16 January 2013

NFP Sector Tax Concession Working Group Secretariat
The Treasury
Langton Crescent
PARKES ACT 2600

Sent via email: NFPReform@treasury.gov.au

Submission in response to the Discussion Paper titled "Fairer, Simpler and more Effective Tax Concessions for the Not For Profit Sector"

We refer to our advice dated 17 December 2012. This submission has been prepared by the National Council of Ambulance Unions (NCAU) in response to the abovementioned Discussion Paper.

The NCAU is the peak body representing Ambulance Officers and Paramedics nationally, furthering the interests of members of our constituent unions. The NCAU is specifically focused on matters that have national implications for paramedics.

This submission is presented in 3 parts.

1. Who the NCAU represents
2. Comments on the benefits of the NFP tax concessions and impacts resulting as a consequence of any changes to NFP tax concessions, relevant to the interests of our member unions
3. Comments on selected questions identified by the NCAU of being specifically relevant to the interests of our member unions.

We note that the Discussion Paper indicates that the Working Group will conduct targeted consultation with interested stakeholders. Representatives of the NCAU would welcome the opportunity to participate in the targeted consultation process prior to the completion of the Working Group's report to Government. We look forward to discussing this submission further with the Working Group and Treasury.

Should the Working Group or Treasury require additional information on this submission please contact me on (03) 9235 7665.

This submission is to be accepted "in confidence".

Yours faithfully

Steve McGhie
President
National Council of Ambulance Unions

Encl.

NFP Sector Tax Concession Working Group Secretariat
Ambulance Employees Australia – Victoria
United Voice Ambulance Section
ABN: 19 845 840 893
117-131 Capel Street, North Melbourne, VIC 3051
PO Box 327, North Melbourne, Vic 3051
Tel: (03) 9235 7665 Fax: (03) 9235 7680
Email: aeavic@unitedvoice.org.au

1. Background information on the NCAU

1.1 The NCAU was formed in 2008 by all of the registered unions representing paramedics in Australian states and territories. We are advised that approximately 10,000 paramedics are members of the organisations we represent.

The objectives for which the council is established are:

- To foster the interests of members of those unions
- To provide a means for officers and members of the council to share information on agreements, awards, decisions, disputes, rates and relativities affecting the industrial interests and welfare of members of the member unions, and to afford opportunities for discussing other matters of common interest.
- To promote the mutual co-operation of members of the NCAU
- To develop policy as agreed for issues of national interest
- Undertake or facilitate research
- To lobby and advocate on agreed issues
- To facilitate the co-ordination of campaigns to foster the best interest of the membership and the Council
- To make representations to governments and other organizations that are in the best interests of the membership
- To facilitate the establishment and maintenance of such publications, including electronic publications such as a website, as may be in the interests of the membership.

1.2 Who does the NCAU represent - 2011 Census data

The 2011 census identified 11940 ambulance officers and paramedics. Paramedic numbers have grown from 9097 or by 31 per cent since the 2006 census.

Women comprised 32 per cent of the paramedic workforce in 2011 compared to 26 per cent in 2006. In the 20-29 age group, 53 per cent of paramedics are women.

The majority of paramedics (89 per cent) worked full-time. Women were twice as likely as men to work part-time (18 per cent to 8 per cent).

Paramedics tended to work longer hours in 2011 than the rest of the employed population working full time. 36 per cent of paramedics worked 49 and over hours per week compared to 26 per cent of the wider population.

Paramedics also volunteer more than average. 29 per cent of paramedics did volunteer work in 2011 in addition to their paid jobs. The comparable figure for the general population of employed Australians was 19 per cent.[1]

[1] Paramedics Australasia, *Paramedics in the Census 2011. November 2012*

1.3 Core workforce descriptors

The core workforce that comprises the members of NCAU constituent unions and their functions are described below. [2]

1.3.1 Ambulance Paramedic

Defined as a health professional who provides rapid response, emergency medical assessment, treatment and care in the out-of-hospital environment.

Paramedics are required to undertake a variety of physical tasks, in some cases over a prolonged period, a suitable level of general health and fitness is required.

Paramedics respond to, assess and manage patients, transport them to a health facility for ongoing care if necessary or arrange alternative referral, treatment or care options. This is the base level professional stream practice in Paramedicine.

The paramedic is often required to make complex and critical clinical judgments without direct supervision. Individuals are responsible for their own continuing professional development which may be supplemented by employer-provided training.

1.3.2 Intensive Care Ambulance Paramedic

An intensive care paramedic (ICP) is an advanced clinical practitioner in paramedicine who provides medical assessment, treatment and care in the out-of-hospital environment for acutely unwell patients with significant illness or injury.

ICPs respond to patients experiencing an acute, life-threatening emergency. They provide rapid and specialist clinical assessment by implementing a targeted management plan for patients with significant alteration or challenge to normal homeostatic function. Whilst this role is tasked with providing clinical oversight during the management of these cases, all patient care is undertaken in a collaborative context with other paramedic staff or health care professionals in attendance.

The ICP is required to make rapid, often complex and critical clinical judgments without direct supervision. Individuals are responsible for their own continuing professional development which may be supplemented by employer-provided training.

1.3.3 Retrieval / Flight Paramedic

A retrieval paramedic (RP) is an advanced clinical practitioner in paramedicine who provides medical assessment, treatment and care in the out-of-hospital environment to facilitate the safe and effective transfer of critically unwell patients to a specialist receiving facility.

RPs respond to critically unwell patients based on either initial information from an incident scene (referred to as a primary response) or where patients have been assessed by a primary treating clinician (e.g. general practitioner/primary responding ambulance crew) as requiring transfer to a specialist clinical facility. The role liaises extensively with onsite clinicians and undertakes a specialist clinical assessment and implements a patient management plan to support the safe transfer of these often complex and time critical

[2] Paramedics Australasia, *Paramedicine Role Descriptors, December 2012*

patients.

The RP is required to make complex and critical clinical judgments often without direct supervision. Like all other professional levels, individuals are responsible for their own continuing professional development which may be supplemented by any employer provided training.

1.3.4 General Care Paramedic (Extended Care Paramedic)

A general care paramedic (GCP) is an advanced clinical practitioner in paramedicine who specialises in facilitating a comprehensive medical history/assessment, initiation of relevant treatment and appropriate referral for low and medium acuity patients in a variety of community and clinical settings with an emphasis on managing a patient in their own environment/context.

GCPs attend both scheduled and unscheduled low acuity patients where they undertake a thorough clinical assessment of the patient's medical history and condition, order any pathology testing as required, interpret the results and, based on a clinical diagnosis, institute a short to medium term care plan with appropriate medical referral as required. The GCP has a significant understanding of pathophysiology, pharmacology and disease process.

The GCP makes complex and critical clinical judgments in a multidisciplinary, collaborative team environment ensuring involvement of the patients primary treating health care professional, where possible, and without direct supervision. Individuals are responsible for their own continuing professional development which may be supplemented by employer provided training.

1.3.5 Patient Transport Attendant Level 1

A patient transport attendant – level 1 is an individual who has completed accredited training in advanced first aid and patient transport and who provides quality care and transport for low acuity and non-ambulant stable patients between health facilities and/ or home.

Patient transport attendants – Level 1 (PTA1) attend to scheduled, clinically stable patients with the aim of transporting them to a health facility for ongoing care or a residence following discharge, where there is no expected requirement for clinical intervention. PTA1's may be required to perform a FR role if a patient's condition unexpectedly deteriorates, they incidentally come across a clinical incident while in transit, or if tasked by a statutory ambulance service in times of significant emergency workload or disaster response.

The PTA1 undertakes clinical management with limited autonomy in relation to a known range of clinical situations usually via the implementation of structured protocols. A thorough medical assessment is used to identity a patient's suitability to be managed by these staff.

1.3.6 Patient Transport Attendant Level 2

A patient transport attendant – level 2 (PTA2) is an individual who has completed accredited training in patient transport and management and who provides quality care and transport for medium acuity, stabilised patients between health facilities and/or home.

PTA2's attend to scheduled, clinically stabilised patients with the aim of transporting them to a health facility for ongoing care (or a residence following discharge) where there is a possibility

of the requirement for clinical intervention during the transfer. These patients may require ongoing clinical monitoring which may involve the taking of basic observations or ECG rhythm strip.

On occasions PTA2's may be required to perform an FR role if a patient's condition unexpectedly deteriorates, they incidentally come across a clinical incident in transit, or if tasked by a statutory ambulance service in times of significant emergency workload or disaster response.

The PTA2 undertakes clinical management with greater individual responsibility and autonomy than the PTA1 in relation to a range of situations where individuals are expected to demonstrate initiative and judgment in clinical practice. Practice, particularly the administration of medications, is usually regulated via structured protocols.

1.3.7 **Basic Life Support Medic (BLSM)**

A basic life support medic (BLSM) is an individual who has completed accredited training in emergency patient care to provide rapid access to clinical assessment, treatment and care in the out-of-hospital environment (particularly in rural and remote areas).

BLS Medics respond to, assess and manage patients in an emergency situation and facilitate either the attendance of a higher level of clinical response or transport the patient to a health facility for ongoing care. The BLS Medic may also facilitate the transfer of patients between health facilities or a residence for which the patient is clinically suitable and there are no other suitable resources available to achieve this.

The BLS Medic is required to operate without direct supervision and perform a defined range of routine and non-routine clinical management strategies in the emergency patient intervention setting.

1.3.8 **Emergency Medical Dispatch Support Officer**

An emergency medical dispatch support officer (EMDSO) is an individual who has completed accredited training to receive and process requests for both emergency (via 000) and non-emergency ambulance attendance.

EMDSOs are most often the first point of interaction between a patient and a paramedical service. These staff are responsible for receiving calls for both emergency and non-emergency ambulance response from a variety of sources e.g. members of the public, health care professionals and residential care facilities. The location of all calls for assistance is rapidly established and a structured process of triage undertaken to identify the urgency of ambulance response required. Once this has been obtained and data entered, where relevant, the EMDSO will provide scripted first aid advice to the caller to commence patient management whilst the service provider is responding.

The EMDSO is required to operate within the defined operating processes of the respective call taking system/software being used by the ambulance service. EMDSO's usually work under the indirect supervision of a communications team leader. Some continuing accreditation requirements exist in relation to some of the proprietary call taking triage products.

1.3.9 **Emergency Medical Dispatcher**

An emergency medical dispatcher (EMD) is an individual who has completed accredited training to triage and coordinate the timely deployment of requests for both emergency and non-emergency ambulance attendance.

EMDs are responsible for the coordination of service provider resources within a defined geographic area in order to respond to requests for both emergency and non-emergency ambulance in a timely manner. EMD's have the crucial responsibility for ensuring that the right paramedical resource is sent to the right patient at the right time.

EMD's will commonly liaise with counterparts in emergency services in relation to attendance requirements.

The EMD is required to operate within the defined processes and business rules being used by the respective ambulance service. EMD's often work with significant autonomy whilst under the indirect supervision of a communications team leader.

2. Benefits of the NFP Concessions currently available members of NCAU constituent unions

2.1 Employees of state and territory ambulance services are currently able to access the following concessions (based on employer/employee arrangements) in delivering out of hospital healthcare and health related services. The concessions are:

- FBT Concessions, $17,000 grossed up (capped); and
- Meal entrainment and entertainment facility leasing benefits (uncapped)

2.2 FBT Concessions

2.2.1 Employees of a public ambulance service are entitled to an FBT exemption of up to an annual cap of $17,000 per employee. This is a standard national employee benefit that is available to all public ambulance service employees as defined in *Fringe Benefits Tax Assessment Act – Scet 57A(3b)*. This cap relates to the grossed up value of the fringe benefits provided but does not include meal entertainment and entertainment facility leasing benefits. Some public ambulance services do not pass on the full FBT exemption to their employees.

2.2.2 Employees working in the functions that make up state and territory ambulance services and those that provide administrative support to it are able to take advantage of the FBT concessions through salary packaging arrangements. Meal entertainment and entertainment facility leasing benefits are included in the items which members are able to salary package.

2.2.3 Access to FBT concessions strengthens state and territory ambulance services' status as an employer of choice, which helps those organisations attract and retain the best and most experienced staff. It also enables state and territory ambulance services to compete for staff in the broader health services marketplace. It assists state and territory ambulance services maintain its market competitiveness in attracting employees in an industry undergoing significant employment challenges. Access to these concessions assists new employees with the cost of living pressures. Due to the nature of the work, ambulance employees require ongoing training and experience plays a vital role in delivering an effective and safe service to the community. With the financial incentives the private sector is able to offer, particularly in relation to Industrial Paramedics in the mining industry, the FBT concession is a significant tool in helping public ambulance services retain staff and build a more experienced and effective workforce.

2.2.4 Having a highly skilled and experienced workforce is essential for state and territory ambulance services to meet their goals of providing a high level of out of hospital emergency and non-emergency healthcare to all residents. Developing these skills is both time and resource intensive. Access to these benefits provides an opportunity for non for profit organisations to retain staff in competition with the commercial market, such as mining and the off shore oil and gas industry.

2.3 Impact of losing the concessions

2.3.1 The impact will differ depending on the quantum of change to the concession and the nature of the concession in question. Outlined below are the expected impacts of losing the concessions completely.

2.3.2 Removal of the concession is likely to lead to a disengaged workforce on the basis that employees have come to expect the benefits provided under the concessions.

2.3.3 The limited available workforce in the industry may put further pressure on wage costs and without the FBT concession it may be difficult for state and territory ambulance services to retain the best staff.

2.3.4 The difficulties in retaining staff and hiring new staff as well as the possibility of a disengaged workforce may have undesirable impacts on the availability and costs of services. Waiting times may increase and the costs to public ambulance services and/or the consumers for the services may increase as well.

2.3.5 High costs of recruitment and training of staff are characteristic of the ambulance industry. This is because there is a long lead time (two years post engagement) for a new graduate to become an autonomous practitioner at ambulance paramedic level. Furthermore, there is a longer lead time (typically five years plus, post engagement) for a paramedic to acquire the necessary experience and develop a skill set that enables him/her to progress to increasingly challenging roles (e.g. Intensive Care Paramedic / Flight Paramedic). In addition, the ambulance industry is currently transitioning to a pre-employment training model, which in the short-term is adding to the fundamental shortages in qualified and skilled staff in the industry.

2.3.6 The nature of the benefits may also be seen to promote increased spending on goods and services (in line with the salary packaging rules) in local communities, thus providing economic stimulus to communities.

2.3.7 The impact of losing the FBT concession will likely be significant due to the large proportion of members that will be affected. For example the net cost of housing for Ambulance Officers will increase. Identified as “Key Workers”, Ambulance Officers will find housing affordability more difficult, as outlined in the *Bankwest 3rd Key Worker Housing Affordability Report 2011*.

2.3.8 The Report, tracks housing affordability for five groups of key public sector workers - nurses, teachers, police officers, fire-fighters and **ambulance officers**.

2.3.8.1 In 543 local government areas across Australia. An area is classified as unaffordable if its median house price is more than five times the salary of a key worker.

2.3.8.2 Housing affordability for key public sector workers has deteriorated in four out of eight capital cities in the past year and in all capital cities over five years.

- *Capital city house price rose by 43% over the past five years*
- *Sydney and Melbourne are the least affordable capital cities key workers*
- *Hobart and Adelaide are the most affordable capital cities for key workers*

2.3.8.3 Housing affordability has deteriorated both in the past year and over the last five years for Australia's 480,000 key workers– *nurses, teachers, police officers, fire fighters and* ***ambulance officers****.*

2.3.8.4 At a local level affordability is worst in Canberra, Darwin and Perth. The median house price was potentially unaffordable in 100% of LGAs (7 out of 7) tracked in Canberra and Darwin (2 out of 2) along with 87% of LGAs in Perth (26 out of 30) in 2010.

2.3.8.5 Ambulance officers and paramedics face marginally less affordability issues. In 2010, ***78%*** *(115 out of 147) of capital city LGAs were viewed as* ***unaffordable for ambulance officers and paramedic****s, the lowest proportion of any key worker group. However, the* ***proportion of unaffordable LGAs for ambulance officers has increased*** *from 70% (103 out of 147) in 2005.*[3]

2.3.9 Removal of the FBT concessions would result in a reduction in the net "take home pay" of employees of state and territory ambulance services that could lead to the following undesirable consequences:

- ► It may be difficult to retain staff and attract new employees to the sector, resulting in a reduction in resources in the public ambulance services, whilst conversely; demand for state and territory ambulance services continues to grow at approximately 8% pa.

- ► Following on from the difficulty to retain staff, it may be necessary to increase salaries for the staff resulting in an increase in costs of providing public ambulance services to the community. This will mean either higher costs to the Government and/or to the community and users of the services. Alternatively, there may be a reduction in the services provided, either in the form of quantity or quality.

- ► The effect of a higher after tax income may determine that employees are no longer eligible for tax benefits such as child care and family payments, which would place a greater burden on ambulance employees with children. Many of these ambulance employees have structured their budgeting inclusive of these concessions. Any change will potentially cause hardship to those working families with significant mortgages and other costs associated with raising families.

2.3.10 Ambulance employees work longer hours (36 per cent work over 49 hours per week) than the general population, with an excess of 35 to 45 per cent of salary being composed of shift penalties and overtime. Ambulance employees have a very limited capacity to compensate for any loss of income as a consequence to changes to FBT concessions.

2.3.11 Women comprise 32 per cent of the paramedic workforce and are twice as likely as men to work part-time (18 per cent to 8 per cent). Ambulance employees have a greater difficulty in obtaining child care due to the type (nights and weekends) and the extended length of shifts they are required to work. Ambulance employees pay higher costs for childcare outside of normal working hours. A consequence of the costs of childcare is an increasing demand to work part time. Changes to the tax concessions that reduce the available take home pay for these employees is compounded as many already work reduced hours and this has the potential to make it less attractive to join the profession and also to retain women in the workforce. The loss of FBT concessions will disproportionally be greater for women.

[3] Bankwest. *3rd Key Worker Housing Affordability Report, March 2011*

2.3.12 Changes to or the loss of tax concessions currently available to ambulance employees will further have a disproportional effect on single income families.

2.4 Competitive Neutrality

2.4.1 Public sector and NFP ambulance services have a charter to provide out of hospital services to the community. As a service to the community, ambulance services are not able to select lucrative or profitable ventures; rather the service is there for the benefit and enhancement of the community.

2.4.2 Ambulance services are provided to the community irrespective of capacity to pay. Many clients are recipients of Government servicers and benefits payments, and have a reduced capacity or no capacity to pay for services.

2.4.3 State and territory ambulance services are registered training organisations that provide specialist industry based training. Training ranges from the non-emergency Patient Transport Officer training through to the Intensive Care Paramedic with Aeromedical or Extended Care Paramedic skills. This breadth of training services is not provided by the private sector.

3. Discussion paper consultation questions

From the discussion paper we have identified the following consultation questions which we believe are most relevant to the employees represented by the member unions of the NCAU.

Part A – Short-term reform options

Option 3.2: Meal entertainment and entertainment facility leasing benefits

Q 31 Should salary sacrificed meal entertainment and entertainment facility leasing benefits be brought within the existing caps on FBT concessions?

No.

The management of bringing meal entertainment and entertainment facility leasing benefits into the existing cap has the potential to complicate existing arrangements for employees that have arranged their affairs under existing guidelines. Further introducing these benefits within the existing cap would increase the complexity of 'manual' meal and entertainment claims (i.e. those not completed on a meal and entertainment card).

Q 32 Should the caps for FBT concessions be increased if meal entertainment and entertainment facility leasing benefits are brought within the caps? Should there be a separate cap for meal entertainment and entertainment facility leasing benefits? If so, what would be an appropriate amount for such a cap?

Yes.

The FBT concessions should be increased if meal entertainment and entertainment facility leasing benefits are brought within the caps.

No, it would increase the net administration cost to the individual. There should not be a separate cap for meal entertainment and entertainment facility leasing.

Q 33 Are there any types of meal entertainment or entertainment facility leasing benefits that should remain exempt/rebateable if these items are otherwise subject to the relevant caps?

Yes, meal entertainment or entertainment leasing benefits should remain exempt / rebateable if these items are purchased and consumed, in line with established rules.

Option 3.3: Only one cap per employee

Q 34 Should there be a requirement on eligible employers to deny FBT concessions to employees that have claimed a concession from another employer? Would this impose an unacceptable compliance burden on those employers? Are there other ways of restricting access to multiple caps?

Yes, the benefit could be regulated nationally by the ATO.

We are not aware of any instances where ambulance employees have access to multiple caps, as our constituent unions are not aware of instances where their members are employed by different ambulance services, concurrently. Ambulance employers have a requirement for staff wishing to undertake a second job to apply for permission to do so. There may be a few new employees moving from another ambulance service within an FBT year who may have salary packaged benefits at their former employment and would be eligible to package up to the full cap in a part FBT year with their new employer.

Option 3.5: Minor benefit exemption

Q 36 Should the limitation on tax exempt bodies in the minor benefits exemption be removed? Is there any reason why the limitation should not be removed?

Yes, the current limitation on tax exempt bodies in the minor benefits exemption should be removed.

Part B – Long-term reform options

Option 3.6: Phase out capped FBT concessions and replace with alternative government support

Q 37 Is the provision of FBT concessions to current eligible entities appropriate? Should the concessions be available to more NFP entities?

Yes.

The ambulance industry is a major employer of key workers and an essential service provider. The concessions should uniformly be available to all emergency service providores, based upon agreed criteria, and passed on in full to eligible employees.

The ambulance industry relies on FBT concessions to be able to attract and retain its workforce. Extending the concession to other emergency services would enable those services to assist ambulance services in delivering out of hospital health care services, in turn easing the burden on hospital emergency departments and health care services. The FBT

concessions enable the necessary shared approach to the provision of a wide range of out of hospital health and other emergency services in the community.

Q 38 Should FBT concessions (that is, the exemption and rebate) be phased out?

No.

The provision of FBT concessions is a well founded system that facilitates a positive net effect to the employer, individual recipient and community through expenditure of the benefit.

The effect of the loss of the FBT concessions on the viability of the public and NFP ambulance industry should be a major factor in the decision to phase out the concession. It is worth noting that the ambulance industry is a significant employer and mobilises a vast number of volunteers in many areas of the country. Any contraction in the industry will likely result in reduced services to the community and ultimately a reduction in beneficial social outcomes.

Q 39 Should FBT concessions be replaced with direct support for entities that benefit from the application of these concessions?

No.

There is a lack of definition of eligible entities, and the level and type of benefit to be extended to the entity, nor how the benefit will be distributed to the employee. The concessions should remain with the employees on the grounds of fairness and support of the vital role that employees play in delivery of out of hospital health care.

Option 3.7: Replace FBT concessions with tax based support mechanisms

Q 40 Should FBT concessions be replaced with tax based support for entities that are eligible for example, by refundable tax offsets to employers, a direct tax offset to the employees or a tax free allowance for employees?

A tax free allowance for eligible ambulance employees, or a direct tax offset to the employees would be a targeted benefit and easily administered by the employer.

The imperative remains that the ambulance industry and its employees as a whole should not be worse off and its viability and employment not compromised.

Option 3.8: Limit concessions to benefits that are incidental to employment

Q 41 Should FBT concessions be limited to non-remuneration benefits?

No.

The impact on ambulance employees need to be considered as they are less able to opt for non-remuneration benefits (as they are employed by public and NFP entities) and therefore there could be a significant impact on employment and staff retention.

Q 42 If FBT concessions are to be phased out or if concessions were to be limited to non-remuneration benefits, which entity types should be eligible to receive support to replace these concessions?

All entities (as individuals and bodies) affected should receive appropriate support to replace the current concessions.