CATHOLIC HEALTH
Australia

Catholic Health Australia

Response to the Productivity Commissions *Contribution of the Not-For-Profit Sector*

Draft Research Report: **October 2009**

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care services, comprising 19,000 residential aged care beds, 16,000 community packages and HACC service users, are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

"I believe that the church and charitable sector does a fantastic job in Australia"
Prime Minister Kevin Rudd, Question Time 18th November 2009

Executive Summary

Is a private not for profit hospital and aged care service a charitable public benevolent institution or not?

Catholic Health Australia (CHA) welcomes the opportunity to respond the Productivity Commission's draft consultation report in to the "*Contribution of the Not-For-Profit Sector*", October 2009. In responding to the Commission's draft report, CHA proposes that Chapter 8 of the draft report should be revisited to include consideration of what a charitable public benevolent institution is, and why tax concessions are and should be extended to all charitable public benevolent institutions.

All Catholic hospitals and aged care services are charitable public benevolent institutions. They were established for and remain committed to their dominant purpose which is the direct provision of services for the relief of sickness, suffering, misfortune, and disability through the direct operation of hospital and aged care services. This purpose is achieved through the advancement of religion, in that not for profit health and hospital services are operated in the image of the healing ministry of Jesus. This healing ministry of Jesus is articulated in a contemporary manner in the Catholic Health Australia Code of Ethical Standards.

Each of the 75 public and private not for profit Catholic hospitals and the 550 not for profit Catholic aged care services advance these dominant purposes through the provision of high quality health and aged care services. Chapter 8 of the Commission's draft report has not considered the role and continuing need for charitable public benevolent institutions.

The promotion or advancement of religion has been recognised as one of the four headings of charity in common law since *Income Tax Special Purpose Commissioners v Pemsel* (1891) AC 531. Similarly, the Australian Tax Office has affirmed that a public benevolent institution (PBI) is a non-profit institution organised for the direct relief of poverty, sickness, suffering, distress, misfortune, disability or helplessness. By questioning the ability of not for profit private hospitals to access certain tax concessions, Chapter 8 of the Commission's report comes close to wanting to redefine not for profit private hospitals as something other than charitable public benevolent institutions, without properly acknowledging their existing charitable public benevolent institution status.

Whilst again not stated, the argument Chapter 8 applies to not for profit hospitals can be just as readily applied to aged care services, employment services, disability services, and other welfare oriented services. As such, we focus our response to the Commission on aged care services as well as not for profit hospitals.

In its entirety, CHA considers that the draft research report provides a comprehensive assessment of the issues facing the not for profit sector. However, CHA submits that the draft report has not appropriately applied principles of competitive neutrality in its discussion of not for profit hospitals, and nor has the

Commission discussed the very different market dynamics that operate in relation to for profit and not for profit private hospitals. In short, Chapter 8 of the draft report has not adequately considered the role of not for profit hospitals and their (in the case of Catholic hospitals) charitable public benevolent purpose. Chapter 8 of the draft report is therefore incomplete, and it has reached conclusions without a full exploration of the charitable public benevolent purpose of most not for profit hospitals.

In finalising the final report, CHA argues the Commission needs to address the following omissions in relation to its Chapter 8 discussion on competitive neutrality and the operation of the private hospital sector:

- Most not for profit hospitals are charitable public benevolent institutions, and all Catholic hospitals are classified as such. Charitable public benevolent institutions currently and have for many years accessed certain tax concessions in recognition of their contribution to the common good, and this recognition has consistently been recognised at common law and by the Australian Tax Office. Chapter 8 gives no rationale as to why the common law and Australian Tax Office approach to charitable public benevolent institutions should be changed in relation to private not for profit hospitals, and in the absence of such discussion, Chapter 8's findings lack validity.

- The Commission's proposed application of competitive neutrality principles to private hospitals is neither valid nor consistent with the Australian Government's current policy approach to competitive neutrality.

- Not for profit private hospitals do not operate with the same motivation as for profit hospitals, in that for not for profit hospitals exist for the purposes of charity and for profit hospitals exist (legitimately) for purposes of profit.

- The result of removal of Fringe Benefits Tax concessions and payroll tax concessions would destabilise hospital services in Australia, with some Catholic not for profit private hospitals likely to cut or close services. CHA foreshadows that removal of Fringe Benefits Tax concessions and payroll tax concessions would probably in time see an increase in public hospital workloads and an increase in the cost of private health insurance.

- Meal entertainment benefits serve a purpose, but the current uncapped scheme can not be justified. There are examples of the current system having been abused, and CHA has been on record for some time proposing reform to the current arrangements. CHA has previously proposed a cap on meal entertainment allowance of $5,000 per annum, and recommends to the Commission that a cap be proposed in its final report.

- The need for all not for profit entities to demonstrate to government their community benefit.

In relation to broader issues contained in the report:

- CHA supports the need for auditable evidence that can measure the contribution of the NFP sector.
- CHA supports the development of capacity in evaluation skills within the sector.
- The issue of access to capital funding is ongoing and long unresolved. This is particularly the case in relation to aged care services, and an Access Economics report is attached to and forms part of this submission to the Commission on this issue.

- CHA supports the establishment of an Office for the Not for Profit Sector Engagement within the Prime Minister's portfolio.

On the issue of meal entertainment allowance, fringe benefit tax concessions, and payroll tax concessions for not for profit hospitals, CHA has commissioned KPMG to provide an independent expert advice on possible alternatives and consequences to changing existing practices. KPMG's independent report is attached, and forms part of CHA's formal submission.

The draft report of the Commission has been published at a time when the Government is preparing its response to the National Health and Hospitals Reform Commission (NHHRC). The NHHRC have undertaken a great deal of work on the future reform of health, and according to the NHHRC, the Minister for Health and the Prime Minister the not for profit sector will play a lead role in the efficient delivery of services into the future. Final recommendations of the Productivity Commission in relation to the contribution of the not for profit sector must be made in consultation with the current work being undertaken by government in response to the NHHRC recommendations, not in isolation. CHA would like noted that the current directions the Productivity Commission are recommending in terms of hospitals in the NFP sector could be destabilizing for the entire health sector, given the direction in health reform. The not for profit hospital sector is a sizable contributor to future health reform.1

CHA extends an offer to the Commission to provide further detail in understanding the charitable nature of not for profit hospitals. CHA is also in a position to demonstrate the financial impact of the possible removal of fringe benefit tax concessions and payroll tax concessions from some CHA private hospitals and aged care services.

"…often the best form of delivery of social services on the ground is where you actually have government working in partnerships with church and charitable organisations."
Prime Minister Kevin Rudd, Question Time, 18th November 2009

What is a charitable public benevolent institution?

Catholic public and private hospitals and aged care facilities are public benevolent institutions. The Australian Tax Office states "A public benevolent institution (PBI) is a non-profit institution organised for the direct relief of poverty, sickness, suffering, distress, misfortune, disability or helplessness." The characteristics of a public benevolent institution are:

- it is set up for needs that require benevolent relief
- it relieves those needs by directly providing services to people suffering from them

[1] At the end of June 2007, there were 102 not-for-profit hospitals in Australia. These organisations employed 55,652 people at the end of June 2007. The industry value added by these organisations was $3.1b and in the 2006-07 financial year, not-for-profit hospitals received $5.3b in income. The main source of income for these organisations was income from services, which accounted for 67.3% ($3.6b) of total income.(Reference ABS http://www.abs.gov.au/ausstats/abs@.nsf/Products/8106.0~2006-07+(Re-Issue)~Main+Features~Hospitals?OpenDocument)

- it is carried on for the public benefit
- it is non-profit
- it is an institution, and
- its dominant purpose is providing benevolent relief.

Applying these characteristics, Catholic public and private hospitals and aged care services were established to provide relief in the form of health and aged care services. These services are applied directly to the sick or aged. The services are carried on for the public benefit, and any Australian may access them. All Catholic services are non-profit and are delivered in an institutional form. The dominant proposes of the health and aged care services are the delivery of benevolent relief.

Catholic public and private hospitals and aged care facilities are also charities, in that they have purposes of the advancement of religion and purposes beneficial to the community. The common law since *Income Tax Special Purpose Commissioners v Pemsel* (1891) AC 531 has recognised the advancement of religion and benefit to the community as two of the four heads of charity, the other two being the relief of poverty; and advancement of education.

CHA therefore represents the largest non-government grouping of not-for-profit health and aged care service charitable public benevolent institutions in Australia. The CHA network comprises 21 public hospitals, 54 private hospitals, and 550 aged care services. Indeed, one in ten Australian's in either a hospital or aged care beds today are being cared for in Catholic charitable institutions.

The Catholic private hospital sector operates one in four of Australia's private hospital beds. To the extent that Chapter 8 of the draft report addresses not for profit private hospital issues, it is in effect discussing the private hospitals operated by the Catholic Church.

The draft Productivity Commission's report into the not for profit sector raises issues of competitive neutrality, and specifically questions if tax free meal and entertainment allowances and fringe benefits tax concessions should be enjoyed by staff of not for profit hospitals. Payroll tax concessions enjoyed by not for profit hospitals are also questioned. What Chapter 8 does not address is why charitable public benevolent institutions currently enjoy tax concessions, and why they should continue to enjoy them into the future.

Neither the common law nor statute law currently defines charitable organisations. Rather, the common law in *Pemsel* has adopted an approach to identifying organisations established for a charitable purpose. This method has served the Australian community well, in that charitable purposes as described in *Pemsel* are:

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

All Catholic hospitals and aged care services have as a purpose the promotion of religion. They promote or advance religion though the provision of care to the sick or the aged.

For example, St John of God Health Care which operates 14 hospitals with 2,000 beds and 8,400 staff has as its mission an aim to continue the healing mission of Jesus Christ through the provision of health

care services that promote life to the full by enhancing the physical, intellectual, social and spiritual dimensions of being human. The Mission is implemented by:

- establishing models of healthcare which reflect the healing ministry of Jesus Christ and give hope to all people with whom we relate
- developing a person centred culture
- relating to each other and to planet earth in ways that are mutually transforming
- being good stewards of our resources, both human and physical
- promoting social justice and the common good
- giving witness of a believing, serving ministry in communion with the Catholic Church

Similarly, The Little Company of Mary Healthcare Health Care provides health, community and aged care services in New South Wales, Victoria, Australian Capital Territory, South Australia, Tasmania and the Northern Territory. Its mission is to bring the healing ministry of Jesus to those who are sick, dying, and in need through 'being for others':

- in the Spirit of Mary standing by her Son on Calvary
- through the provision of quality, responsive and compassionate health and aged care services based on Gospel values, and
- in celebration of the rich heritage and story of the Sisters of the Little Company of Mary.

Using these two mission statements as illustrations of most mission statements common to all Catholic hospitals and aged care providers, it is relevant to note that neither make reference to the operation of a private hospital. The direct provision of services to the sick or the aged in the spirit of the teachings of the Catholic Church are the purposes of these organisations. Applying the common law definition of charity, and the Australian Tax Office definition of a public benevolent institution, it is evident that Catholic not for profit hospitals or aged care services are indeed charitable pubic benevolent institutions. Advancement of religion or put another way, charity are the first purposes of Catholic hospitals and aged care services.

The common law approach of identifying an organisation as charitable serves the important function of facilitating the identification of the motives for performing the activity.

For example, two bodies could carry on the same activity that appears charitable in form, but would be quite different in essence once the different motivations and purposes of the agents are known. Thus, a private company, with the intention of making a profit in the long-term, might open a hospital and charge low fees. It is able to sustain losses in the short-term, however due to the shareholders' imperative to gain good returns on investment, some services would be discontinued and other lucrative ones aggressively pursued. Consequently, the investor-owned hospital takes decisions concerning the services it will conduct based on the financial needs of its shareholders. A not for profit hospital's imperative is to meet the health needs of the community served, irrespective of the relative profitability or otherwise of the treatments or procedures.

In a competitive environment, where only profitable services are sustainable, hospitals lacking commitment to the full range of health needs of the local community will undermine the sustainability of social capital. In this environment, not for profit hospitals take decisions to conduct essential non profitable as well as profitable services in order to enhance the social safety net for the local community. Nevertheless, difficult decisions sometimes need to be taken about which services should or should not be provided in light of resources constraints and the availability of similar services from

other providers. These decisions are not motivated by the desire to maximise return on shareholder investment but by a desire to maximise the range of services available to meet local needs.

In the above example, whilst both providers have delivered a basic human good (life and health care) their motivations are starkly different. It is possible to say one was carrying on a charitable or public benevolent activity and the other was not. The sole or dominant purpose of the for profit hospital was to make a profit, whereas the sole or dominant purpose of the not for profit hospital was to provide sustainable health care to its patients so that they may have the means of "human flourishing".

It is possible to discern the motivation or purpose of the activity, by reference to the nature of the organisation that is carrying out the activity. That is, whether an activity is benevolent or not can be determined by whether the body carrying it out is one that is established either, on the one hand, for profit or, on the other hand, not for profit but so that others may flourish.

The rationale outlined in Chapter 8 of the Commission's draft report for the removal of tax concessions from not for profit hospitals (most of which are charitable public benevolent institutions) is the contention that differential tax treatment between for profit and not for profit hospitals gives the benevolent provider a competitive advantage over the for profit provider, thus having a negative impact on the profitability of the enterprise and efficiency due to decreased competition. If such treatment could be removed, then, it is argued competitiveness will increase.

The argument for similar tax treatment of not for profit and for profit providers of human services is flawed because it overlooks the advantages that for profit providers already have over non-profit providers in the fundamental area of the ability to attract capital resources. For profit providers attract capital investment precisely because they can offer investors a return on that investment. Not for profit providers do not offer any such return to contributors.

The differential tax treatment for not for profit hospitals can be seen as a means of levelling the playing field already tipped in favour of for profit hospitals. Accordingly, arguments for removing the special tax status of charitable benevolent bodies turn out to be arguments for maintaining the competitive advantages of for profit hospitals. Without government support in the form of payroll tax exemptions and fringe benefit tax exemptions for employees, the ability of many charitable benevolent hospitals to operate in a sustainable manner will be substantially reduced. Overall, their ability to continue functioning at current levels of activity would be seriously compromised. For some Catholic hospitals, activity may indeed need to cease.

The Commission's argument for abolishing the special tax status for not for profit hospitals is aided by the suggestion that what is lost to the hospitals in this fashion could be paid in the form of direct grants. There are two major flaws with this proposal.

First, most not for profit hospitals that currently enjoy these special tax advantages are not funded by a government program. They are instead funded through either consumer contribution or health insurance rebate payments. Replacing the revenue lost and compensating hospitals or their employees for higher costs by paying them direct grants would require a new complicated arrangement that may in fact be more complicated than current fringe benefits tax concessions arrangements and payroll tax exemptions.

Secondly, and more fundamentally, such an approach would dissolve any distinction between for profit and non profit providers, and there would be no special support or recognition by government of the vital role of charities providing health care.

The move would also signal to other charitable benevolent organisations that their tax status was in question. At present, charitable public benevolent institutions are entitled to payroll tax exemptions and fringe benefits tax concessions. If they were to be removed from one class of charitable benevolent institution, other charitable benevolent organisations could expect their concessions to also be removed. The result in time is that civil society organisations would be indistinguishable from for profit organisations. Such an outcome would be detrimental to the development of social capital.

Community Benefit

The Catholic Health Association (CHA US) of the United States (the equivalent body to CHA Australia) has been a leader in the community benefit field, helping not-for-profit health care organisations fulfill their community benefit mission. Community benefits are programs and services designed to improve health in communities and increase access to health care. They are integral to the mission of Catholic and other not-for-profit health care organisations, and are the basis of tax exemption for not for profit hospitals in the USA. In the US in the last fiscal year, Catholic-sponsored, not-for-profit member hospitals contributed more than $5.7 billion in services identified as community benefit using CHA US's guidelines.

In the US a community benefit must respond to an identified community need and meet at least one of the following criteria:

- Improve access to health care services.
- Enhance health of the community.
- Advance medical or health knowledge.
- Relieve or reduce the burden of government or other community efforts

Within Australia there is a need for auditable evidence that can measure the contribution of the NFP sector and the presence of such a tool would provide a level of comfort to government in continuing the current tax concessions. CHA hospitals and aged care facilities are mission-based and focus on improving the health of the communities they serve and operate to promote health in a manner that serves a charitable and public benevolent purpose and, and in CHAs view accordingly merits tax-concession status.

"…the excellent forms of partnership which exist between governments, state and federal, and many church and charitable organisations, whether it is in health, education or the broader delivery of social services."

Prime Minister Kevin Rudd, Question Time, 18th November 2009

The New Zealand Experience

In the past ten years in New Zealand there have been moves to develop stronger relationships between government and the NFP sector, specifically the appointment of a Minister with specific responsibility for the sector (1999), creation of the Office for the Community and Voluntary Sector (2003), and the Statement of Government Intentions for an Improved Community-Government Relationship (SOGI) in

2001, and illustrates movement towards closer relationships. A range of other initiatives followed in 2001, such as increased tax relief for contributions to non-profit organisations.

In New Zealand there was a lack of data on the non-profit sector's size and structure. In the absence of this information, policy making, planning for service delivery, and international comparisons were difficult. To counter this lack of understanding New Zealand government instigated two projects:

- The development by Statistics New Zealand of a non-profit institutions 'satellite account' which involves collecting, assembling and analysing financial and non-financial data on these institutions and then determining their value to the New Zealand economy.
- Participation in an international comparative study of the non-profit sector led by the Centre for Civil Society Studies in Johns Hopkins University (Baltimore).

Within New Zealand favourable tax treatment of charitable and other non-profit organizations is considered to indicate a significant area of government support for the sector.

Competitive Neutrality

In Australia, all governments have agreed to implement competitive neutrality policies as part of the National Competition Policy reform package.

Competitive neutrality policies aim to promote efficient competition between public and private businesses. Specifically, they seek to ensure that government businesses do not enjoy competitive advantages over their private sector competitors simply by virtue of their public sector ownership.

Competitive neutrality is about ensuring that the significant business activities of publicly owned entities compete fairly in the market when it is in the public interest for them to do so.

The draft consultation report of the Productivity Commissions applies a new and broader definition. The application of the concept of 'competitive neutrality' appears to extend beyond government owned businesses competing with the private sector, to apply to not for profit businesses - specifically hospitals competing with private hospitals. It could be argued that the broadening of these principles are not necessarily valid as this does not align with the original intent of the National Competition Policy, 1996.

CHA believe it is difficult to argue for a level playing field between for profit and not for profit hospitals in that they in fact operate in different markets. Their clients are different, their services are different, their funding agreements with private health funds are different, and their reasons for establishment are different. They do not compete on a level playing field.

Health Funds

The discussion of competitive neutrality across the hospital sector is currently inadequately described in chapter 8 of the Commission's draft report, in part because the Commission makes an assumption that for profit private hospitals and not for profit private hospitals receive the same rates of funding for work undertaken. This assumption is incorrect.

The role that the many private health insurers play in setting the price, confidentially, across different providers, both within the not for profit and the for profit sectors, has not been explored in Chapter 8.

There is evidence that health funds factor the existence of tax concessions (payroll, fringe benefits, and meal and entertainment allowance) to the annual price setting negotiation process and have reduced their rates to the certain not for profit hospitals as a consequence. Likewise, there is evidence that suppliers do the same to some extent. Chapter 8 of the draft report is incomplete while ever the price setting process between private hospitals and health funds is not considered.

No profit in not for profits in South Australia

Calvary Health Care Adelaide Ltd is a service of the Sisters of the Little Company of Mary which provides health care services in New South Wales, Victoria, ACT, Tasmania and South Australia. Calvary Health Care, Adelaide, comprise four not for profit hospitals:

Calvary North Adelaide Hospital, and includes the Mary Potter Hospice Palliative Care Service
Calvary Wakefield Hospital
Calvary Central Districts Hospital
Calvary College Grove Rehabilitation Hospital

This group makes up the second largest private health care provider in South Australia. For this group of four hospitals reduced rates are provided by some health insurers, in lieu of their NFP status – i.e. tax concessions are a consideration in annual price setting negotiations. Should the existing tax concession arrangements be withdrawn by government it is possible that all four hospitals would be unviable.

No profit in not for profits in rural areas

Catholic NFP hospitals are the main providers of rural private hospital services – there are no larger for profit providers in rural areas. Removal of existing tax concessions would push these NFP hospitals over into unsustainable operations. Most of these NFP hospitals already run at a loss, but are supported through other health provision activities in urban areas.

Unfair advantage within the private sector

The Productivity Commission's draft report does not examine certain advantages that the for profit hospital sector has over the not for profit hospital sector.

The for profit private hospital sector payroll tax is 100% deductible, so that shareholders who receive franked dividends as a return on investment are actually receiving a portion of the payroll tax paid, whereas in the case of the not for profit sector there is no benefit to the owners –therefore the for profit hospital sector is receiving specific benefit.

Another example of a for profit hospital advantage is how at executive staff level the private hospital sector is able to provide generous packages with attractive share options. For profit private hospitals offer higher remuneration for equivalent positions in not for profit hospitals and offer additional incentives to attract and retain staff, such as annual bonuses, employee share plan offers and discounts on in-house products. It is CHAs view that the Meal and Entertainment concession may be equivalent to the provision of year-end/annual incentives/bonus payments in commercial organisations that not for profit hospitals are less able to provide. The consequence is that for profit hospitals are very often better able to attract and retain staff. The loss of employee tax concessions would make this advantage enjoyed by for profit hospitals even more stark.

Use of surplus

For profit hospitals, particularly listed companies, pay dividends to shareholders so that most of a for profit hospital's annual surplus (estimated at over 50%) flows out of the health care system completely.

Not for profit hospitals retain their surpluses within the hospital system. Catholic private hospitals reinvest their surpluses in infrastructure and equipment or by way of investment in charitable works. Many Catholic private hospitals are also networked to Catholic public hospitals. It has long been the case that Catholic private hospitals utilize in some instances a component of their annual surplus to support the operation of public hospital services. To this end, Catholic private hospitals are in fact supporting the delivery of public health.

Type of work undertaken

There is no 'level playing field' between the not for profit hospitals and for profit private hospitals. The work undertaken in the two hospital groups is often different – the private hospitals look for complete cost recovery whilst the not for profits take the sicker low profit patients.

The large not for profit hospitals tend to carry out more complex work than many for profit hospitals, and also take on more medical patients. Most Catholic not for profit private hospitals have emergency departments and all undertake teaching and research –making them look more like public hospitals and representing a benefit to the public.

If the motivation is to provide a 'level playing field' as described in the Commission's draft report, then the existing benefits and tax concessions should also be removed from the public sector – knowing that the public sector also compete for privately insured patients.

Assuming that the Productivity Commission's widened interpretation of competitive neutrality is valid, then what would the impact be of ensuring private for profit hospitals and not for profit hospitals operated in a competitively neutral manner?

The draft report of the Productivity Commission argues there are a number of tax concessions that apply to the not for profit sector that raise competitive neutrality concerns. However the extent to which tax concessions distort resource allocation and provide incentives to reduce competition has and probably cannot be quantified.

CHA agree that in terms of the current arrangements for tax concessions they are noted to be 'complex, inequitable and costly to administer' for Government. However, CHA members have in place accessible and efficient processes for the administration of meal entertainment allowance, fringe benefits tax concessions, and payroll tax concessions. To the extent that employees and employers have to interact with these three tax measures, CHA submits that workable practices are in place and the case for change in relation to fringe benefits tax and payroll tax concessions has not been made.

The three areas where there would be specific impact on CHA members if concessions were removed are outlined below.

Area	Issue
Changes to Payroll tax	• Changes to payroll tax would have an affect on CHA members as there would be significant new liabilities. The net impact is difficult to establish as members would claim the payroll tax supplement, but several CHA member not for profit private hospitals have stated that the cost of payroll tax to their organisation might result in the need for service cuts, service closures, or hospital closures. • Aged Care services currently face financial constraints. Few not for profit Catholic aged care services are returning sustainable year end results. The application of payroll tax to not for profit aged care services would result in some aged care services facing significant losses, which would result in service cuts or service closures. • Changes to payroll tax would have a significant impact on retirement villages, as they are resident funded operations and the relevant legislation (Retirement Village Acts) may prohibit payroll tax costs being absorbed by the resident funded budgets. • In the for profit private hospital sector, payroll tax is a tax that is 100% deductible so shareholders who receive franked dividends as a return on investment are actually receiving a portion of the payroll tax paid, whereas in the case of the not for profit sector there is no benefit to the owners and therefore the 'for profit' sector would be receiving a greater benefit.

Changes to FBT	• On average 50-65% of staff in the not for profit Catholic hospital sector salary sacrifice in order to obtain the benefits of FBT.
	• The current FBT exemption has not been sufficiently indexed and hence the actual value is declining. Regardless:
	  ○ Loss of salary packaging would have significant impacts as packaging is a major tool in recruitment and retention of staff, particularly within aged care –where pay rates are significantly less than in the acute sector.
	  ○ Facilities' would be required to increase the amount paid to staff, and therefore reduce services or compromise standards of care because of insufficient staff numbers.
	  ○ Removal would lead to upward pressure on labour costs resulting in decreased access to care for the more vulnerable in the community and increased demand on public funding.
	  ○ If changes made to FBT led to the requirement that employers compensate employees for the loss of benefit then this may induce serious viability issues for some not for profit hospital and aged care providers.
	  ○ Without salary packaging benefits it is likely that nurses would move to the public sector where workloads are lighter due to more generous nurse to patient ratios.
	  ○ The attraction of nurses to nursing positions is a major workforce challenge. Salary packaging within hospitals is an allowance that places CHA hospitals on an equal footing

	with government owned public hospitals.
Changes to Meal & Entertainment	• On average 10-30% of staff have taken up the meal and entertainment benefits. • CHA membership agrees that the entitlement should be capped at around $5,000 per annum. • The value of participating caregivers in the meal and entertainment card appears to be less than $5,000 per annum for most employees. This should be quantified further by the Productivity Commission.
General comments	• Removal of tax concessions for not for profit private hospitals may see the cessation –particularly in the smaller regional hospitals – of those marginally viable services like: palliative care; chemotherapy; chronic disease management and possibly birthing services.- the impact of which would mean the not for profit hospitals, instead of integrating closely with community, would begin to operate like profitable for profit hospitals with more high return surgeons employed. • It would also see a potential cost shift to both the government and to consumers of hospital services and aged care services. In order to remain viable, most hospitals would need to reduce services or increase costs to the consumer to cover added salary and wages costs. Service reduction could include the review and reduction of use of emergency departments and teaching and research. • Within aged care these types of tax concessions allow services to have a greater ability to provide services within rural and remote areas, where the level of bonds is greatly diminished. • Within aged care stand alone facilities are neither independently viable nor profitable –changes to tax concessions would see closure of many standalone facilities. • Within the community services settings the 'for profit' providers appear to be more selective about clients they choose to admit into their programs –they ensure there is a profit margin in them. This does not occur within the not for profit sector as mission drives service delivery, i.e. those with greatest need are preferenced. • The quantum of community works conducted by not for profits organisations such as homeless shelters, aged care, indigenous health, drug & alcohol support services, community mental health, international health initiatives and prisoner support would likely decrease markedly with the removal of the proposed tax concessions, particularly payroll tax & fringe benefits concessions. Health education activities for health professionals would also decrease.

Aged Care

The draft report of the Commission does not give attention to aged care. However, the intent of Chapter 8 is to argue that where both for profit and not for profit organisations operate in similar ways, the not for profit provider should no longer be entitled to tax concessions. Given this intent of Chapter 8, CHA notes that questions raised about the ability of not for profit hospitals to retain tax concessions are also being directed at not for profit aged care services.

Chapter 8's focus on competitive neutrality and withdrawal of existing concessions, whilst largely focused on hospitals, would have a devastating effect on the aged care sector. One CHA Aged care CEO writes:

> *There is presently a struggle in the aged care sector to achieve any sort of financial return, with no capacity to generate funds for replacement of building stock. If the FBT benefit were to be removed it would seem inevitable that the sector would have to pay increased wages to attract staff. This would surely be the killer blow for many facilities, including our own.*

Not for profit aged care organisations are prepared to provide services in those geographic locations and for special needs groups where for profit operators cannot generate a profit or adequate profit. It could be argued that in these cases, the not for profits are subsidising the Government through the use of their tax concessions or cross subsidising from services where surpluses are generated.

Increase and index the Fringe Benefits Tax capping limit for Public and Not-for Profit Hospital employers

CHA re-iterates the proposal made in its first submission to the Productivity Commission with regard to indexation of the existing fringe benefit tax concessions.

The existing capping limit for Public and Not-for-Profit Hospitals should be increased from $17,000 per annum per employee to $40,000 per annum as a means of providing incentives for employment within public and not-for-profit hospitals.

The existing cap was introduced from 1 April 2000 and has not been increased. This limit has not be increased despite the following statement from the then Treasurer at the time of implementation: *The Government has further agreed to review the level of the cap from time to time in the light of general salary movements*.

The CPI has increased by 30.3 % in the period June 2000 to June 2008. The Senate Standing Committee on Finance and Public Administration made the following recommendation in June 2008: *The committee recommends that the government consider the appropriate level of the cap on FBT-exempt benefits for NFP sector employees and whether the cap should be indexed to the CPI*.

The use of the FBT exemption is a significant tool for hospitals to attract and retain staff, as outlined above. This sector is under extreme pressure and will continue to be under increasing pressure over coming years because of the aging Australian population, skills shortages and changing demographics.

Comment on other Recommendations

CHA also provide the following comments in relation to the rest of the recommendations contained within the Productivity Commissions report into the Contribution of the Not for Profit Sector. CHA have only responded directly to recommendations that pertain to their health and aged care services.

Improving the knowledge base

Recommendation 5.1

The Australian Government should initiate an Information Development Plan (IDP) for the not-for-profit sector. Given its central role in providing data on the sector, and its legislated responsibility for statistical coordination, the Australian Bureau of Statistics should be given responsibility for formulating the IDP, consulting other key stakeholders as appropriate. Among the issues the IDP should address are:

- ***the appropriate frequency for publication of the satellite account on the sector and the scope for expanding measurement in the satellite account beyond economically significant entities***
- ***the scope to improve administrative and other longitudinal data sets to support analysis of net impacts of sector activities***
- ***the feasibility of obtaining accurate estimates of the number of unincorporated not-for-profit organisations in a cost-effective manner.***

Recommendation 5.2

Australian governments should endorse a common framework for measuring the contribution of the not-for-profit sector. Having regard to the diversity of the sector's activities and structures, measurement using this framework should embody the principles of proportionality, transparency, robustness, flexibility, and applicability.

To the extent possible, evaluations should be used to help identify the contributions, especially in respect of the impacts on individuals and the community, and inform the development of data collections.

CHA is supportive of these recommendations. A common framework could help to eliminate reporting and regulatory burden. The need for auditable evidence that can measure the contribution of the NFP sector may assist government to review it's thinking around withdrawal of tax concessions. CHA hospitals and aged care facilities are mission-based and focus on improving the health of the communities they serve and operate to promote health in a manner that serves a charitable purpose and, and in CHAs view accordingly merits tax-concession status.

Recommendation 5.3

To minimise compliance costs and maximise the value of data collected, Australian governments should agree to implement a reform agenda for reporting and evaluation requirements for not-for-profit organisations involved in the delivery of government funded services. This should:

- ***commit to basing reporting and evaluation requirements in service delivery contracts on a common measurement framework (appropriately adapted to the specific circumstances of service delivery)***
- ***require expenditure (input) measures to be based on the Standard Chart of Accounts***
- ***ensure that information generated through performance evaluations are returned to service providers to enable appropriate learning to take place and for organisations to benchmark their performance***
- ***embody, where practicable, the principle of 'report once, use often'.***

CHA is supportive of this recommendation and it follows on from recommendation 5.2. CHA would like to ensure that the measurement framework actually measures, accurately, the contribution of the NFP sector, and does not just measure 'inputs'.

The equivalent membership to CHA in the United States undertake a significant process in measuring *Community Benefit,* so as to justify their tax exempt status. They specifically report on the following:

- Identifying community needs and assets.
- Evidence of making prudent choices for scarce resources.
- Evidence of budgeting proactively.
- Use of standardized accounting and reporting methods (as suggested by the Productivity Commission).
- How they have built and strengthened relationships in the community.
- Demonstrate accountability and transparency.

Some of these parameters may be applicable within the Australian context. Support for developing capacity to evaluate services should be considered under this recommendation –rather than the current reliance on external consultants and academia.

Recommendation 5.4

The Australian Government should provide funding for the establishment of a Centre for Community Service Effectiveness to promote 'best practice' approaches to evaluation, with an initial focus on evaluation of government funded community services. Over time, funding could also be sought from state/territory governments, business and from within the sector. Among its roles, the Centre should provide:

- ***a publicly available portal containing evaluations and related information provided by not-for-profit organisations and government agencies***
- ***guidance for undertaking impact evaluations***
- ***'meta' analyses of evaluation results.***

This recommendation goes some way in developing capacity within the NFP sector in relation to evaluation of services. There is however a step missing, that is how to ensure that evaluation results, and particularly meta analysis, is fed back to providers to ensure results are acted upon. In essence how will the quality loop be closed and action taken on results?

The NFP sector requires support in conducting evaluations and research, but equally support is required to ensure action is taken. It is CHAs opinion that the sector should be pursuing action and research outcomes at the same time.

Regulation

Recommendation 6.2

To promote confidence in the not-for-profit sector and reduce regulatory burden, Australian governments, initially through the COAG Business Regulation and Competition Working Group, should:

- ***agree to and implement harmonised fundraising regulation and mutual recognition across Australia***
- ***support the development of a fundraising register for cross jurisdictional fundraising organisations, to be administered by the proposed national Registrar***

- ***endorse the adoption by all governments of the Standard Chart of Accounts for reporting by not-for-profits in receipt of government grants or service contracts ensure that the Standard Business Reporting initiative be expanded to include reporting requirements by not-for-profits.***

CHA is supportive of the principle behind adoption of the Standard Chart of Accounts for reporting of NFPs. However CHA would prefer Specific Purpose Financial Reports were used, as has been argued for in residential aged care where CHA believe they should replace the General Purpose Financial Reports required under the Conditional Adjustment Payment.

Recommendation 6.3

The Australian Government should adopt a statutory definition of charitable purposes in accordance with the recommendations of the 2001 Inquiry into the definition of charities and other organisations.

CHA is supportive of this recommendation as it should assist in reducing the current complexity of tax concessions, and hence reducing the administrative and compliance burden on NFPs.

Recommendation 6.4

The Australian Government should establish a one-stop shop for Commonwealth regulation by consolidating various regulatory functions into a new national Registrar for Community and Charitable Purpose Organisations with the following key functions to promote confidence in the not-for-profit sector:

- ***register and regulate Commonwealth incorporated associations, companies limited by guarantee and Indigenous corporations***
- ***register and endorse not-for-profits for commonwealth tax concession status***
- ***registration of cross-jurisdictional fundraising by not-for-profit organisations***
- ***a single reporting portal for public record corporate and financial information, proportionate to the size and scope of functions of not-for-profit organisations***
- ***provision of appropriate governance education***
- ***complaints handling.***

The establishment of one body to determine and regulate charitable status, as described above, has already been recommended by the National Roundtable of Nonprofit Organisations. This is an approach that CHA supports. It would provide a level of comfort to those NFPs that are smaller and more locally based in terms of ongoing support and transparency.

Not for profit funding

Recommendation 7.1

Australian governments should recognise the tax concession status endorsement of not-for-profits at the Commonwealth level, and explore the scope for a single national application process for organisations for tax status endorsement, or mutual recognition of endorsement, across all jurisdictions.

This is a complex area of discussion and recommendations in this area should not be made ahead of the outcomes of the Review of the Australia's Future Tax System. However if the five main design principles are adhered to – equity, efficiency, simplicity, sustainability and policy consistency – then it could be

argued that the differential application of tax concessions across the not for profit sector must be addressed. The question of whether all not for profit organisations require tax concessions over and above income tax exemption is key to this, given that the United Kingdom and New Zealand only provide tax concessions to those organisations with a charitable purpose.

Recommendation 7.4

The Australian Government should establish a joint working party made up of representatives of the not-for-profit sector, business, philanthropic and other government to explore obstacles to not-for-profits raising capital and evaluate appropriate options to enhance access to capital by the sector.

The issue of access to capital funding is an ongoing and long unresolved issue.

In the aged care sector there are serious short-term operational and long term capital problems facing the residential aged care sector. These shortcomings have most recently been identified by a report of Access Economics, commissioned by the Church Providers of Aged Care (of which CHA is a founding member). The Access Economics Report demonstrates that capital finance provision by Government and regulation that prevents those who can afford to pay for their High care accommodation from contributing to its cost is inadequate to the point that the cost of providing accommodation in a residential high care facility costs more than $13 per day than can currently be recovered from either government financing or consumer contributions. This Access Economics report is attached to and forms part of this submission.

There are strict government certification standards but the requirements leave the high care component of the sector heavily dependent upon cross subsidies from low care funding. Overall there is a lack of access to capital funding which is clearly unsustainable. Capital stock will not be built unless other means of accessing capital funds are made available, or certification standards are relaxed. Added into this mix is the increasing cost of wages and higher interest rates. It is estimated that currently over 40% of high care providers operate at a loss.

In 1999 the aged care standards accreditation framework came into being requiring all approved providers to have their approved residential aged care services independently quality assessed against 44 set Standards Outcomes. Neither the care subsidy levels nor the subsidy indexation factor were adjusted to incorporate any increased cost of accreditation.

In 1999 a new building quality certification instrument was introduced that laid down minimum space and privacy requirements to be achieved by 2008. This meant that new residential aged care facilities constructed since 1999 have been required to have no more than an average of 1.5 persons per bedroom and 3 per toilet and 4 per shower.

The resultant capital and staffing cost increases have not been reimbursed through any real increases in basic subsidies, nor a change in the subsidy indexation factor nor the capacity to finance the capital cost of High care through refundable lump sum loans known as Accommodation Bonds as is the case in Low care.

Based on a simple analysis, to build a high care residential place at a conservative minimum cost of $180,000 per bed, the following would apply:

- Where such a cost is wholly debt funded at an annual interest of **7.6%** payable over **15** years, it would cost a provider **$20,146** per annum, or more significantly **$55.23** per bed per day to cover this debt. Such a cost is well in excess of what is provided by way of the Accommodation Charge, which is **$26.88** per bed per day.
- It must be noted too, that as part of the roll-out of ACFI, the previous Pensioner Supplement of $7.60 per day was taken away, being instead included in the adjusted Accommodation Charge. In real terms the Accommodation Charge was only increased by a couple of dollars compared to how it was under pre-March '08 arrangements
- Rather, by using the same rate of interest and term, the Accommodation Charge of $26.88 per day is only sufficient to support a capital cost of **$87,600** per place.
- However, if the adjustment of the removal of the Pensioner Supplement is factored, the Accommodation Charge more realistically is only capable of supporting a capital cost of **$63,000** per place whereas the real cost can now vary between **$200,000** and **$300,000** per bed.

These matters are explored in further detail in the Access Economics report that is attached to and forms part of this submission.

Industry bench-mark analysis is demonstrating, on a recurrent basis, High Care facilities are progressively becoming more and more marginal, which results in there being no surplus from ordinary operations to cross-finance capital debt. It is fair to say the strictures of the Accommodation Charge, as the only capital funding option permitted in non-extra service high care facilities is an enormous problem for the sector spanning all the way back to 1997.

In the not for profit hospital sector capital funding is just as precarious, and is reliant on a healthy balance sheet, which is unlike the private for profit sector who can access capital through equity and stocks and shares. This has an impact on what type of capital works can be undertaken, and a balance is made between purchasing of equipment and capital, and both rely on services being financially healthy. CHA would support government providing capital funds to organisations that offer significant community benefit –with not for profit hospitals being one such type.

Social Innovation

Recommendation 9.2

State and territory government programs aimed at building the capacity of not-for profits for service delivery or community development should include specific guidance and training on undertaking evaluations.

Please see comments under recommendation 5.4

Workforce

Recommendation 10.1

Australian governments should explore the feasibility of establishing a system of 'Working with Vulnerable People Checks' similar to that proposed by the ACT. These checks should be portable between organisations for a designated time period.

CHA supports this initiative.

Recommendations 10.2, 10.3 & 10.4

CHA is broadly supportive of the recommendations made with regard to the not for profit workforce. The not for profit health and aged care industries are at a disadvantage when it comes to employing staff. As discussed previously at executive staff level the private hospital sector is able to provide generous packages with attractive share options. Private hospitals offer higher remuneration for equivalent positions and offer additional incentives to attract and retain staff, such as annual bonuses, employee share plan offers and discounts on in-house products.

The main way in which the not for profit health and aged care sectors remain competitive in terms of recruitment and retention is through the use of FBT and meal and entertainment allowances. Loss of salary packaging would have significant impacts, particularly within aged care –where pay rates are significantly less than in the acute sector. Ultimately facilities' would be required to increase the amount paid to staff, and therefore reduce services or compromise standards of care because of insufficient staff numbers.

The development of support for boards through governance training would be a crucial initiative. Planning for future leadership capacity in the not for profit sector is also vital.

Direct government funding

Recommendation 11.1

Australian governments should, in the contracting of services or other funding of external organisations, determine and clearly articulate whether they are fully funding particular services or activities undertaken by not-for-profits, or only making a contribution towards the associated costs and the extent of that contribution.

Australian governments should fully fund those services and activities that they would otherwise provide directly. In applying this criterion, governments should have regard to whether the funded activity is considered essential, as part of the social safety net or an entitlement for eligible Australians.

These recommendations make sense in theory, but in practice how would government decide what components of service provision they would otherwise provide directly if it weren't for the not for profit sector. The ability to quantify this would need to be developed. The real underlying cost of service provision could then be explored. So whilst in principle CHA would support these recommendations, in practice they would be difficult to deliver.

Recommendation 11.3

Australian governments should ensure that service agreements and contracts include provision for reasonable compensation for providers for the costs imposed by changes in government policy that affect the delivery of the contracted service, for example, changes to eligibility rules, the scope of the service being provided or reporting requirements.

CHA supports this recommendation as it provides a degree of certainty that full and reasonable costs associated with the delivery of the service would be covered.

Delivery of Government funded services

CHA supports all recommendations contained in Chapter 12 –they are well written and far reaching. Their implementation should see more efficient and effective service delivery. CHA is of the opinion that because the scope of what needs to be achieved is so wide ranging that there is justification in establishing an Office for the Not for Profit Sector Engagement within the Prime Minister's portfolio.