Commercial Hospital Operators Australia

POLICY OPTIONS PAPER – COMPETITIVE NON-NEUTRALITY IN THE PRIVATE HOSPITAL SECTOR

1. About Commercial Hospital Operators Australia

Commercial Hospital Operators Australia (CHOA) was formed in 2008 to represent commercial private hospitals. Its members include Healthscope, Ramsay Health Care and the Healthe Group. Together CHOA's members run over 120 private hospitals and day surgery units in Australia employing over 32,000 people, of which over 21,500 are nurses.

2. Background and purpose

CHOA has made representations to the Treasurer and to the Australian Government's Review of Australia's future tax system review (the Henry Review) in relation to the current competitive non-neutrality of the Fringe Benefits Tax (FBT) arrangements within the hospital sector in Australia and the implications for workforce and sector viability. To illustrate the extent of this problem, CHOA commissioned Access Economics to undertake economic modelling of the impact of the current arrangements.

CHOA also made representations to the Productivity Commission in relation to its Review of the Contribution of the not for profit sector, particularly as it pertains to the area of competitive neutrality.

This paper presents for consideration and review CHOA's suggested policy options designed to remedy the existing competitive non-neutrality of tax arrangements between not-for-profit (NFP) and commercial hospital operators in the private hospital sector. It is designed to supplement CHOA's submissions to the Henry Review and the Productivity Commission and act as a basis for further consultation. CHOA would like to work with the AFTS, the Productivity Commission and the Australian Government to further develop and refine the options presented in this paper.

3. Policy context

The role of commercial private hospitals in a viable health sector:

The strength of Australia's health system, compared to health service provision in countries around the world, is its mix of private and public services. The economic and social challenges posed by Australia's growing health expenditure, and its workforce shortages, is well established and the subject of numerous reviews.

Within the private sector, NFP and commercial private hospitals deliver vital services for the Australian community, and support a stressed public hospital system.

Commercial private hospitals play an essential role in meeting Australia's demand for hospital services. Of 7.8 million admissions to all Australian hospitals in 2007/08, 3.1 million (39.7 per cent) were admissions to private hospitals.[i] Currently commercial private hospitals account for 56.6 per cent of private hospital beds in Australia (excluding day procedure centres), and a proportional percentage of admissions, with the remainder operated by NFP private hospitals.[ii] Of the private hospital beds operated by commercial private hospitals, CHOA members operate 84.3 per cent.[iii]

CHOA members operate the majority of private hospitals located in non-metropolitan areas and owned by either CHOA members or major NFP religious/charitable groups. Of the 67 private hospitals which are located outside Melbourne, Sydney, Brisbane, Perth, Adelaide, Hobart, Darwin and Canberra (excluding day procedure centres) and owned by either CHOA members or major NFP religious/charitable groups, CHOA members operate 42 or 63%[iv] (refer to Appendix 1). CHOA members operate private hospitals in locations where no other private hospital services are available, including Dubbo (NSW), Orange (NSW), Nowra (NSW), Armidale (NSW), Tamworth (NSW), Wangaratta (VIC), Shepparton (VIC), Mildura (VIC), Nambour (QLD), Cairns (QLD), Ipswich (QLD) and Burnie (TAS).

Changed structure and operations within the sector:

CHOA recognises the significant contribution made by NFP private hospitals. However, the taxation treatments of the NFP sector and commercial providers introduced over the years does not reflect the structure and operations of the sector today.

In recent times a paradigm shift has occurred at the higher end of the NFP hospital sector with a demonstrable change in operations and client base. Over the past ten years, a series of acquisitions and developments of close to $1 billion have been made by the NFP sector in direct competition with commercial operators (refer to Appendix 2).

In line with these acquisitions, increasingly, NFP private hospitals are behaving in a commercial fashion: providing the same services and competing for patients, doctors, staff and infrastructure. The primary users of their services are people who enjoy middle to upper socio-economic status and can afford private health insurance, not the disadvantaged. Pathology services and others have become part of the suite of services offered by NFP providers despite already being covered by Medicare for universal access. In this way NFP private hospitals enjoy tax concessions for activities which do not closely resemble, or form more than an incidental part of, their original charitable purpose.

Increasing commercial activity within the hospital sector is also evidenced by public hospitals, who are now deliberately competing with private hospitals for private patients.

A tax-induced non-competitive neutrality:

The current tax arrangements applying to Australia's hospitals, (public, NFP and commercial) has unintentionally created a tax-induced competitive distortion that has wide ranging implications for the health system.

The tax-exempt status applying to NFP private hospitals creates a lack of competitive neutrality across the hospital sector which is particularly pronounced when the arrangements for NFP private hospitals and commercial private hospitals are compared. The market distorting potential of the different tax regimes has been recognised by previous policy reviews. CHOA believes this distortion impacts both on the comparative operations of NFP and commercial private hospitals and the level playing field in relation to acquisitions. Major NFP private hospital groups actively factor tax concessions into their pricing structures for acquisitions, thereby providing them with an unfair advantage when competing with CHOA members to acquire assets.

CHOA believe that the concessions available to NFP private hospitals, which are substantial and include not only Fringe Benefits Tax but also payroll tax, income tax, land tax and stamp duty, are no longer appropriate and should be reviewed closely and a remedy introduced to bring the taxation base back to a level playing field which closely reflects the composition of the sector to ensure competitive neutrality.

The Productivity Commission's draft report into the Contribution of the Not-for-Profit sector:

The Productivity Commission's recent draft report into the Contribution of the Not-for-Profit (NFP) sector reflected CHOA's views. The Commission found that input tax concessions violate competitive neutrality as a principle in the case of for-profit companies who compete in the same markets as NFPs, with the hospital sector being the main example of this occurring in practice, placing for-profit hospitals at a significant disadvantage compared with NFP and public hospitals:

> *"Overall, the Commission concludes that the competitive neutrality principle is violated by the provision of input tax concessions, especially for FBT and payroll tax, to NFPs that compete against for-profit companies in the provision of similar goods and services on a significant scale. However, in practice concerns about competitive neutrality are confined to a relatively small part of the NFP sector, of which hospitals are the major example.*[v]
>
> *"it seems likely that for-profit hospitals face a significant competitive disadvantage compared with both NFP hospitals and public hospitals."*[vi]

The Commission reported that FBT concessions create a distortion in three areas within the hospital sector:

1. A distortion exists between for-profit and NFP/public hospitals. The uniform nature of registered nurses' salaries leads to hospitals providing the same gross salary, with nurses receiving different net salaries depending on their employer.
2. A distortion also occurs in the allocation of funding capital and labour, whereby hospitals that are classified as Public Benevolent Institutions (PBIs) are incentivised to purchase more labour at the expense of capital owing to the relatively less expensive cost of labour.
3. Although not of directly relevant to CHOA, the Commission found a distortion also exists between employees at PBI hospitals whereby those employees with higher salaries will benefit commensurately more than other employees, as might those with large one-off entertainment expenses.[vii]

In determining the existence of these distortions, the Commission noted:

- for-profit and NFP private hospitals have grown rapidly over the past 15 years;[viii]
- in recent years the use of meal and entertainment concessions has grown much wider than the original intent of the policy with salary packaging providers promoting the use of this benefit for large expenses such as holidays and weddings;[ix]
- given the NFP hospitals operate in full competition with for-profit hospitals, NFP hospitals can afford to offer market-based salaries;[x]
- hospitals are often located in close proximity such that nurses in theses hospitals get paid roughly the same gross salary, yet nurses employed in NFP hospitals get a significantly higher net salary;[xi] and
- the increasingly difficulty in obtaining nursing services will likely exacerbate these competitive neutrality tensions.[xii]

The Commission refrained from making formal recommendations in relation to competitive neutrality in the hospital sector, deferring to the findings of the Henry Review as well as responses to its draft report.

International policy settings:

In its recent draft report, the Productivity Commission noted the tax treatment of commercial activities run by 'charitable' organisations in various international jurisdictions including the United States, Canada, England and Wales and Ireland, which act to separate commercial from charitable activities. Further details from the Commission's report are contained in Appendix 3.

Further investigation conducted by CHOA indicates that eligibility for tax concessions in these jurisdictions requires charities to conduct activities which are substantially related to the organisation's charitable purpose and offer goods and services to a broad section of the public without financial/socio-economic restrictions. Activities outside of an organisation's charitable purpose must form only a small or incidental part of its operations. The following section outlines in greater detail the policy settings in these jurisdictions.

United States:

In the United States, NFP organisations that derive $1,000 USD or more from unrelated business activity are required to pay Unrelated Business Income Tax.[xiii] Unrelated business activity is defined by a test of an organisation's activities against three requirements:

1. It is a trade or business;
2. It is regularly carried on; and
3. It is not substantially related to furthering the exempt purpose of the organisation.[xiv]

Carrying on a trade or business is defined as:

> *"… any activity carried on for the production of income from selling goods or performing services… Activities of producing or distributing goods or performing services from which gross income is derived do not lose their identity as trades or businesses merely because they are carried on within a larger framework of other activities that may, or may not, be related to the organization's exempt purposes."*[xv]

Activities not substantially related to furthering the exempt purpose of the organisation are characterised as follows:

> *"To determine if a business activity is substantially related requires examining the relationship between the activities that generate income and the accomplishment of the organization's exempt purpose. Trade or business is related to exempt purposes, in the statutory sense, only when the conduct of the business activities has causal relationship to achieving exempt purposes (other than through the production of income). The causal relationship must be substantial. The activities that generate the income must contribute importantly to accomplishing the organization's exempt purposes to be substantially related."*[xvi]

Canada:

Canada recognises two types of 'related businesses', the first being those substantially run by volunteers and the second being those that are linked to a charity's purpose and subordinate to that purpose. To remain subordinate to a charity's purpose, a business is required to meet the following criteria:

1. Relative to the charity's operations as a whole, the business activity receives a minor portion of the charity's attention and resources.
2. The business is integrated into the charity's operations, rather than acting as a self-contained unit.
3. The organisation's charitable goals continue to dominate its decision-making.
4. The organisation continues to operate for an exclusively charitable purpose by, among other things, permitting no element of private benefit to enter in its operations.[xvii]

Conversely, 'unrelated business', which is treated as a separate taxable corporation, is determined with reference to a number of criteria, including:

- The rationale of running the business is to generate profit, or, if it does not yield a profit, it is capable of earning a profit or has a history of returning profit.
- The person or organisation that is undertaking the activity has been selected because of their commercial knowledge, skill, or experience (they are not volunteers).
- Fees are charged in respect of goods or services which are not provided for the purpose of altruism and public benefit. Importantly, charitable activities involving the charging of fees are *not* considered to be a business where they do not offer services comparable to those otherwise available in the marketplace.
- Fees are set according to a market objective rather than a charitable objective (fees designed to relieve poverty by being set in accordance with the users' means).
- The business is carried on in a continuous or regular fashion.[xviii]

England and Wales:

In England and Wales, the Charity Commission will not register an organisation as a charity (and therefore allow it to access tax concessions) unless it demonstrates that its aims are for the public benefit. This is known as 'the public benefit requirement'.

Under Principle 1 of this requirement, the benefits of the activity must be related to its aims. If they are not related, they must form a small or incidental part of what the charity does:

> *"Where an organisation has more than one aim, each of those aims must be for the public benefit. The public benefit shown by one or more of its aims cannot be used to 'off-set' any lack of public benefit of its other aims.*
>
> *Some charities carry out incidental activities that are not related to achieving their charitable aims. Such activities may be permitted, on the basis that they are a small or incidental part of what the charity does…"*[xix]

Under Principle 2 of this requirement:

- The beneficiaries must be appropriate to the aims, meaning the benefits must be widely available to a 'public class' of people.[xx]
- The opportunity to benefit must not be unreasonably restricted to a section of the public by geographical restrictions or the ability to pay any fees charged. *"The fact that the charitable facilities or services will be charged for, and, will be provided mainly to people who can afford to pay the charges, does not necessarily mean that the organisation does not have aims that are for the public benefit; however, an organisation that excludes people from the opportunity to benefit because of their inability to pay any fees charged would not have aims that are for the public benefit."*[xxi]
- People in poverty must not be excluded from the opportunity to benefit.[xxii]
- Any private benefits must be incidental.[xxiii]

Ireland:

In Ireland, organisations are not granted tax exemptions where they have a mix of charitable and non-charitable purposes. To determine charitable purpose, an organisation's activities must come within four categories:

1. Trusts for the Relief of Poverty.
2. Trusts for the Advancement of Education.
3. Trusts for the Advancement of Religion.
4. Trusts for other purposes beneficial to the community.[xxiv]

A need for policy change:

The arrangements in place in comparable international jurisdictions suggest that within the broad policy framework governing tax treatment of NFPs, Australia, which does not have in place an effective mechanism to tax separately NFPs' commercial activities from their genuinely charitable activities, is out of step.

The eligibility criteria for PBI status includes activities being carried on for the public benefit and having a dominant purpose of providing benevolent relief, defined as:

"The dominant purpose of a PBI is the direct relief of poverty, sickness, suffering, distress, misfortune, disability or helplessness. Other purposes and activities must be incidental to that purpose. They will be minor in extent and importance."[xxv]

The evidence suggests that the activities of large, commercially-focused NFP groups are now not rigorously assessed against these criteria, allowing them to continue to access tax concessions for their entire operations. In this context CHOA believes these international policy settings are worthy of examination for their possible application in Australia.

Impact on the hospital sector:

Of immediate concern to CHOA is the impact of this policy vacuum on the hospital sector. NFPs who for ten years have acquired and operated private hospitals have not attracted separate tax treatment despite their increasingly commercial behaviour. By allowing NFP private hospitals to continue to access generous tax concessions in respect of their commercial activities, a tax-induced competitive distortion has been created in the hospital sector which has wide-ranging implications for the viability of Australia's health system.

In particular, the differential FBT regimes create an uneven playing field between commercial and NFP hospitals which exacerbates the existing shortage of nurses available to commercial private hospitals. FBT concessions are used by NFP and public hospitals to enhance their nurses' remuneration, thereby shifting limited workforce resources away from the commercial private sector.

Even if unintended, the impact of this on commercial hospital operators is significant. Despite the structural and functional efficiencies achieved in commercial private hospitals, as Access Economics' modelling has demonstrated if commercial operators were to scale up salaries to equalise the FBT differential this would result in substantial reductions in market returns. In turn this would force difficult decisions about operational viability, bed numbers and the type and mix of services offered relative to the availability and affordability of nursing staff needed to maintain quality care for Australians.

CHOA believes this should be urgently addressed through the development of a policy that treats the commercial activities of NFP private hospitals separately from their broader NFP activities which do align with the PBI criteria.

4. Policy reform options

The following options appear to CHOA to go some way to addressing the present inequitable taxation arrangements. CHOA acknowledges that introducing system and tax reforms as set down in these options reasonably involves operational adjustments on the part of NFP private hospitals. Accordingly CHOA suggests that a phase-in period of 12 months – three years may allow these hospitals adequate time to adjust.

The first option (Option A) addresses the wide raft of tax concessions that are, in CHOA's view, incongruous with the commercial behaviour of many NFP private hospitals. It also proposes to bring Australia in line with the policy settings in place in comparable international jurisdictions. The second option (Option B) deals with FBT concessions specifically in the hospital sector. The third option (Option C) deals with the meal and entertainment benefit which is widely acknowledged to be utilised beyond its original intention and in some instances to an excessive degree and by the same employee in more than one hospital. Options A and C or B and C may operate together.

CHOA proposes these options in the knowledge that a further option exists whereby commercial private hospitals would be extended the same entitlements to tax concessions enjoyed by NFP private hospitals. However, CHOA proposes solutions which are both financially prudent and which address the substantive problem of competitive non-neutrality in the private hospital sector.

Option A: Sliding scale of access to tax concessions

Under the *Income Tax Assessment Act 1997*, NFP hospitals are eligible for tax concessions which are afforded to charities and, by virtue of their position as public benevolent institutions (PBIs), deductable gift recipients (DGRs). The origins of these concessions lay in the fact that religious and other NFP hospitals were established to care for poor, needy and disadvantaged Australians.

The Henry Review's discussion paper, *Architecture of Australia's tax and transfer system* notes:

"Charities are eligible for a range of tax concessions, including refunds of imputation credits, income tax exemptions and GST concessions. To be eligible for endorsement as a charity, an organisation must be operated for public charitable purposes. Charitable purposes are: the relief of poverty, sickness, or the needs of the aged; the advancement of education; the advancement of religion; and other purposes beneficial to the community. A charity can only carry on a business or commercial enterprise where that activity is merely incidental to its charitable purpose."[xxvi]

The activities of many larger NFP private hospitals have moved away from this definition and are actively competing with the commercial sector.

CHOA proposes the introduction of a 'trigger' whereby the operations of a NFP private hospital are reviewed to assess the appropriateness of their continued access to tax concessions. Access to the full range of tax concessions (FBT, payroll, income and land tax and stamp duty) would be determined through the application of a test designed to examine whether an organisation is genuinely charitable or directly competing with private commercial operators on services (such as pathology) or major acquisitions – a test of whether the operations of NFP private hospitals remain consistent with public charitable purposes.

According to this assessment, NFP private hospitals could access tax concessions on a sliding scale with various access points across the spectrum ranging from no access to degrees of partial access.

An appropriate set of criteria and sliding scale of tax concessions could be established to measure the commercial behaviour of an organisation with reference to the policies in place in international jurisdictions. It could include assessing an organisation's activities to determine:

- Whether they are substantially related to furthering its charitable purpose (other than through the production of income alone);
- Whether goods and services are offered for the public benefit and not restricted by geographical or financial/socio-economic factors; and
- Whether the activity is regularly carried on.

This option would address CHOA's concerns while at the same time create a policy framework which is in harmony with international jurisdictions and applicable to all sectors where NFPs compete with commercial providers.

Consistent with the need to phase in reform to allow organisations to make the necessary operational adjustments, this option may be introduced in a phased approach both in terms of time and degrees of access. For example, NFP private hospitals who meet the criteria for no access to tax concessions may have access to them at a partial rate of 50 per cent for two years before having them phased out altogether.

CHOA submits that it is not necessary for this transition period to apply to new hospital acquisitions and greenfield hospital developments which are entered into by NFP private hospital groups following the introduction of this option. That is, private hospital groups would still have access to tax concessions consistent with their entitlement under the test criteria; however the applicable level of access would apply immediately. Restricting access to a transition period for new acquisitions and greenfields developments would level the playing field with respect to the ability of major NFP private hospital groups to factor tax concessions into their pricing structures for acquisitions.

Option B: Sliding scale of access to FBT concessions

Under this option, CHOA proposes the introduction of a sliding scale of access to FBT concessions. This option allows for a timely solution which minimises the adverse impact of FBT concessions on the operations of commercial private hospitals, acknowledging the Productivity Commission's finding that the hospital sector is the main example of input tax concessions violating competitive neutrality.

This option adopts the same principles as those proposed in Option A by introducing a 'trigger' whereby the operations of a NFP private hospital are reviewed to assess the appropriateness of their continued access to FBT concessions through a test of whether their operations are genuinely charitable or directly competing with private commercial operators. On this basis, NFP private hospitals could access FBT concessions on a sliding scale with various access points across the spectrum ranging from no access to degrees of partial access.

A set of criteria and sliding scale of tax concessions could be established which are specific to the hospital sector. They could include:

- Services offered in competition with commercial operators and Medicare (pathology, radiology);
- Patient type/client mix;
- Hospital acquisitions;
- The existence of contracts held with private health insurers;
- Threshold for annual turnover.

These test criteria may apply such that NFP private hospitals hit a 'trigger' point for various levels of access to FBT concessions. For example, reduced access may be triggered by an NFP private hospital meeting 'core' criteria in relation to annual turnover/staff threshold together with one or two other 'optional' criteria including services offered, patient type/client mix, hospital acquisitions and contracts with private health providers. Alternatively, reduced access may be triggered by an NFP private hospital meeting a set number, perhaps two or three, of any of the above criteria.

CHOA submits that this sliding scale of access could be established and monitored according to the true structure and operation of the private hospital sector. Importantly, it could be structured to ensure the commercial operations of the large NFP private hospital groups are placed on a level playing field with commercial private hospitals without unduly penalising the smaller, genuinely charitable, community-owned NFP hospitals. For example, under this option a large NFP private

hospital group such as the Epworth would nave nil entitlement to FBT concessions while a small, 14 bed[xxvii] community-owned NFP hospital such as the Lithgow Community Private Hospital (NSW) would not be penalised.

Consistent with Option A, to allow NFP private hospitals to make the necessary operational adjustments, this option may be introduced in a phased approach both in terms of time and degrees of access. For example, NFP private hospitals who meet the criteria for no access to FBT concessions may have access to them at a gross threshold of $8,000 for two years before having them phased out altogether.

Consistent with Option A, CHOA submits that it is not necessary for this transition period to apply to new hospital acquisitions and greenfield hospital developments which are entered into by NFP private hospital groups following the introduction of this option. Private hospital groups would still have access to FBT concessions consistent with their entitlement under the test criteria; however the applicable level of access would apply immediately.

Option C: Abolish meal and entertainment concessions

As previously stated, the Productivity Commission's finding that in recent years the use of meal and entertainment concessions has grown much wider than the original intent of the policy (see Appendix 4 for examples of promotion and use of this policy as shown in the Productivity Commission's draft report).

Employees of NFP private hospitals have access to meal and entertainment concessions over and above the $17,000 FBT threshold. Additionally, it is possible for a nurse, doctor or other medical professional to work at two NFP or public hospitals and claim FBT concessions and meal and entertainment benefits through both hospitals – potentially utilising their full household income for this purpose.

Consistent with the growing use of this entitlement and anecdotal evidence of its misuse (including examples of this entitlement funding weddings, holidays and dining expenses incurred by large groups rather than just the individual entitled to the tax concession), under this option meal and entertainment concessions would be abolished.

CHOA submits that this option requires relatively little operational change on the part of hospitals and could be introduced with a short phase-in period, for example, 12 months.

This option could operate in conjunction with option A or B.

5. Conclusion

In closing, it is important to recognise that the differences between commercial and not-for-profit providers are marginal with respect to the services we offer and the support provided to the community. Through corporate social responsibility and, where appropriate, pastoral care services, commercial operators, be they in the health sector or other industries, have an obligation to support the communities where they operate. While not deemed 'charitable' for the purposes outlined above, the quantum of community support, donations, and the like is comparable.

The Government has confirmed that Australia's mix of public and private health care is important now and into the future. The Government has also noted the operational and financial efficiencies that can be generated through competition. Healthy competition requires a level playing field – an outcome CHOA is seeking from Government to maintain a viable hospital sector and health system for Australia.

Appendix 1: Non-metropolitan private hospital ownership

The following information shows the ownership of non-metropolitan private hospitals, including those hospitals located outside of Melbourne, Sydney, Brisbane, Perth, Adelaide, Hobart, Darwin and Canberra which are owned by either CHOA members or major NFP religious/charitable groups.

Non-metropolitan private hospital ownership

NSW

Location	Hospital	Ownership	Holding Company
Albury-Wodonga	Albury-Wodonga Private Hospital	Commercial	Ramsay Health Care Limited
Armidale	Armidale Private Hospital	Commercial	Ramsay Health Care Limited
Bathhurst	St Vincent's Private Hospital (Bathhurst)	NFP	Ramsay Health Care Limited
Bowral	Southern Highlands Private Hospital	Commercial	Ramsay Health Care Limited
Coffs Harbour	Baringa Private Hospital	Commercial	Ramsay Health Care Limited
Bega	Bega Valley Private Hospital	Commercial	Ramsay Health Care Limited
Woy Woy	Brisbane Waters Private Hospital	Commercial	Healthscope Limited
Wagga Wagga	Calvary Private Hospital	NFP	Calvary Health Care
Dubbo	Dubbo Private Hospital	Commercial	Healthe Care
Orange	Dudley Private Hospital	Commercial	Ramsay Health Care Limited
Wollongong	Figtree Private Hospital	Commercial	Ramsay Health Care Limited
Wollongong	Lawrence Hargrave Private Hospital	Commercial	Ramsay Health Care Limited
Gosford	Gosford Private Hospital	Commercial	Healthe Care
Hawksbury	Hawsbury District Health Service	NFP	Catholic Health Care
Hawksbury	St John of God Private Hospital	NFP	St John of God Health Services
Lake Macquarie	Lake Macquarie Private Hospital	Commercial	Ramsay Health Care Limited
Lake Macquarie	Warners Bay Private Hospital	Commercial	Ramsay Health Care Limited
Lake Macquarie	Toronto Private Hospital	Commercial	Healthe Care
Lismore	St Vincent's Private Hospital (Lismore)	NFP	Trustees of the RCC Diocese of Lismore
Newcastle	Newcastle Private Hospital	Commercial	Healthscope Limited
Newcastle	Lingard Private Hospital	Commercial	Healthe Care
Maitland	Maitland Private Hospital	Commercial	Healthe Care
Nowra	Nowra Private Hospital	Commercial	Ramsay Health Care Limited
Port Macquarie	Port Macquarie Private Hospital	Commercial	Ramsay Health Care Limited
Tamworth	Tamara Private Hospital	Commercial	Ramsay Health Care Limited
Wyong	Berkeley Vale Private Hospital	Commercial	Ramsay Health Care Limited

VIC

Location	Hospital	Ownership	Holding Company
Ballarat	St John of God Health Care (Ballarat)	NFP	St John of God Health Care
Bendigo	St John of God Health Care (Bendigo)	NFP	St John of God Health Care
Geelong	St John of God Hospital (Geelong)	NFP	St John of God Health Care
Geelong	Geelong Private Hospital	Commercial	Healthscope Limited
Mornington	Beleura Private Hospital	Commercial	Ramsay Health Care Limited
Mildura	Mildura Base Hospital	Commercial	Ramsay Health Care Limited
Shepparton	Shepparton Private Hospital	Commercial	Ramsay Health Care Limited
Wangaratta	Wangaratta Private Hospital	Commercial	Ramsay Health Care Limited
Warrnambool	St John of God Hospital (Warrnambool)	NFP	St John of God Health Care
Wodonga	Murray Valley Private Hospital	Commercial	Ramsay Health Care Limited

Non-metropolitan private hospital ownership

QLD

Location	Hospital	Ownership	Holding Company
Benowa	Pindara Private Hospital	Commercial	Ramsey Health Care Limited
Buderim	Sunshine Coast Private Hospital	NFP	UnitingCare Health
Bundaberg	Mater Misericordiae Hospital	NPF	Mater Health Services
Cairns	Cairns Private Hospital	Commercial	Ramsey Health Care Limited
Caboolture	Caboolture Private Hospital	Commercial	Ramsey Health Care Limited
Caloundra	Caloundra Private Hospital	Commercial	Ramsey Health Care Limited
Carina	Belmont Private Hospital	Commercial	Healthe Care
Currumbin	Currumbin Clinic	Commercial	Healthe Care
Gladstone	Mater Misericordiae Hospital Gladstone	NFP	Mater Health Services
Gold Coast	John Flynn Gold Coast Private Hospital	Commercial	Ramsey Health Care Limited
Hervey Bay	Hervey Bay Surgical Hospital	NFP	UnitingCare Health
Ipswich	St Andrew's Ipswich Private Hospital	Commercial	Ramsey Health Care Limited
Mackay	Mater Misericordiae Hospital Mackay	NFP	Mater Health Services
Maryborough	St Stephen's Private Hospital	NFP	UnitingCare Health
Nambour	Nambour Selangor Private Hospital	Commercial	Ramsey Health Care Limited
Noosa	Noosa Hospital	Commercial	Ramsey Health Care Limited
Oxley	Canossa Private Hospital	NFP	Canossian Daughters of Charity
Redcliffe	Peninsula Private Hospital	Commercial	Healthscope Limited
Rockhampton	Mater Misericordiae Hospital Rockhampton	NFP	Mater Health Services
Rockhampton	Hillcrest Rockhampton Private Hospital	Commercial	Ramsey Health Care Limited
Southport	Allamanda Private Hospital	Commercial	Healthscope Limited
Strathpine	Pine Rivers Private Hospital	Commercial	Healthscope Limited
Toowoomba	St Vincent's Hospital	NFP	Sisters of Charity & Holy Spirit Health Serv
Townsville	Mater Hospital Pimlico	NFP	Mater Health Services
Townsville	Mater Women's and Children's Hospital	NFP	Mater Health Services
Yeppoon	Mater Hospital Yeppoon	NFP	Mater Health Services

TAS

Location	Hospital	Ownership	Holding Company
Burnie	North West Private Hospital	Commercial	Healthe Care
Launceston	St Vincent's Hospital	NFP	Calvary Health Care
Launceston	Calvary Health Care - St. Luke's Campus	NFP	Calvary Health Care

WA

Location	Hospital	Ownership	Holding Company
Bunbury	St John of God Hospital Bunbury	NFP	St John of God Health Care
Geraldton	St John of God Hospital Geraldton	NFP	St John of God Health Care

* Note: all South Australian private hospitals located outside Adelaide are community owned.
* Note: the Northern Territory currently has no private hospitals in existence outside of Darwin.
* Note: in addition, the commercial operator Pulse Health also owns four non-metropolitan private hospitals including Bega Valley Private Hospital, Gympie Private Hospital, Kingaroy Private Hospital and Forster Private Hospital.

Appendix 2: Not for profit sector (NFP) acquisitions and developments

NFP sector acquisitions and developments

The NFP sector has invested considerably in expansion through acquisitions, new constructions and equipment. Over the past 10 years the following acquisitions and developments have been made by the NFP sector, in competition with the commercial sector.

St John of God:

- Murdoch (Perth) 327 beds (built)
- Peninsula Rehabilitation (Melbourne) 70 beds (acquired)
- Mt Alvernia (Bendigo) 132 beds (acquired from Sisters of Mercy)
- Berwick (Victoria) 70 beds (merger and subsequent investment of $14.5m)
- Pine Lodge (Dandenong) 70 beds (acquired)

Little Company of Mary (Calvary):

- John James (ACT) 142 beds (acquired)
- Wakefield Street (Adelaide) 180 beds (acquired)
- St Lukes / St Vincents (Launceston) 208 beds (acquired and merged)
- Central Districts (Adelaide) 68 beds (acquired)
- College Grove (Adelaide) 65 beds (acquired)

Sisters of Charity:

- Northside (Brisbane) 162 beds (built)

Uniting Healthcare Queensland:

- St. Andrews (Brisbane) 200 beds ($75m expansion)
- Wesley (Brisbane) 178 beds (estimated $80m expansion)

Case study: Epworth and Healthscope

The Epworth group (Epworth HealthCare) is a private NFP hospital group that operates under its own Act of Parliament, "The Epworth Foundation Act 1980". All surplus revenue generated is reinvested in improving patient care.

It has announced a major redevelopment as detailed on their website:[xxviii]

> **Major $350million redevelopment planned for Melbourne's leading private hospital group**
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> Epworth HealthCare has announced a $350m major redevelopment of their leading not-for-profit private hospital in Richmond. The hospital will be redeveloped and expanded to provide world class facilities with an extra 270 inpatient beds including emergency department beds further enhancing the excellence of care provided for its patients.
>
> The Group Chief Executive Alan Kinkade confirmed today that the application lodged with the City of Yarra is to upgrade and expand facilities at Epworth Richmond in line with Victorians' expectations of timely access to private hospital rooms to meet their medical, surgical and rehabilitation needs. Purpose built facilities will promote collaboration between teaching, research and clinical care.

“Overall, the plans provide for an exciting vision that includes 430 new private rooms with 160 of the poorer quality beds being replaced; a new emergency department; 17 new operating theatres and 19 extra beds in new state-of-the-art Intensive Care and Coronary Care Units. Significantly expanded cancer services have also been incorporated,” Mr Kinkade said. “New rehabilitation facilities will extend the specialist rehabilitation and trauma services for people across Victoria.”

“Currently we run at full capacity and have to care for some patients in shared wards. While our chemotherapy and the renal dialysis services provide excellent care, the facilities are poor and in great demand. Our priority is to increase the number of beds in response to demand and for patients to be more comfortable in private rooms.”

Mr Kinkade added that Epworth’s expansion and redevelopment will create more than 1440 new jobs in the construction phase and over 400 extra full-time staff at the hospital when the project is completed.

The Epworth group competes directly with Healthscope. Its main Richmond campus competes with Healthscope’s John Fawkner and Melbourne Private Hospitals, whereas Epworth Eastern competes with Bellbird, Ringwood and Knox private hospitals.

The vision statements of key Healthscope competitors suggest that they are, for all intents and purposes, acting as a private hospital competing in the market place while retaining surpluses for reinvestment. Healthscope on the other hand must generate profit to provide for company tax, distributions to shareholders and capital re-investment.

Epworth (and other religious and non-religious NFP hospitals) operate with commercial drivers. In addition to what is most likely the largest commercial redevelopment of any private hospital in Australia’s history, the Epworth group have:

- Constructed and equipped Epworth Eastern (Melbourne) 223 beds
- Acquired Brighton Rehabilitation (Melbourne) 58 beds
- Acquired Freemasons (Melbourne) 233 beds
- Acquired Cedar Court (Melbourne) 71 beds
- Acquired Camberwell Rehabilitation Hospital (Melbourne) 74 beds

The imbalance in the competitive playing field and modus operandi is self evident.

Appendix 3: Determining charitable purpose and tax treatment in international jurisdictions

The following information appears in the Productivity Commission's draft research report into the Contribution of the Not-for-Profit Section. [xxix]

Box 8.7 **Business income — treatment in selected overseas jurisdictions**

In the United States, net income from 'unrelated business activities' is subject to the Unrelated Business Income Tax (UBIT) which effectively taxes such income at ordinary corporate (or trust) tax rates (although dividends, interest, rents and royalties are excluded from UBIT). The UBIT applies to commercial activities 'unrelated' to the organization's charitable purpose (Brody 2009).

In Canada, a business operation of a charity cannot be a purpose in its own right — it is subsidiary to the charitable purpose of the organisation. Unrelated businesses of a charity are to be in a separate and taxable corporation (Hunter 2009).

In England and Wales:

the Charities Commission for England and Wales will not register a charity when its purpose is, or includes, the carrying out of trade. (Breen 2009, p. 7)

In Ireland for fund-raising, the Irish Revenue Commissions can grant a concession from tax liability:

In respect of profits arising from small-scale activities which have been run to raise funds for charitable purposes only. (Breen 2009, p.13)

Appendix 4: Examples of use of the meal and entertainment benefit.

The following information appears in the Productivity Commission's draft research report into the Contribution of the Not-for-Profit Section.[xxx]

Box 8.4 **Examples of packaging benefits**

Peter, a doctor in an NFP hospital, organises dinner with 10 of his friends. The bill comes to $200 each, or $2200. Peter pays the bill with his PBI credit card and collects $2000 from his friends. Peter has a salary of $250,000. This transaction reduces his after-tax income by $1023. Since he has received $2000 from his friends, Peter has enjoyed a free dinner with his friends and increased his after-tax income by $823.

Jane, a PBI employee, decides to package her $40,000 wedding. Jane has a $90000 salary. By packaging the wedding, Jane reduces her tax payable from $23000 to $9050. Her after-tax income from packaging increases from $26650 to $40650. Effectively the taxpayer has contributed $13 950 to Jane's wedding. Marketing information from Salary Options (2009, p. 1):

John and Mary book a holiday in Europe which includes two weeks in London and Paris and a cruise down the Seine for a week. Under the new arrangements, they can package as exempt items: (a) meals while on holiday in a sit down restaurant, café or bar, including the meals on the cruise if they can be separately identified; … and (b) accommodation costs in London and Paris.

Marketing information from the McMillan Shakespeare Meal Entertainment Payment Card Brochure (2009, p. 2):
Did you realise you can pay for your dining-out expenses (excluding take-away) through salary packaging? This means you can pay for meal expenses, including drinks and taxi fares to and from your dining venue, from your pre-tax salary and experience tax savings each pay! (subject to your employer's Meal Entertainment Policy)
Did you also realise that you can salary package the catering for your special occasions, such as weddings, engagements or birthday parties?
And these expenses can be salary packaged over and above your capping limit that applies to Fringe Benefit Tax (FBT) benefit items such as mortgage repayments.

Marketing information from EPAC Salary Solutions (EPAC 2009):
The EPAC meal entertainment card provides instant access to your meal entertainment funds. This is the most efficient way for employees of a Public Benevolent Institution or Hospital to package tax free the purchase of food and drink. The meal entertainment benefit is not included in your Fringe Benefit Tax thresholds, that is, it is an additional benefit.

ENDNOTES:

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[i] Department of Health and Ageing, *The State of our Public Hospitals June 2009 report*, p.6.
[ii] Internal CHOA records.
[iii] Internal CHOA records.
[iv] Internal CHOA records.
[v] Productivity Commission Draft Research Report, *Contribution of the Not-for-Profit Sector*, October 2009, p.8.17.
[vi] *Ibid*, p.8.17.
[vii] *Ibid*, pp.8.14 - 8.16.
[viii] *Ibid*, p.8.18.
[ix] *Ibid*, p.8.14 – 8.15.
[x] *Ibid*, p.8.19.
[xi] *Ibid*, p.8.16.
[xii] *Ibid*, p.8.17.
[xiii] United States Department of the Treasury Internal Revenue Service, *Unrelated Business Income Tax – Special Rules*, http://www.irs.gov/charities/article/0,,id=96106,00.html Cited 5 Novemer, 2009.
[xiv] United States Department of the Treasury Internal Revenue Service, *Unrelated Business Income Defined*, http://www.irs.gov/charities/article/0,,id=96104,00.html Cited 5 Novemer, 2009.
[xv] United States Department of the Treasury Internal Revenue Service, *"Trade" or "Business" Defined*, http://www.irs.gov/charities/article/0,,id=158841,00.html Cited 5 Novemer, 2009.
[xvi] United States Department of the Treasury Internal Revenue Service, *"Substantially related"*, http://www.irs.gov/charities/article/0,,id=158843,00.html Cited 5 Novemer, 2009.
[xvii] Canada Revenue Agency, *Policy Statement – What is a related business?* http://www.cra-arc.gc.ca/tx/chrts/plcy/cps/cps-019-eng.html Cited 5 November, 2009.
[xviii] *Ibid.*
[xix] Charity Commission, *Charities and Public Benefit,* http://www.charity-commission.gov.uk/Library/publicbenefit/pdfs/publicbenefittext.pdf Cited 6 November, 2009, pp.14-15.
[xx] *Ibid*, p.17.
[xxi] *Ibid*, pp.22-23.
[xxii] *Ibid*, pp.26-27.
[xxiii] *Ibid*, p.27.
[xxiv] Irish Revenue Commissioners, *Frequently Asked Questions – Charities* http://www.revenue.ie/en/index.html Cited 6 November, 2009.
[xxv] Australian Taxation Office, *Characteristics of a Public Benevolent Institution*, http://www.ato.gov.au/nonprofit/content.asp?doc=/content/26553.htm&page=2&pc=001/004/031/005&mnu=1445&mfp=001/004&st=&cy=1, Cited 6 November, 2009.
[xxvi] Australia's future tax system review discussion paper, *Architecture of Australia's tax and transfer system*, August 2008, p.20.
[xxvii] NSW Health Department website, http://www.health.nsw.gov.au/resources/hospitals/phc/pdf/private_hospitals.pdf Cited 1 December, 2009.
[xxviii] Epworth HealthCare website, media release, *Major $350 million redevelopment planned for Melbourne's leading private hospital group*. http://www.epworth.org.au/Main-Site/News-and-Events/News.aspx?newsID=25 Cited 5 November, 2009.
[xxix] *Ibid*, p.8.20.
[xxx] Productivity Commission, *op. cit.,* p.8.15.