

6 Reform of the Tax Regime and Subsidies for Medical Scheme Cover

6.1 Overview

According to Price *et al* (1995), the debate about the tax deduction arose primarily as a consequence of the funding crisis in the public health sector, and perceived inequality between the public and private sectors.

Employees currently contribute a certain portion of their salary to a medical scheme, with employers also making a contribution on their behalf. The Income Tax Act allows the employer's contribution to be deducted as an expense before tax. On the employee's side, a deduction is available only where an individual's medical expenses exceed 5 percent of income or R5,000. For pensioners, all medical expenses are tax deductible.

The Melamet Commission wrote that the tax deduction "*encourages consumption of health care beyond the point where the costs of obtaining extra cover equate to the value of the marginal benefits received. Price signals are badly muffled. Medical cost inflation is thus encouraged.*" (Melamet Commission, 1994, p.44).

Price *et al* (1995) concluded in their evaluation that given "... *the scarcity of health care resources in any country, the prime responsibility of government with respect to funding should be to improve the health care of the poorest in society. The very structure of the private health sector in South Africa goes against this principle, since it distributes health care resources predominantly according to ability to pay. The subsidisation of this sector by the government is not consistent with the principles of health care funding by the state. The current specific concessions allowed in South Africa are furthermore inequitable across income groups with high earners receiving a greater subsidy than low earners on medical aid, while self-employed individuals (including the whole informal sector) receive almost no subsidy at all.*"

6.2 Value of the Tax Deduction

A 1995 study (Price *et al*, 1995) estimated the net impact on the central revenue through the removal of the employer tax deduction. The analysis took account of the various offsetting influences. The study also assessed the extent to which an inflexible demand for medical scheme cover will impact differently on the Central Revenue Fund. The least flexible is 0 percent where the individual reduces private health consumption by the value of the lost subsidy. The assumed marginal tax rate used is 32 percent. Scenario 1 assumed the employer contribution is 50 percent while scenario 2 puts it at 75 percent. The analysis does not include the tax subsidy for out-of-

pocket expenses, exempted medical schemes and pensioners. The analysis suggests that the net impact on government revenue of any reduction in the tax subsidy would range from R3,2 billion to R5,9 billion. Given the inelastic demand for medical scheme cover, the true impact could be of the order of R4 to R6 billion based on the extent of the employer subsidy.

Table 6.1: Impact on the Government Revenue from a removal of the employer tax deduction (R'billion) (based on 1999 registered medical scheme expenditure and 2000 prices)

	Reduced consumption of private medical care				
	100%	75%	50%	25%	0%
Scenario 1	3,284	3,443	3,602	3,760	3,919
Scenario 2	4,927	5,166	5,403	5,641	5,880
	Per capita value of the tax subsidy				
Scenario 1	549	576	603	629	656
Scenario 2	824	864	904	944	984

Based on Price *et al*, 1995)

A microsimulation run by the National Institute of Economic Planning (NIEP) was performed for the Committee to estimate the total medical deduction allowable under income tax. The value was estimated at R7,9 billion and included both the individual's contribution as well as the employer contribution. The amount was broken down according to the following family types

- o Single individuals: R5, 056 billion;
- o Couples with no children (1 or 2 taxpayers): R2, 072 billion;
- o Couples with children (2 taxpayers): R15,576 billion;
- o Single parents: R12,662 billion.

The per capita value of coverage in the public sector ranges from just over R300 (2000 prices) in provinces such as Mpumalanga and Northern Province to around R500 in Gauteng and Western Cape excluding conditional grant allocations. When conditional grants are taken into account, in 2000 public sector per capita expenditure averages just over R700.

According to the evidence the value of tax subsidies in respect of private health care expenses exceed per capita expenditure in the public sector. In certain provinces this amount is significantly less than the estimated R1,127 available as a subsidy in the private sector. In fact the total value of the subsidy is higher than the total budget spent by the Gauteng Health Department, which effectively covers in excess of 7 million people.

6.3 National Health Insurance Committee proposals

The NHI Committee (1995) identified serious problems with the existing tax regime. *“The Committee recognises serious inequity and distortions resulting from present tax policies regarding medical scheme contributions. These disproportionately reduce the price of high-cost packages, encouraging inefficient use and allocation of medical resources. In addition, if mandatory cover is extended to all employees, the current tax treatment of contributions would result in decreases in employees’ after tax income, and would affect disproportionately on the self-employed.”*

Price *et al* (1995) recommended that tax concession be restructured as follows:

- (a) All contributions, whether by employer or employee should be considered part of an employee’s taxable income.
- (b) A fixed absolute amount (not percentage) of all medical scheme expenditure, including contributions to approved medical schemes, should be allowed as a deduction from table income before tax.
- (c) This fixed amount should ideally be set at a level so that the per capita subsidy (including dependants) is not greater than what the state spends on each individual in the public sector for personal care (i.e. individual medical care, excluding community level interventions). The amount should also not be set so that the net income of people earning less than a specified figure does not increase.
- (d) Consideration should be given to allowing that portion of total medical expenses that exceeds 15 percent of income to be deductible before tax. This would provide disaster relief for households hit by an unexpected catastrophe.
- (e) There should be further discussion and research regarding expenditure by employer on in-house medical services that benefit individuals but are not a necessary part of the occupational health service. Our provisional view is that, where possible, these should be considered benefits taxable in the hands of employees.
- (f) The policy could be implemented over a few years by increasing the proportion of the employer’s contribution which becomes taxable each year.
- (g) The Department of Health should attempt to negotiate a once-off increase in public health spending to absorb the tax windfall from removing the concession, in order to keep total health expenditure (public and private) constant. The new level of expenditure should be pegged as a percentage of total government spending.

Taking note of its findings and the above recommendations the NHI Committee proposed the following measures:

- (a) All contributions, whether by employer or employee should be considered part of an employee's taxable income.
- (b) A fixed amount of all medical expenditure, including contributions to approved medical schemes, should be allowed as a deduction from taxable income before tax.
- (c) Consideration should be given to increasing the current threshold above which medical expenses are tax deductible.

6.4 Assessment of the Tax Subsidy Framework

The existing subsidy framework has to date been considered within a fairly narrow policy framework. Furthermore, the outcomes of the policy have drifted away from the achievement of any rational public policy objectives. It is fairly clear that the subsidy policy has had an impact on the way in which the private health system has evolved. It is just as clear, however, that the concession in its existing form has had little impact on the fundamental problems of the private health system and the health system as a whole. Although it may have initially played an important role in supporting social solidarity goals within the system of private medical scheme cover, these have been substantially eroded. The subsidy in its current form promotes inefficiency and inequity rather than countering these trends.

The problems can be summarised as follows:

- Very little of the tax concession genuinely benefits the final consumers of health care services. Much of the intended cost reduction impact is lost to inefficiency in health care service provision and excessive administration costs.
- The tax concession results in a misallocation of publicly directed health resources in favour of higher income earners and private sector service providers.
- The subsidy system is an off-balance-sheet transfer to income earners and is therefore not transparent. Approximately R4 billion to R6 billion lies outside of a clear health policy framework.
- The per capita value of the tax concession appears to exceed the value of per capita expenditure in the public sector.
- There are no clear policy principles and objectives underlying the current subsidy framework.

6.5 Reform Options

Consideration needs to be given to bringing the tax concession policy into a consistent overall strategic health policy framework. This would imply that it ceases to be an implicit policy area within the domain of tax policy. Health care is functionally related to both population and income in a stable way. Revenue insecurity only creates instability in this framework and promotes

inefficiency. A restructuring of the tax concession should therefore promote transparency and certainty in revenue flows. It should also comply with public health policy in relation to equity.

A revised strategic framework should take consideration of the following:

- (a) Consideration should be given to a reconsideration of the tax subsidy within the context of strategic health policy and not tax policy.
- (b) The tax subsidy be reconsidered in favour of an explicit on balance-sheet subsidy provided to medical scheme members. The level of the subsidy should be related in some functional and rational way to the value of cover available through the public sector.
- (c) Within a broader and longer-term reform process consideration should be given to raising the subsidy through an earmarked tax in line with proposals to introduce a universal contribution of one form or another. Initially the subsidy should be funded from the increased general government revenue resulting from the withdrawal of the tax subsidy.
- (d) The allocation mechanism, whether the funds are raised from general or earmarked taxes, would need to comply with standard equity principles. Consideration should therefore be given to allocating the funds via the proposed system of risk equalisation for medical schemes discussed in **section 7**.

6.6 Prioritisation

Given that certain reforms would need to be phased in and integrated with other reforms sequencing and prioritisation is important. The following lists reforms that could be considered initially and those that would emerge in conjunction with a broader more integrated reform process:

- (a) The tax subsidy should be withdrawn for all contributions to medical schemes.
- (b) Simultaneously, the estimated increased revenues should be budgeted from general taxes, through the Department of Health budget, as a per capita subsidy to medical schemes based on the number of beneficiaries covered. The subsidy should be set per beneficiary covered and not per member.
- (c) A temporary mechanism would need to be considered for making the subsidy allocation. Ultimately the allocation would be made to a risk-equalisation fund and allocated to schemes on the basis of an equity formula (see **section 7**).
- (d) The subsidy should ultimately be raised as part of the revenue obtained from a universal mandatory contribution toward a national health insurance fund. Both the collection and distribution of funds would become incorporated within an integrated framework.