SUBMISSION ON DRAFT REVENUE LAWS AMENDMENT BILL, 2005 – SECTIONS DEALING WITH MEDICAL CONTRIBUTIONS AND EXPENSES

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Introduction

The AIDS Law Project ("ALP") welcomes the objectives underpinning Sections 27, 70 and 71 ("the Sections") of the proposed Draft Revenue Laws Amendment Bill, 2005 ("the Bill") to increase access to private health services. In this way, the Bill seeks to achieve its objective through the provision of tax subsidies for medical contributions and expenses to self employed and formally employed persons, including their dependants (beneficiaries). It also aims to remove the distinction between on site and off site medical services, an area of the proposals that we are particularly supportive of.

However, we are concerned about a number of issues, both in relation to the substance of the Sections of the Bill as the process by which it has been developed. While this submission will focus on the key substantive concerns raised by the Sections, it is important that we also place our reservations regarding the process on record.

First, we are concerned about the extremely short deadlines imposed for public comment on both the 'Discussion Document on the Proposed Tax Reforms Relating to Medical Scheme Contributions and Medical Expenses' ("Discussion Document") and the Bill.[1]

[1]The Discussion Document was released for public comment on 2 September 2005. It called on interested parties to comment on the proposals by 21 September 2005 (within three weeks). In subsequent correspondence dated 22 September 2005 with the National Treasury, the ALP noted its support for the policy objective of the proposals and given its importance, requested an extension of the deadline. On 3 October 2005, the National Treasury advised that the deadline would be extended to 10 October 2005 (a week). On 4 October 2005, the ALP requested at least until end October 2005 to submit its comments. In response, a senior official in the National Treasury advised that the 'proposals' had already been included in a Bill; that it had just been published for public comment (the day before); that National Treasury would present the Bill to the Portfolio Committee on Finance on 18 October 2005; and that Parliamentary hearings were scheduled for 19 and 20 October 2005.

Second, we believe that the current proposals should not be viewed in isolation from broader health policy reforms currently underway. In particular, several processes undertaken by the National Department of Health (NDoH) seek to redress the current inequities in the allocation of resources to the public and private health sectors. These are dealt with below.

For this reason, we believe that Sections 27,70 and 71 (read with sections 29) of the Bill should be jointly considered by the Portfolio Committee on Health and the Portfolio Committee on Finance. A joint committee is necessary given that the proposals do not only have tax implications for individual taxpayers. Instead, it directly determines the level of future tax subsidies (generated or foregone) for users of the private health sector for many years to come - since an amendment to the proposed Sections in the next few years is unlikely.

Executive summary

The amendments have the potential to reduce the tax burden on low, middle and high-income earners. However, a number of outstanding issues have to be resolved in order to do so. Below we summarise what we believe are the main outstanding issues:

- The Portfolio Committee on Health and Finance should jointly consider and finalise the Sections pertaining to medical contributions and expenses.
- The rationale for choosing Option 1A must be explained by the NT (especially if it leads to an *increase* in the current tax subsidy for middle and high income earners).
- The tax threshold and its effect on low-income earners and elderly people who fall below it must be urgently reviewed.
- The taxpayer must be able to claim for the medical *expenses* on behalf of all his/her beneficiaries.

- The benefit applicable to a taxpayer that contributes to a foreign benefit fund must be carefully considered and re-drafted.
- The benefit available to on and some off site treatment programmes must be extended to all off site programmes that provide relevant health services.

The context of health care reform

As mentioned above, several regulatory reforms are currently underway that directly impact on the proposed tax amendments. Significantly, these reforms precede the current tax proposals.

They are:

- Cabinet's approval and adoption of the *Risk Equalisation Fund* (REF) for the purposes of creating a single mechanism to fund the provision of the Prescribed Minimum Benefits (PMBs) as defined under the Medical Schemes Act, 131 of 1998.
- The *Government Employee Medical Scheme* ("GEMS"), which is expected to be operational shortly.
- The *'Charter Of The Private and Public Health Sectors Of The Republic Of South Africa'* ("the Charter"), which explicitly recognises the funding inequities of our current two-tier health system.[2]

[2] Released in August 2005, the Charter states that:

> The financing of health care in South Africa currently contributes to the inequity between the public and private health sectors. Slightly more than 38% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the national, provincial and local departments of health) while 62% flows via private intermediaries. Medical schemes are the single largest financing intermediary accounting for nearly 47% of all healthcare expenditure followed by the provincial health departments at 33% and households (in term s of out-of-pocket payments directly to health care providers) at 14% of all health care expenditure. The national and local government health departments and direct expenditure by firms account for less than 6%. … From the provider perspective, about 39% of all health care expenditure occurs on public sector providers and 61% on private sector providers. This is inequitable when one considers the number of persons treated by private sector providers as opposed to public sector providers.

The Discussion Document states that "based on current medical scheme coverage rates and medical scheme expenditure per taxpayer income group" that there is an "inequitable distribution of the existing tax subsidy" (at page 13). In our view, the amendments must be measured against governments stated objective of undoing the public-private skew in the allocation of resources.[3]

It is unfortunate that the Discussion Document does not include the amount of tax foregone by the State in the current financial year (and in preceding years) because of tax subsidies for medical contributions and expenses. This makes it difficult to assess the true impact of the proposed subsidy.

While industry sources estimate the current subsidy to be in the region of ZAR 10 billion, according to the National Treasury, using Option 1A would cost an additional ZAR 3.7 billion in the form of tax subsidies. In other words, we need to be convinced that the proposed increase (by ZAR 3.7 billion) in the current tax subsidy is justifiable.[4]

The Discussion Document and the listed 'Options'

The Discussion Document identified four possible Options (1, 1A, 2, 2A) for the proposed revised tax rebate. However, Option 1A has been chosen by the NT as its preferred 'model' for calculating the new tax rebate. It is unclear on what basis this was done.

In any event, the Discussion Document stated that Option 1A would result in an *additional ZAR 3.7 billion* tax subsidy. This is a significant amount. We have

[3] For example, the Council for Medical Scheme in its 2004 Annual Report indicates that the private sector accounted for about 7 billion rand in health expenditure in 2004 alone. The private sector consists of about 6 million beneficiaries.

[4] The Charter states that the "inequitable application of resources results in inadequate access for many. In 2003/4 medical schemes spent approximately R8 800 per beneficiary while in the public sector the figure was approximately R1050 for persons who were not members of medical schemes".

consulted with several industry players who advise, that based on their calculations, the increase in subsidy will mainly benefit middle and high-income earners.

We support the view that tax benefits may provide incentives for taxpayers and their beneficiaries to use private health services (and thereby lessen the burden on public services). However, we have great difficulty in understanding why it is necessary to *spend more* in the form of the proposed increase in tax subsidies on an already very highly subsidised and insured section of our population. Given that the objective of the proposed tax reforms is to reduce the tax burden on *low* income earners (and encourage them and their dependants to join medical schemes) it is unclear why the NT has chosen Option 1A.

We now turn to the relevant Sections in the Bill.

Section 27 (1)

This amendment deals with the applicability of the tax benefit.

The tax benefit applies to those that fall *above the tax threshold*. In other words, the amendment only applies to those who earn more than *ZAR 2971 per month*. Those that fall below the threshold are exempt form paying income tax and are therefore not in the tax system. In other words, they do not receive any tax subsidies relating to medical contributions and expenses, but neither do they receive a state subsidy for any out of pocket payments.

The Discussion Document makes it clear that the objective of the reforms is to encourage low-income earners to join medical schemes. We support this. However, what incentive exists for very low-income earners (less than ZAR 2971) to join medical schemes?

What is clear is that the proposed reforms are not fully capable of meeting its objective of getting very low-income earners to join medical schemes. It will also not benefit the elderly who fall outside of the tax system (ZAR 5000).

Therefore, the NT and NDoH need to investigate ways of creating other incentives for very low-income earners and the elderly (who earn less than ZAR 5000) to join medical schemes. In particular, considering making a state subsidy available to these groups. A single funding mechanism should also be considered.

In addition, with GEMS, a substantial number of civil servants will be mandated by law to join the government medical scheme (compulsory membership). This means that very low-income earners who are forced to join GEMS by law but who fall outside of the tax system will not benefit from these reforms. We believe that in this particular case, the rationale of the reforms should be more closely interrogated. In addition, government should make available to these workers, a state subsidy on proportionate par with the tax subsidy given to people who fall above the tax threshold.

What can be deducted?

Section 27 (1)(a)

Contributions made to a 'benefit fund' [5] in South Africa (i) **<u>or</u>** in any other country ((ii) [where it is similarly regulated] on behalf of the tax payer, his/her spouse[6] and his/her dependant/s can be deducted.

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[5] 'Benefit fund' under the Income Tax Act, 1962, as amended, is defined as:

a) any friendly society registered under the Friendly Societies Act, 1956 (Act No.25 of 1956), or any fund established before 13 June 1986 which is not so registered solely because of the provisions of section 2(2)(a) of that Act; or

b) any medical scheme registered under the provisions of the Medical Schemes Act, 1998 (Act No. 131 of 1998).

[6] Spouse under the Income Tax Act, 1962, as amended, is defined as:
In relation to any person, means a person who is the partner of such person—

a) in a marriage or customary union recognised in terms of the laws of the Republic;

b) in a union recognised as a marriage in accordance with the tenets of any religion; or

The provision as it stands, provides no incentive to join a scheme registered in terms of the MSA. We are worried about providing a rebate in *all* circumstances to a taxpayer who is making a contribution to a foreign benefit fund. In our view, in order to ensure that requisite regulatory oversight is exercised over foreign benefit funds, at a minimum, the section should ensure that a contribution to foreign benefit fund is only tax deductible if the fund complies with the MSA or it has been exempted from complying with some or all of the provisions thereof (and not just similarly regulated in another country).

This will ensure that effective regulatory oversight exists over complex regulatory areas such as risk pooling, the mandatory provision of PMBs, open enrolment and anti-selection. We support the framework of the MSA that has sought over a number of years to put in place certain mechanisms to avoid historical insurance practices of anti-selection and thereby encourage social solidarity and risk pooling amongst members and beneficiaries in South Africa. Therefore, this section needs to be slightly re-drafted to take these complexities into account.

Who can claim?

Section 27 (1) (b)

This amendment provides for a deduction for medical expenses and payments relating to three broad categories, which we will for ease of reference refer to as ‘professional services’ (i); ‘health services’ (ii); and ‘pharmacy services’ (iii). However, unlike Section 27 (1) (a) referred to above, which permits deductions for contributions made on behalf of the ‘tax payer, spouse, dependant/s’ this section only applies to expenses and payments of the ‘taxpayer, his/her spouse, his/her child, and his/her step-child’.

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c) in a same-sex or heterosexual union which the Commissioner is satisfied is intended to be permanent,

and ‘married’, ‘husband’ or ‘wife’ shall be construed accordingly: Provided that a marriage or union contemplated in paragraph (b) or (c) shall, in the absence of proof to the contrary, be deemed to be a marriage or union without community of property.

First, the word ‘step-child’ should be deleted and replaced with ‘child/ren of spouse’. The former is derogatory and an affront to the dignity of a child and his/her parent and/or caregiver. This applies to **all** references to ‘step-child’ and ‘step-children’ as it appears in the Bill.

Second, the benefit should extend to the taxpayer and all of his/her dependants - and not limited to immediate beneficiaries (spouse, child/ren, ‘child/ren of spouse’). This is particularly important given that the Discussion Document itself is hopeful that the proposed reforms will result in a broader class of dependants being registered, such as ‘aging parents and other relatives’. (See page 9 of the Discussion Document).[7]

We note that in terms of the Medical Schemes Act, ‘beneficiary’ is defined quite broadly to mean:

a) the spouse or partner, dependent children or other members of the member's immediate family in respect of whom the member is liable for family care and support; or

b) any other person who, under the rules of a medical scheme, is recognised as a dependant of a member. [8]

Because of this, for a number of years, schemes have been overseeing the total number of dependants that a beneficiary is permitted to register. Therefore, if a scheme accepts a person as a beneficiary (including spouse, child/ren, child/ren of spouse, aging parents, parents, family relatives, domestic workers, gardeners etc) then so too should our tax laws - and in particular, Section 27 (1) (b). This will not ‘open the floodgates’ as a regulatory and oversight system already exists within schemes (with rights of recourse to the Council for Medical Schemes) to ensure that taxpayers do not claim on behalf of beneficiaries that do not exist or

[7] Discussion Document, at page 9: “It is also important to note that the members of medical schemes will be encouraged to take on more beneficiaries, e.g. their aging parents and other relatives”.
[8] See Section 1 of the Medical Schemes Act, 131 of 1998.

are in fact not dependant on the taxpayer. The section should therefore be broadened to include all registered beneficiaries.

Our recommendation in respect of recognising all beneficiaries (as understood and regulated by the MSA) applies to all sections in the Bill relating to medical expenses - that at time seek to limit the benefit to immediate beneficiaries (spouse, child/ren, child/ren of spouse).

Section 27 (1) (c)

This amendment provides for expenses and payments relating to medical services and medicines incurred outside of South Africa.

Again, this section only applies to medical *expenses and payments* of the 'taxpayer, his/her spouse, his/her child, and his/her step-child'. First, for reasons already set out above, the benefit should extend to all beneficiaries and not limited to the taxpayers immediate beneficiaries.

Section 27 (1) (d)

This section provides for a deduction on *"any expenditure necessarily incurred and paid by the taxpayer in consequence of any physical disability suffered by the taxpayer, his or her spouse or child or stepchild".*

It is unclear why 'mental disability' is not included alongside physical disability. We recommend that all forms of disability should be included.

Section 27 (2)(c)

This amendment deals with the percentage (%) tax rebate available to taxpayers. We welcome that taxpayers, and particularly larger extended families, will be assisted by the allowance of a capped tax deduction for medical aid contributions for each person covered by a medical scheme.

As mentioned earlier in our submission, the rationale for choosing Option 1A over the three other Options identified in the Discussion Document is unclear. Given that the current amount of the tax subsidy is not known, it is difficult for the ALP to conclusively comment about whether the proposed increase is justifiable or not. Our preliminary view however (based on the industry estimate of 10 billion in tax foregone and the NT's own estimate of an additional 3.7 billion subsidy as a result of implementing Option 1A) is that a substantial *increase* in the current tax subsidy, which we have been advised will mainly benefit middle and high-income earners, is not justifiable.

Sub section (b) provides "… where the taxpayer, his or her spouse, child or stepchild is a **handicapped person**, the sum of the amounts …".

The drafters have in error used the phrase 'handicapped person'. This should be replaced with 'person with disability' in line with the earlier wording of the Bill [see here Section 1 (a) (d), already discussed above].

Section 71 (1)
Insertion of paragraph 12B in Seventh Schedule to Act 58 of 1962

This amendment makes provision for the tax-free provision of employer provided medical services in *certain* circumstances*.* We welcome this. For a long time the ALP, Treatment Action Campaign (TAC), South African Business Council on HIV/AIDS (SABCOHA) and the Congress of South African Trade Unions (COSATU) have advocated for the elimination of the on site - off site distinction.[9]

According to the *Explanatory Memorandum on the Revenue Laws Amendment Bill, 2005:*

[9] See attached ALP memo on FRINGE BENEFIT TAXES IN RELATION TO OFF SITE WORKPLACE TREATMENT PROGRAMMES FOR HIV/AIDS, which was presented to the Chair of the Portfolio Committee on Finance on 25 August 2004.

> "In order to assist low-income earners and their family members who cannot afford even the most basic medical scheme package but are entitled to employer provided medical care, employer provided medical care will be tax exempt in the hands of employees irrespective of where the care is provided. This concession *will apply* to employer programmes which carry on the business of a medical scheme but which have been exempted by the Registrar Council for Medical Schemes from registering as such. The employer is entitled to deduct the cost of providing this benefit in terms of existing tax law" (at page 48).

The Discussion Document also states:

> The key advantage of the proposal to cap medical scheme contributions per beneficiary and to allow the entire amount up to the cap as a tax-free fringe benefit will make medical scheme coverage more affordable for low-income earners. It is expected that the monetary cap per beneficiary will put pressure on medical schemes to reduce the price of high-cost packages. Low-income earners will also benefit from amendments to allow for tax-free fringe benefit in respect of off-site employer-provided medical treatment (at page 10).

We support the views expressed in the Explanatory Memorandum and Discussion Document. However, as Section 71 currently stands, it does not give proper effect to what is contemplated in the above documents.

To explain:

According to Section 71 (1), the new 12 B (3) (c) provides that where services are provided **on site** it is regarded tax exempt, in other words no value will be placed on it. This is irrespective of whether the benefit provides falls within the definition of 'doing the business of a medical scheme, or whether it falls within any of the PMB categories. We welcome and support this.

The new 12 B (3) (a) provides that services will be tax exempt only if:

- an employer provides *any category* of the Prescribed Minimum Benefits to an employee and his/ her immediate beneficiaries (spouse, child, step child) in terms of a workplace scheme; **and**

- where such a service constitutes the *business of a medical scheme* as understood by the Medical Schemes Act; [10] **and**
- the Council for Medical Schemes has as such granted an *exemption* from applying with all or some of the provisions of the Medical Schemes Act (assuming retrospective to March 2006); **and**
- all employees have *equal access* (equitable-unfairly discriminatory) to the said workplace programme.

(Emphasis added)

At the outset, we welcome and support the policy rationale of not attaching a value on the said benefit. Presumably, the section is dealing with **off site** services as the new 12 B (3) (c) deals with on site services.

In any event, the Section fails to deal with two very likely and possible situations. This is probably due to an oversight in the drafting process, which can be easily rectified.

First, the benefit is premised on the employer "doing the business of a medical scheme" [12B (3) (a) (i)]. The question is, what if it is not doing the business of a medical scheme, either according to the Council, the employer or a Court of law. No provision is made for such a possibility.

This is important because we believe that on a proper interpretation of the MSA, the provision of HIV/AIDS treatment both on and off site does not constitute 'doing the business of a medical scheme' and therefore does not require an exemption as is contemplated by the MSA. If this is correct, as the section currently stands, current off site HIV/AIDS workplace treatment programmes will continue to attract a fringe benefit tax in the hands of an employee. The

[10] Mainly that it collects monthly contributions, accepts liability on behalf of X and his/her beneficiaries and defrays medical expenses on their behalf.

Discussion Document clearly states that this not the intention of the reforms. 12 B (3) (a) needs to be re-drafted.

In any event, we submit that the provision of relevant health services off site– irrespective of whether it falls within the definition of doing the business of a medical scheme should be tax exempt (such as all on site services).

We therefore propose the insertion of a new clause to the following effect:

> 'In the event that a benefit that is provided off site is not doing (or is determined as not doing) the business of a medical scheme, no value will be attached to the benefit'.

This is because, in any event, the Council for Medical Schemes will regulate and oversee whether a benefit falls within the definition of 'doing the business of a medical scheme'. Unless such a clause is added, the section as it stands gives the benefit solely to off site programmes that are 'doing the business of a medical scheme' with the requisite exemption, and nothing beyond.

Second, as the amendment currently stands, in the event that an employer chooses to provide treatment / services off site that do not fall within any of the narrow categories of the PMBs, the tax benefit does not apply [12 (3) (a)]. Surely, this was not the intention of the drafters. It will discourage employers from providing anything more than the narrow category of PMBs (which are only regarded as basic minimum package of services).

In addition, our health system is premised on primary health care (PHC), which currently are not included as part of our PMBs. The section will therefore discourage employers from providing off site PHC services and thereby increase the PHC burden of our public health system. The reference to PMBs should therefore be deleted, as it is a very narrow category of relevant health services.

Instead, the section could refer to 'relevant health services', which are generally offered as part of or over and above the PMBs - Paragraph 12 B (3) (a) should therefore be redrafted.

The sentence "*listed in any category of the prescribed minimum benefits determined by the Minister of Health in terms of section 67(1)(g) of the Medical Schemes Act, 1998 (Act No. 131 of 1998)*" should be deleted.
Perhaps the phrase 'relevant medical services' (as defined in the MSA) should be used.[11]

In addition, the benefit should extent to all the beneficiaries of the employee and not limited to "spouse, child or step-child". This is because we have been lobbying business to extend off site treatment programmes to all dependants – as this reduces the burden on the public health sector. A failure to extend the benefit to all beneficiaries will limit the scope and reach of employer funded health services.

Finally, 12 (3) (a) (ii) provides that "all employees of that employer are entitled to participate equally in that scheme or programme". We disagree. The amendment should insist on equity in access not equality. For example, a worker who belongs to a medical scheme should NOT have access to employer-funded services on or off site. The service should only be available to those workers who

[11] Relevant health service means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object-a) the physical or mental examination of that person; b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency; c) the giving of advice in relation to any such defect, illness or deficiency; d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof; e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or f) nursing or midwifery, and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practiced, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy.

do not belong to a medical scheme, that is, those who cannot afford to join a scheme.

Conclusion

We appreciate and welcome the attempts by the NT to try to reform the mal-distribution of resources in the public and private sectors. However, tax reforms are just one step towards increasing equity and access in health care. This is because tax reforms do not cover large sections of our population that are not part of the tax regime. Clearly, government has to address and investigate alternative ways of providing subsidies for very low-income earners and the elderly – especially those who are forced to make use of the services of the private health sector. Hopefully, this will be the start of a much needed process of looking at how, as a country, we can create a single funding mechanism to cater for the needs of all people who need access to quality and affordable health care services.

Cape Town

18 October 2005

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