report on the Contribution of the not-for-profit sector and the Commission's invitation to respond to the draft report. Please find below background about Epworth HealthCare and our comments on Chapter 8 of the report.

Epworth: a not-for-profit hospital

Like many other not-for-profit hospital, Epworth was founded by a combination of church and private philanthropy. Epworth was founded by the Methodist Church (now the Uniting Church) with the support of a small group of philanthropic church members in 1920. Many of the philanthropic families that supported Epworth at its foundation are among our strongest donors to this day. For the last two financial years, approximately, one-third of Epworth's capital expenditure has been funded by philanthropy. We are about to launch a large capital appeal to raise $50 million towards funding our ambitious program to redevelop our Richmond campus – at a total cost of around $350 million. Funding of $75 million for this project was also unsuccessfully sought from the Commonwealth's Health and Hospital Fund. It also should be understood that the $350 million development is a staged project over at least 7 years with each stage costing under $85 million. Epworth will only commit to each stage as funds become available from its donations, operations and banking facility. While this project's business case supports its feasibility, it is a great example of a not-for-profit hospital not having access to the equity market because if we did there would be no need to stage this project over such a long time frame.

The reason these philanthropists and church groups are prepared to support us is that they wish to encourage the activities that Epworth undertakes. Epworth's strategy documents show that Epworth seeks to maximize the extent to which it undertakes certain activities – providing excellent care for patients and contributing to the training of the next generations of doctors, nurses and allied health staff. Although we define our objectives in terms of these activities, we pursue these objectives subject to meeting the financial constraint of breaking even over the long term.

Epworth's focus as outlined in the preceding paragraph is similar to a number of not for profit private hospitals which provide a range of services that are either not done at all or very rarely in the for profit sector or are introduced in the first instance in the not-for-profit sector. This is due to the poor financial returns gained from providing these services. However, such services provide a valuable safety valve to the public sector, who are already struggling to manage the demand currently imposed on their services or provide innovation to the Australian health system earlier than would otherwise occur. Such clinical services in the not-for-profit sector include bone marrow transplantation, highly complex medical oncology patients, and fully integrated palliative care services. In Epworth's specific case there has been a number of impressive firsts where Epworth has taken the risk of introducing services into Australia or into the private health sector. Examples of Epworth's innovation include Epworth being the first hospital:

- in Victoria to introduce open heart surgery in a private hospital
- in Australia to establish an ICU in a private hospital
- in Australia to introduce the da Vinci robotic surgery, i.e. Epworth was the first hospital either public or private in Australia to have such a service and remains the leading hospital in Australia for the provision of such services.

The fact that not-for-profit hospitals have a focus on service provision rather than profits is supported by analysis undertaken 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 (refer table 2.3);
- The average cost per patient day is high as hospital size increases. This is a reflection of the greater complexity of procedures undertaken at the larger hospitals. Refer page 18;
- There are also considerable differences in the average recurrent expenditure per patient day according to for-profit/not for profit sector. Religious or charitable hospitals had the highest average costs per patient day ($1,054) in 2006/07.

As an organization that maximizes the undertaking of activities subject to a break-even financial constraint, Epworth does not fit easily within the analytical frameworks of the Draft Research Report. For example page 8.8 suggests that not-for-profit hospitals seek to maximise surplus (or profits). Page 8.9 suggests that not-for-profit hospitals seek to maximize its output subject to a cost constraint. Epworth sees itself as maximizing activities subject to a break-even financial constraint.

Two issues raised by chapter 8

Chapter 8 of the Draft Research Report questions the tax treatment the Government offers not-for-profit hospitals, such as Epworth. The questioning raises two issues. The first is whether Government treatment of not-for-profit hospitals is competitively neutral. The second is whether the FBT exemption is an efficient form for the Government to adopt in attempting to increase the services provided by not-for-profit hospitals. We shall deal with each of these issues.

Competitive neutrality

Governments offer tax concessions to not-for-profit hospitals for the same reason that they fund public hospitals directly: that is, like private philanthropists, they wish to support the activities of not-for-profit hospitals.

As the Draft Research Report notes, this funding could take the form of direct payments for output as occurs (more or less) in the public system. (See page 8.9.) However, this is likely to lead to the highly-inefficient bureaucratic controls and reporting systems that exist in the public system. It may well be that the most efficient form of state funding of not-for-profit hospitals is for the state to offer non-bureaucratic tax concessions.

As is noted in the Draft Research Report, not-for-profit hospitals such as Epworth compete with both Public Hospitals and with for-profit hospitals – see page 8.13. The Deloitte Touche Tohmatsu submission that is quoted extensively by the Draft Research Report seems to offer a highly partial analysis. In truth, each of the three kinds of hospital has certain competitive advantages and disadvantages. These might be summarized as follows:

1. Public hospitals are bucket-funded by the state. Although this may be seen to give them a great competitive disadvantage over their for-profit and the not-for profit competitors, they also suffer great disadvantages in the bureaucratic constraints imposed upon them. Public hospitals are able to provide services to both public and private patients whereas private hospitals generally only service private and compensable patient's needs. The exception to this is if a public hospital decides to contract some limited work to private hospitals.
2. Not-for-profit hospitals generate funds in the form of patient fees, loans and donations. They do not have access to equity. This means that they rely on loans and donations to finance capital works. Debt for not-for-profit is generally more expensive than the debt available for for-profit hospitals because there is no equity to act as a buffer for lenders during lean times.
3. For-profit hospitals have access to patient fees, debt and equity – but not to donations. Donors will be unlikely to donate to for-profit organisations if the donations may find their ways into the hands of shareholders in the form of dividends. For profit hospitals have access to special incentives that the Federal Government has used to stimulate capital investment e.g. the 50% investment allowance, whereas such incentives are not available to the not-for-profit hospitals.

Viewed in this way, it is simply not true that not-for-profit hospitals have a cost advantage over for-profit hospitals. Each has certain advantages and disadvantages. Indeed, if one form had a clear cost advantage over another, the lower-cost form would always eliminate the higher-cost form. However, this is not what one observes. In many countries, such as the United States, the leading research and teaching hospitals are private, not-for-profit organisations e.g. The Cleveland Clinic, The Mayo Clinic etc.

Any analysis of competitive neutrality should take account of the three-way pattern of competition within which hospitals operate. The question of competitive neutrality of government policy with respect to hospitals should consider whether government policy is neutral between public, for-profit and not-for-profit hospitals. This raises questions of the range of government policies that affect hospitals. The issue of competitive neutrality cannot be dealt with by considering one form of tax at a time – in the way that it is dealt with in chapter 8.

FBT Concession

Although the Draft Research Report acknowledges the three-way pattern of competition between not-for-profit, for-profit and public hospitals, its analysis of the FBT concession concentrates on competition between not-for-profit and for-profit hospitals. As noted above, it is inappropriate to analyse competitive neutrality within such a partial-equilibrium framework.

Even within the restricted vision, the analysis of the Draft Report seems to be partial. It points to three forms of distortions that are produced by the FBT concession.

The first is that it works to subsidise labour employed by the not-for-profit hospitals compared with labour employed by for-profit hospitals (page 8.14 – 8.15). This is undoubtedly true. However, this is very close to a subsidy of activity (avoiding the bureaucracy associated with the usual state funding) as noted above. Governments subsidise the activities of not-for-profit hospitals for the same reasons as private philanthropists – that is, they wish to support the activities that organizations like Epworth undertake. By helping to relieve their financial constraints, government and private donors enable more funds to be directed to the activities that organizations like Epworth seek to maximize. Whether such a subsidy is competitively neutral must be considered within a more general context of the three-way competition between for-profit, not-for-profit and public hospitals.

The second distortion noted might seem more plausible: this is that the FBT concession encourages a higher ratio of labour to capital ratio in the not-for-profit than in the for-profit organizations (page 8.16). It is not clear that this is true – even as a matter of theory. Not-for-profit organizations find that the best way they can elicit donations is to propose capital works projects. As a matter of theory, this may create a bias in favour of capital expenditure over expenditure on labour. (A similar – but stronger – bias is likely to exist in public hospitals.)

The third distortion noted is between categories of labour: “Those employees with higher salaries, and those employees with greater financial freedom to spend their salaries on items not included in the $17,000 cap will benefit commensurately more than other employees.” (p 8.16)

Each of these noted distortions is raised as a matter of theory – comparing the incentives facing for-profit hospitals compared with the incentives facing not-for-profit hospitals. There are two real problems with this way of arguing. The first is that the competition facing not-for-profit is three-way competition: public hospitals must be included as an integral part of any analysis of competitive neutrality in hospitals. Secondly, the multiple competing incentives can only be analysed if one has a feel for the rough orders of magnitude of the various incentives. Unless one has a feel for these orders of magnitude, one is likely to give a heavy weight to relatively unimportant incentives and to ignore other factors whose effects are much greater. Little or no empirical evidence is provided in the draft report.

The Commission should appreciate that many of the base rates for nurses, allied health and administrative staff are determined through enterprise agreements negotiated with Unions and vetted by Industrial Commissions in various jurisdictions. These negotiations negotiate around parity on the base rate excluding any FBT implications with a parity proposition being between public not-for-profit and for-profit Private Hospitals. It should also be appreciated that in the for-profit sector, there are many other reward mechanisms available to them such as share options, which can be effectively taxed packaged, which are not available to the not-for-profit sector.

Conclusions

The Draft Report invites comments on whether procurement guidelines should explicitly require that tax expenditures should be considered in Commonwealth Government procurement decisions. (See p 8.13.) Epworth would have no objection to this move. Indeed, the burden of this submission is that tax concessions are somewhat similar to state subsidies to public hospitals – except that they avoid the heavy bureaucratic burden of the subsidies in the public system.

The state offers tax concessions to not-for-profit hospitals such as Epworth because it wishes to enhance incentives for more of this activity to be undertaken. That is, the reasons for the tax concessions are exactly the same as those for state funding of public hospitals. The benefits are that (a) it avoids the heavy bureaucratic burdens of systems of state funding of public hospitals; and (b) it avoids subsidising the activities of the for-profit hospitals and their owners.

We would welcome and like to meet with representatives from the Commission to further expand on the above and our President, Dr Philip Williams, who is also Chairman of Frontier Economics and I would be available for such a meeting at the Commission's convenience.

Yours sincerely

Alan R Kinkade
Group Chief Executive Officer
Epworth HealthCare