



**Johannesburg**

PO Box 4056 | Cramerview 2060

**Tel** 011 884 0270 | **Fax** 011 884 5672

**Email** [fmf@mweb.co.za](mailto:fmf@mweb.co.za)

**Cape Town**

PO Box 805 | Cape Town 8000

**Tel** 082 941 5375

**Email**

[tembanolutshungu@fmfsa.org](mailto:tembanolutshungu@fmfsa.org)

**Durban**

PO Box 17156 | Congella 4013

**Tel** 031 572 3308 | **Fax** 031 572 3308

**Email** [jassonurbach@fmfsa.org](mailto:jassonurbach@fmfsa.org)

14 October 2016

**Submission**

**to the**

**Davis Tax Committee**

**on the**

**funding of the National Health Insurance (NHI)**

**as covered in Chapter 7 of the White Paper**

## About the Free Market Foundation

The Free Market Foundation (FMF) is an independent public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations, and sponsorships.

Most of the work of the FMF is devoted to promoting economic freedom as the empirically best policy for bringing about economic growth, wealth creation, employment, poverty reduction, and human welfare. As a think-tank the FMF's fundamental approach to policy questions is consumer-based. Individual consumer choice is placed at the centre of any policy recommendations that the FMF espouses. Consumer satisfaction is generally achieved by an absence of barriers to entry into the provision of goods and services, allowing consumers a choice between the offerings of freely competing providers, and the absence of regulations that impose avoidable costly burdens on the providers of goods and services.

## Introductory Comments and Opening Remarks

The National Department of Health (NDOH) published its latest policy proposals on the planned National Health Insurance (NHI) in the Government Gazette on 10 December 2015 (the White Paper), and invited interested persons to submit comments and representations on the White Paper policy proposal. The FMF welcomes the opportunity to participate and provide input in this critical debate.

The FMF is dedicated to promoting a sound economic policy approach to the provision and funding of health care. The FMF maintains that the private supply of competitive health care services and the incremental extension of private funding is the most effective method of supplying high quality health care to the entire South African population.

The FMF urges government to devote its limited health budget to the supply of services to the poor, to purchase an increasing percentage of those services from private providers, and to allow and encourage the rapid growth of the private healthcare sector, enabling it to provide services to an increasing percentage of the population.

*It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medication somehow think that we can afford to pay for doctors, hospitals, medication and a government bureaucracy to administer it.*

*Thomas Sowell*

This submission demonstrates that the consequences of adopting the proposed National Health Insurance (NHI) scheme are entirely predictable. We believe that it is neither necessary nor appropriate for government to provide "free healthcare for all" because doing so is not a particularly good use of scarce taxpayer resources. Having taxpayers funding healthcare for those who can't afford it is one thing, but to insist on interfering in the arrangements of those who can afford it is counter-productive and unnecessary. The proposed National Health Insurance will:

- Reduce the quality of healthcare provision;
- Drive more healthcare professionals out of the country;

- Create a bureaucracy entirely incapable of handling the huge volume of claims; and
- Impose an unnecessary and intolerable burden on both government and taxpayers

At the outset we wish to voice our concern that despite 40 different versions, and a period of over four years having elapsed since the publication of the Green Paper on NHI, South Africans are no closer to understanding any of the material details of the proposed NHI including, but not limited to: how much the proposed scheme will cost, where the funding to finance the scheme will come from, and where we will obtain the additional personnel (both medical and bureaucratic) to staff the ambitious proposal. Yet the government appears to be going ahead with the NHI scheme and in fact we are now entering the second phase of implementation of the project. We are concerned given the conspicuous absence of the material details underlying the proposed scheme that this is a politically motivated event that will not materially improve the health outcomes of the poorest and most vulnerable members of society and may in fact do more harm than good.

*Our fear is that the proposed NHI will fail to meet the expectations of the poor, will leave medical scheme members (including the working poor) worse off, will be massively expensive or even completely fiscally unaffordable, and will require far more doctors and nurses than are available. The danger is that it could well become a highly costly failure that will further increase frustration with service delivery.*

*Professors Servaas van der Berg and Heather McLeod*

### **NHIs Proposed Funding Options**

In his 2016 state of the nation address, President Jacob Zuma stated, “To achieve our objectives of creating jobs, reducing inequality, and pushing back the frontiers of poverty, we need faster economic growth. When the economy grows fast, it delivers jobs. Workers earn wages and businesses make profits. The tax base expands and allows government to increase the social wage. We must act decisively to remove domestic constraints to growth. We cannot change the global economic conditions, but we can do a lot to change the local conditions”.

According to John Kane-Berman from the South African Institute of Race Relations, “Fifteen years ago there were 312 people employed in this country for every 100 on social grants. Now, because we have extended social security faster than we have generated jobs, there are only 86 people employed for every 100 on social grants”. The National Development Plan adopted in 2012 warned that South Africa might one day not have enough taxpayers to finance its social security commitments. Since then the risk of running out of taxpayers has increased. As President Zuma correctly noted, the solution is not to remove the grants, but to get more people into work.

The Davis Tax Committee (DTC) acknowledges that in order to implement the NHI, “the tax to GDP ratio will need to rise quite significantly”. In the White Paper, the NDOH acknowledges the government’s preference for a broad tax base and low tax rate, rather than a narrow tax base and high tax rate. Economic growth, it correctly notes, is a prerequisite for the expansion of the tax base. But, as this section shall demonstrate, South Africa has an extremely small (or narrow) tax base and the country’s economic growth forecast is dismally bleak.

I contend that for a nation to try to tax itself into prosperity is alike a man standing in a bucket and trying to lift himself up by the handle.

*Winston Churchill*

In this tough economic climate many South Africans are feeling the pinch as their household debt rises and disposable incomes fall. An over-taxed middle class is naturally feeling cheated as it is being forced to fork out increasing amounts of tax. In 1994, for every rand of tax taken by government, taxpayers kept R2.62, whereas today we keep only R1.54. The economy grew 2 percent last year, but the tax to gross GDP ratio increased to 25.7 percent from 24.9 percent and the economic growth forecast for 2016 is a meagre 0.6 percent.

More importantly, the White Paper states, “NHI financing requirements are uncertain...”. Let us try add some certainty by looking at the joint publication by National Treasury and the South African Revenue Service: Tax Statistics, 2015. According to the joint annual publication of the National Treasury and the South African Revenue Service (SARS) there were 18.2 million individuals registered for personal income tax for the 2014/15 tax year. But just because someone is registered for tax doesn’t mean they actually pay personal income tax. Of course everybody pays tax because everyone pays VAT, but PIT is the government’s main source of tax revenue – comprising 35.9% of total tax revenue – and is considered the main source of revenue for financing the NHI. Of the 6.6 million people that were liable to submit tax returns, SARS assessed about 5 million (approximately 75%). If we disaggregate the data, we find that the top 10 per cent of taxpayers (approximately 480,000 individuals) with taxable income in excess of R500,000 per annum, account for over half (57.3%) of the total income tax assessed.

If we include those with a taxable income in excess of R120,000 per annum, we find that approximately 3.4 million people (68%), account for 99 per cent of the total personal income tax payments. It should be clear that South Africa has a very narrow tax base and as the White Paper states, “A narrow tax base requires higher tax rates while a relatively broad tax base requires lower tax rates to generate the same amount of tax revenue. To the extent that high tax rates tend to cause distortions, lower rates and a broad tax base should be preferred”. Given South Africa’s narrow tax base, it’s surprising that the government is even considering imposing yet another tax on already overburdened taxpayers rather than trying to get more people actively involved in the workforce

The “uncertain” funding sources proposed in the White Paper will be difficult if not impossible to implement. Government should use funds already at its disposal and not impose further taxes on an already overtaxed population. Proposed mandatory payments into a central NHI Fund will crowd out private insurance as many individuals, unable to pay voluntary private insurance premiums as well as the compulsory NHI Fund payments, will be forced to move to an already over-stretched, public health service.

Given South Africa’s level of economic development and vast social problems, which include but are not limited to, a high level of unemployment, poverty and high crime rates; it is seriously doubtful whether we are in a position to afford an ambitious proposal such as the NHI. We are of the view that the introduction of an NHI will place an unnecessary and intolerable burden not only on South Africa’s people but also the South African government – a burden that will be felt for many generations to come if it is introduced.

Once again we can only speculate how it is envisaged that the proposed system will be funded. But it has been suggested that the NHI will be funded out of either:

- A surcharge on taxable income;
- A specific progressive payroll tax for taxpayers above a minimum tax threshold;
- An increase in value added tax (VAT), or
- A combination of these three sources.

But before the government contemplates introducing yet another tax (or increasing any existing tax rate), it is important to consider the implications.

### **Increasing VAT hurts the poor**

Although some individuals might find the idea of raising VAT to fund NHI politically palatable, raising VAT is a bad idea as it will disproportionately affect the very people that it is supposedly trying to assist because VAT is what economists refer to as a regressive tax. Whether rich or poor, the amount we pay on a certain product as a percentage of its price is the same. The tax burden for a given product, therefore, forms a larger share of a poor person's income than that of a rich person. Increasing VAT will therefore make poor people worse off and will increase inequality.

The Davis Tax Committee (DTC) acknowledges this fact in its first interim report on VAT. The DTC finds that "...an increase in VAT would have a greater negative impact on inequality than an increase in personal income tax or company income tax. Should it be necessary to increase the standard rate of VAT, it will be important for the fiscal authorities to think carefully about compensatory mechanisms for the poor who will be adversely affected by the increase. A range of measures should be considered, such as increases in social grants or the strengthening of the school nutrition programme".

Increasing taxes on the sickest and most vulnerable members of society and then off-setting the tax with a compensatory mechanism is counterintuitive. The South African government needs to bear in mind that it should not prevent people improving their quality of life, especially the poorest members of society. If we assume the South African government wants a healthy and productive workforce, a more logical approach would be to eliminate VAT on pharmaceutical products and devices in order to increase access to these goods. For example, exempting medicines – or at least medicines contained on the WHO's Essential Medicines List – from VAT would have a number of beneficial outcomes.

These include but are not limited to the following:

- Increase access to medicines by lowering the cost of pharmaceutical drugs.
- Reduce the cost of self-medication, encouraging patients not to use their GP when it is not necessary.
- Reduce the administrative burden for community pharmacies (and the Treasury) who have to reclaim VAT.

Taxes on medicines are highly regressive and severely penalise the poorest and most vulnerable members of society. In a democratic state, removing them should be both politically popular and feasible. Rather than increasing VAT in order to fund the proposed NHI scheme and in the process "hurting poor people to help them", the government should first consider eliminating taxes that keep essential medicines out of the hands of the poorest of the poor and reducing the VAT burden.

## **Surcharge on taxable income and a payroll tax**

Taxes interfere with the ability of individuals to pursue their goals and as the White Paper correctly points out, increased economic activity is the key. The White Paper states, “...Increased economic activity ultimately contributes to poverty alleviation, better quality of life and human development and will reverse the significant income inequalities in the country”. But one of the surest ways to boost economic activity is to reduce taxes and encourage savings and investment.

It should be noted that a lack of investment retards capital accumulation and a lower capital to labour ratio reduces real wages and perpetuates the poor savings and investment cycle. Without investments to fund and establish new ventures that create jobs, the smaller the economy and the lower the economic growth rate will be. The government would therefore do well to avoid inflicting further pain on South Africans by increasing taxes. However, the White Paper actually acknowledges as much. The White Paper states, “A higher overall personal income tax burden would impact on the disposable income of households and...on consumption expenditure and economic activity. A further concern with this option is the potential negative impact on savings”.

Since the main funding option for the NHI scheme will necessarily come from a surcharge on taxable incomes and or a payroll tax, the NHI would be a tax on labour. A payroll tax is ultimately borne by workers, either in reduced compensation or job losses. Once again, the White Paper acknowledges the link between payroll taxes and reduced employment opportunities. It states, “Payroll taxes...add to the costs of employment... (and) the impact of higher payroll taxes on overall employment and job creation has to be considered carefully. High payroll taxes can lead to a bias against formal sector employment, and an increase in informal and unprotected work...”.

Forcing employers to do “the right thing” may be politically attractive rhetoric for politicians, but such efforts would effectively lower wages and destroy jobs – precisely the opposite of what the poor in this country require. As noted previously a tax on labour leaves workers less disposable income to spend on things that improve their lives, and less money for savings and investment. It worth reiterating that without investment to fund new ventures, there will be fewer job opportunities and lower economic growth. So while the NHI scheme is supposed to help people access medical care, it would instead undermine their chances of economic success by either cutting their wages or eliminating their jobs altogether. In short, adopting the proposed NHI has the potential to wreck South Africa’s already weak economy. Government spending has to be curbed. The government must adopt policies that promote economic growth and address unemployment, which has relegated almost 9 million South Africans to lives of hopelessness.

The NHI white paper notes that “productive public expenditure” will encourage economic growth, ignoring that the government has customarily mismanaged funds and resources, especially within the government health infrastructure. Rising expectations and the government’s willingness to continuously spend more, will place an impossible burden on taxpayers. The recent leadership fiasco within the finance ministry is no consolation.

We found the following statement contained in the White Paper both confused and confusing: “In the long run households will also benefit from increased disposable income as a result of a significantly lower mandatory prepayment”. There is currently no mandatory prepayment – all contributions to private medical schemes are voluntary – and thus it is impossible to pay an amount

“significantly lower” than zero. More importantly, the proposed NHI will itself introduce a mandatory prepayment – that is the basic underlying premise of the NHI. Moreover, despite the lack of clarity contained on the funding options that are to be used to raise taxes to fund the NHI, what is clear is that taxes will undoubtedly rise – as the DTC has confirmed – and thus disposable incomes will ipso facto fall.

### **How much will NHI cost?**

The White Paper figures are based on “a modified costing from the Green paper on NHI”. This leads to a number of questions such as:

- Why after a period of no less than four years having elapsed since the publication of the Green Paper have there been any new cost estimates?
- Where is the Treasury’s analysis that was supposed to be released in conjunction with the White Paper?
- What are the costing figures based on – the White Paper has still not provided any details on the so-called “comprehensive package of health services?

*If you think health care is expensive now, wait until you see what it costs when it’s free!*

*P.J. O’Rourke*

In an interview with the Business Day the Minister of Health dismissed the costing figures presented in the White Paper. He stated, “NHI is a long-term project that should be financed on a programme-by-programme basis”. Setting aside the fact that the Minister should have known what was presented in the White Paper, something that he signed off, we dispute the assertion that NHI will be adopted on a programme-by-programme basis, since as the White Paper states, “NHI represents a substantial policy shift that will necessitate a massive reorganisation of the current health care system, both public and private...”. Moreover, we found the following statement “...focussing on (the) question of ‘what NHI will cost’ is the wrong approach” disingenuous.

Without any consideration of costs, adopting the NHI could be potentially disastrous considering the very serious implications for the economy of adopting the scheme. Given the lack of details on what exactly the NHI will cover at this point it’s impossible to do an exact calculation of what the NHI will cost. However, we have done some “back of the matchbook calculations” and if we assume a modest R567, which happens to be average cost per beneficiary per month for the Prescribed Minimum Benefits, then the cost per person per annum is R6,804. Considering SA’s population of approximately 54 million people, we can estimate that the NHI will cost about R367.4bn per year. When one considers that in 2014/15 tax year, total personal income tax collections – government’s main source of tax revenue – only amounted to R353.9bn, we start to get some idea of the futility of this ambitious proposal.

Prof Anne Mills (Head of the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine) had to say as part of her input into the 1994 Finance Committee that was established by the Department of Health to advise on NHI. Professor Mills, succinctly summed up the situation regarding the appropriateness of a NHI-style system for South Africa:

It is clearly financially unaffordable to offer universally either the benefits currently on offer in medical aid schemes, or free and complete in the public sector. Benefits would therefore have to be severely restricted. However, it is difficult to see how this can be achieved because the setting up of a universal scheme would raise expectations about access to care. Moreover, the scheme would put in place a financing mechanism before having in place the health service infrastructure to satisfy demand. Benefits would inevitably be unevenly available, causing justifiable grievance.

*Professor Anne Mills*

Jasson Urbach  
Director

**PLEASE NOTE**

Attached below is the FMF's submission to the High Level Panel on **making healthcare affordable**.



## **Free Market Foundation submission to High Level Panel on MAKING HEALTHCARE AFFORDABLE**

To: Committee 1 (Triple Challenges of Inequality, Poverty and Unemployment)

High Level Panel on the Assessment of Key Legislation

By: Free Market Foundation

### **1. The Free Market Foundation**

The Free Market Foundation (FMF) is an independent non-profit public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations and sponsorships.

### **2. Overview**

Please note: The bullet points below are supported by attached documentation.

- If South Africa wants better health outcomes, it must have economic growth. It is intuitive that there is a strong relationship between income and health, not least because greater wealth buys greater access to the basic determinants of health: nutrition, better accommodation and sanitation.
- This relationship was confirmed by a seminal 1996 study by economists Lant Pritchett and Lawrence Summers, who showed the dramatic effect that increases in incomes can have on health. Pritchett and Summers found a strong causative effect of income on infant mortality and demonstrated that, if the developing world's growth rate had been 1.5 percentage points higher in the 1980s, half a million infant deaths would have been averted.
- The FMF maintains that the private supply of competitive health-care services and the incremental extension of private funding is the most effective method of supplying high quality health care to the entire South African population.
- Government should not be in the business of providing healthcare to all South Africans. Rather, government should devote its limited health budget to the supply of services to the indigent, to purchase an increasing percentage of those services from private providers, and to allow and encourage the rapid growth of the private healthcare sector, enabling it to provide services to an increasing percentage of the population.
- The FMF contends that public healthcare is not in fact cheaper than private healthcare and that this assertion misdirects public policy in the healthcare arena.
- Given the revealed preferences of South Africans, to access private medical facilities whenever possible, reforms should focus on enrolling more individuals in private medical schemes. This will reduce the burden on public sector healthcare facilities and free up scarce taxpayer resources so that the government can focus on purchasing the best available care from privately competing healthcare providers.
- Far from marginalising medical schemes, government should be promoting their proliferation because regular, small, fixed payments to a medical scheme make intuitive sense, as opposed to the rare but devastating high out-of-pocket payments required when illness strikes.
- Considering South Africa's relatively small tax base and thus limited available pool of revenue, and given our chronic levels of unemployment as well as our limited number of skilled

healthcare personnel, the proposed National Health Insurance scheme is simply inappropriate for South Africa. Moreover, attempting to provide universal coverage is not a particularly good use of scarce resources since each additional rand committed to healthcare expenditure necessarily precludes funding for other objectives, which may be more efficiently utilised at the margin.

- The economic consultancy, Econex, has demonstrated that the proposed National Health Insurance scheme faces a R200 billion shortfall by 2025-26 – almost double the amount initially anticipated by the Department of Health.
- The FMF contends that in order to alleviate the chronic shortage of skilled medical personnel in South Africa, a short-term response would be to allow more skilled foreign health professionals to practise in South Africa. The majority of foreign doctors in South Africa work in rural areas – without them the rural system would be sure to collapse. Foreign doctors with the appropriate skills can alleviate the chronic shortages virtually overnight as opposed to training doctors in South Africa (or foreign nations that have completely different diseases profiles and often don't even speak the same languages).
- A longer-term strategy to alleviate the chronic staff shortages requires the government, and more specifically, the Department of Education, to relax the controls on tertiary education facilities, make entrance to these facilities less restrictive, and allow the private sector to provide a large percentage of tertiary medical education for doctors. If private education facilities are established they could operate on either a for-profit or non-profit basis and would have the potential to relieve a significant part of the burden currently faced by the public sector.

### **3. The FMF's alternative solutions to improved health care for all**

- Encourage more private hospitals by deregulating the industry and eliminating Certificates of Need. **See FMF submission.**
- Remove price controls, which send mixed messages to the industry. **See FMF submission.**
- Zero rate VAT on all medicines being sold legally within South Africa. **See FMF submission.**
- Remove prescribed minimum benefits provisions. **See FMF submission.**
- Focus on funding the indigent ie finance health care for the poor – preferably via state-sponsored vouchers, which the indigent can spend where they choose.
- Reduce prices and increase health care quality through increased competition.
- Train more doctors and nurses (the number of doctors is limited to 1,300 a year; this number has remained the same since the 1970s despite increases in the population and the disease burden).
- Allow the private sector to train doctors and nurses.
- Encourage income-producing medical tourism.
- Retain skilled South Africans and attract others by removing the limit on skilled foreign doctors.
- Deregulate medical schemes so they can offer their clients exactly what they want.
- Deregulate pharmacies.
- Speed up registration of clinical trials.
- Give those who pay for their own health care a tax deduction.

**Attachments**

1. Submission: Encourage more private hospitals by deregulating the industry and eliminating Certificates of Need.
2. Submission: Remove price controls, which send mixed messages to the industry.
3. Submission: Zero rate VAT on all medicines being sold legally within South Africa.
4. Submission: Remove prescribed minimum benefits provisions.

## **Free Market Foundation Submission on the National Health ACT**

To: Committee 1 (Triple Challenges of Inequality, Poverty and Unemployment)  
High Level Panel on the Assessment of Key Legislation

By: Free Market Foundation

### **1. The Free Market Foundation**

The Free Market Foundation (FMF) is an independent non-profit public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations and sponsorships.

### **2. Introduction**

Affordable and quality healthcare is innately important to overcoming the triple challenges of inequality, poverty, and unemployment in South Africa. Individuals spend substantial amounts of their money on their medical needs, meaning that in the case of the poor, they often lack access to healthcare completely or need to spend well over half of their income on it. It is with this in mind that it is of fundamental importance that the government not exacerbate the cost of healthcare, and allow competition in the market as to keep prices as low as they can possibly, and responsibly, be.

In terms of sections 36 to 40 of the National Health Act (61 of 2003) health agencies may not be established or substantially expanded without applying for and getting a 'certificate of need' from the Director-General of Health. Certificates of need are intended to match health services provided in a particular geographic area with the medical needs of the population in that area. It certainly amounts to an attempt by the government to centrally plan the healthcare market, which, despite the best of intentions, has and will lead to higher costs and monopolisation and harks back to an era of apartheid-style social planning

Because sections 36 to 40 of the Act have very little basis in rational economic thinking, we submit that they must be repealed in toto from the Act. Note: These sections were promulgated and then retracted by the Constitutional Court but they still remain in the Act.

### **3. Certificates of need are economically unfeasible**

Section 36(1)(a) provides that new healthcare agencies, such as clinics or hospitals, cannot legally be established without a certificate. Section 36(1)(b) further provides that existing agencies cannot expand in terms of the amount of beds or technology they may acquire.

Logic dictates that these provisions, firstly, benefit existing large healthcare companies at the expense of small and emerging companies, because new health agencies must go through the process of applying and being approved for a certificate of need, which costs a substantial amount of money for startups. Secondly, the provisions hinder existing companies which have already proven their market sustainability and quality service to the public, from expanding. Therefore, the Act not only has the effect of being a barrier to healthy competition, but also has the very perverted effect of denying healthcare at an existing facility (which seeks to expand its capacity), to untold numbers of South Africans.

Perhaps most troubling is that section 40 of the Act criminalises the act of providing healthcare.

Bear in mind that these provisions do not relate to standards of medical quality or health and safety regulation, but instead to a political desire to 'rationalise' the provision of healthcare. Our society is plagued by a lack of access to healthcare, and it is in this light that we believe it is neither morally nor economically justifiable to hold the threat of imprisonment over South Africans who seek to provide desperately needed services to their fellow countrymen.

#### **4. Case study: the United States of America**

Certificates of need are not a South African invention. In fact, they have been tried elsewhere, most notably in the United States of America. Certificates of need were mandated on the federal (national) level in America from 1972 onward, and were also adopted in various states. The United States has the highest health expenditure per capita in the world and a significant explanation for this, as will be demonstrated below is in large part due to the certificate of need laws that artificially cause prices to rise due to the effect that they have on blocking potential competition.

The United States federal government realises this error and repealed the certificate of need legislation in the early 1980s on the national level. Some states, however, have kept their certificate of need laws, which created the opportunity to compare states with, and without, such laws. Healthcare costs are 11% higher in the states which kept certificate of need laws than in those which did not.

The American Federal Trade Commission and Department of Justice said the following in a 2004 report:

"The Agencies' experience and expertise has taught us that Certificate-of-Need laws impede the efficient performance of health care markets. By their very nature, CON laws create barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs. Together, we support the repeal of such laws, as well as steps that reduce their scope."

South Africa should take heed of the American experience. It was not their context which necessitated the repeal of certificate of need laws, but rather the ordinary and widely-accepted principles of economics which apply just as much to South Africa as they do to the United States.

#### **5. Conclusion**

In light of the above, the FMF proposes that sections 36, 37, 38, 39, and 40 of the National Health Care Act be repealed in their entirety.

## **Free Market Foundation Submission on the Medical Schemes ACT**

To: Committee 1 (Triple Challenges of Inequality, Poverty and Unemployment)  
High Level Panel on the Assessment of Key Legislation

By: Free Market Foundation

### **1. The Free Market Foundation**

The Free Market Foundation (FMF) is an independent non-profit public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations and sponsorships.

### **2. Introduction**

The triple challenges of inequality, poverty, and unemployment cannot be seen as distinct from the healthcare needs of millions of impoverished South Africans. The government has in various ways attempted to address healthcare concerns, most recently, with the proposed introduction of the National Health Insurance (NHI) programme, which the FMF believes is deeply flawed and may result in unintended, harmful consequences.

In this submission, however, the FMF wants to address the Medical Schemes Act (131 of 1998), which introduced open enrolment, community rating, statutory solvency requirements, and prescribed minimum benefits into the medical schemes market.

### **3. Community rating and open enrolment**

Community rating means health insurers must charge the same price to all members regardless of their age, sex, or health status. Open enrolment means they must accept anyone, regardless of age, sex, or health status, into the scheme. This is provided for in section 29(1)(n) and (s) of the Act.

Unfortunately, despite the good intentions underlying these principles, they have the effect of driving healthy and poor individuals out of medical schemes, while incentivizing mostly the elderly to join them. The consequence is that the risk pool of insured people becomes smaller and less healthy, driving up contribution levels and making health insurance unaffordable.

Medical schemes must be able to 'risk rate' individuals and vary their premiums. This places the responsibility of individuals' health in their own hands. This will reward healthy behaviour and not unduly push younger, and, inevitably, poorer, individuals out of the potential benefits of medical schemes.

### **4. Prescribed minimum benefits**

In terms of section 67(1)(g) the Minister of Health may prescribe the scope and level of minimum benefits to which clients of a medical scheme shall be entitled. By 2001 there were 295 conditions which all medical packages had to cover.

While this seems just and fair, the economic consequences of this are harmful. Medical schemes are now unable to tailor packages for certain demographics, such as younger and older individuals, and have to offer the same package across the board insofar as the minimum benefits are concerned. This makes packages more expensive than they otherwise would be, especially for younger clients who do not have the same level of healthcare needs as the elderly.

As Jasson Urbach, the FMF's Health Policy Unit director writes:

"PMBs act as a de facto entry barrier because they prevent actuaries from designing low-income insurance packages... The consequence is that low cost medical schemes that cover the specific basic needs of low-income people cannot be designed accordingly."

Prescribed minimum benefits seem very attractive on paper, but in reality only cause fewer people to buy into medical schemes because they artificially raise the price of medical scheme cover.

## **5. Statutory solvency requirements**

In an effort to ensure medical scheme members are not adversely affected by the insolvency of their scheme, the government introduced statutory solvency requirements whereby the accumulated funds of schemes must be at least 25% of the gross annual contributions to the scheme. While this seems logical, the solvency ratio was not determined with how medical schemes function.

According to the Actuarial Society of South Africa, solvency is an asymptotic function of contribution increase. In other words, the higher the solvency requirement, the greater the increase required to improve solvency by 1 per cent. For example, increasing the solvency requirement from 10 per cent to 11 per cent requires a contribution increase of 1.39 per cent. However, increasing the solvency requirement from 24 per cent to 25 per cent requires an increase of 2.07 per cent in contributions. Increasing the solvency requirement drives up membership contributions disproportionately and this negatively affects the rate of increase in the number of members entering a scheme.

The statutory solvency requirements introduce a considerable regulatory bias in favour of some medical schemes and against others. A scheme that has accumulated reserves that exceed the required minimum is in a better position to attract new members than one that has a shortfall. It will be particularly difficult for new medical schemes to enter the market and rapidly growing schemes will be at a disadvantage relative to slowly growing ones. This is not a desirable situation given the substantial expected future demand for healthcare in the country.

## **6. Conclusion**

In light of the above, the FMF proposes the following:

1. That age, sex, and health status be removed as prohibited criteria from section 29(1)(n) and (s) of the Act.
2. That the prescribed minimum benefits provisions of the Act be removed, or at the very least, exempt low-income benefit options from having to cover PMBs so that medical scheme actuaries are in a position to devise more affordable options
3. That the statutory solvency requirements in the regulations under the Act be determined (if at all) with due regard to the functionality of medical schemes.

## **Free Market Foundation Submission on Medical Price Control Regulations**

To: Committee 1 (Triple Challenges of Inequality, Poverty and Unemployment)  
High Level Panel on the Assessment of Key Legislation

By: Free Market Foundation

### **1. The Free Market Foundation**

The Free Market Foundation (FMF) is an independent non-profit public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations and sponsorships.

### **2. Introduction**

Affordable and quality healthcare is innately important to overcoming the triple challenges of inequality, poverty, and unemployment in South Africa. Individuals spend substantial amounts of their money on their medical needs, meaning that in the case of the poor, they often lack access to healthcare completely or need to spend well over half of their income on it. It is with this in mind that it is of fundamental importance that the government not exacerbate the cost of healthcare, and allow competition in the market as to keep prices as low as they can possibly, and responsibly, be.

The 'Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances', which was promulgated in terms of section 22G of the Medicines and Related Substances Act (101 of 1965), unfortunately props up such a substantial barrier which has the effect of hindering competition and pushing prices up.

Most pressingly, it reintroduces price controls, which were rightfully dismantled in other sectors and industries after the end of Apartheid. Price control is a complete departure from sound economic policy and has consistently led to harmful consequences for the most vulnerable individuals in society. There is no reason to believe that it is any different this time.

The FMF submits that the price control provisions in these regulations be repealed, and that the Regulations as a whole be brought into line with the Constitution and the rule of law.

### **3. The problem of price controls**

Attempting to control the price of any good or service from a position of force, rather than by making use of ordinary market forces, causes often irreparable harm to consumers. In the absence of controls, consumers have the power to punish or reward providers based on the quality of their performance. This applies at every stage of the production and consumption process, and applies to ordinary 'civilian' consumers as well as large corporate or state consumers.

The pricing function is one of the most important roles the market fulfils in society. It sends 'signals' to buyers and sellers which can be traced back all the way to the natural resources which have been used to produce the end product. As consumer tastes and needs change on a continuous basis, demand for a particular product also rises or falls, which leads to the price rising or falling. This sends signals to the manufacturers to adjust the supply of the product.

Government controlled prices require a protracted research and consideration period, and, once set, cannot be quickly or spontaneously adjusted to meet changing market circumstances. Price controls



distort the pricing mechanism and interrupt the dynamic demand and supply process. How are pharmaceutical manufacturing companies to cope with the plummeting rand which has greatly increased the price of the imported active ingredients on which they rely to manufacture their products?

#### **4. Allow private negotiations**

The Health Department has taken an irrational and highly confrontational stance toward private healthcare providers, with the Minister threatening to take control of almost every aspect of the private healthcare sector. As mentioned above, this posture has and will continue to reduce competition and force prices up.

In 2004, the government introduced the Single Exit Price (SEP) mechanism which is applied to all medicines supplied to the private healthcare sector. SEP compels all manufacturers and importers to sell their products at the same price to all of their private sector customers, regardless of the size of the order, and prohibits them from offering any discounts. The most perverted aspect of this, however, is the fact that this regulation does not apply to the government. The government is entitled to discounts for private manufacturers and imports, and it has taken advantage of this with certain medicines being made available to the state at around 1/10th the cost to the private sector.

#### **5. Constitutional concerns**

The formulation process of the Regulations also invites concern. Section 22G of the Act, in our view, does not give the Minister or the pricing committee the power to prescribe the price of medicines. Even if it did, however, such far-reaching power without specified objectives and criteria in accordance with the constitutional guidance principle, would be unconstitutional.

#### **6. Conclusion**

With the above in mind, the FMF proposes:

1. Price controls be abandoned entirely.
2. Private companies in the medical sector be allowed to negotiate on the same level as government, and thus be entitled to discounts for bulk purchases.
3. The Regulations be brought in line with the Act and the Constitution.

## **Free Market Foundation Submission on the Value-Added Tax on Medical Products**

To: Committee 1 (Triple Challenges of Inequality, Poverty and Unemployment)  
High Level Panel on the Assessment of Key Legislation

By: Free Market Foundation

### **1. The Free Market Foundation**

The Free Market Foundation (FMF) is an independent non-profit public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations and sponsorships.

### **2. Introduction**

Affordable and quality healthcare is innately important to overcoming the triple challenges of inequality, poverty, and unemployment in South Africa. Individuals spend substantial amounts of their money on their medical needs, meaning that in the case of the poor, they often lack access to healthcare completely or need to spend well over half of their income on it. It is with this in mind that it is of fundamental importance that the government not exacerbate the cost of healthcare, and allow competition in the market as to keep prices as low as they can possibly, and responsibly, be.

According to section 11 of the Value-Added Tax Act (89 of 1991), in what is known as a 'zero rating', certain goods can be exempted from the value-added tax (VAT). These goods are located in schedule 2 of the Act. For example, section 11(1)(j) provides that foodstuffs provided for in schedule 2 will have a 'zero percent' VAT levied on them. Part B of schedule 2 thus lists such things as maize meal, dried beans, rice, and vegetables, which will not be 14% more expensive in stores such as other goods, because of VAT.

The FMF has proposed in its submissions to the Davis Tax Committee in 2014 and 2015 that all medicines should be similarly exempted from the imposition of VAT. The South African government has taken some first steps, for example, by eliminating all tariffs on pharmaceutical products entering the country. Unfortunately, the VAT still applies at 14% to all medicines sold.

### **3. VAT mainly harms the poor**

The High Level Panel is tasked with identifying those legislative and regulatory measures which currently hinder the emancipation of South Africans from the shackles of poverty. It is therefore important to note that the value-added tax may be an inconvenience for the wealthy, but is disastrous for the poor.

As the FMF said in its 2015 submission to the Davis Tax Committee, referencing a study by the Institute of Economic Affairs:

"Unsurprisingly, the wealthy tend to spend more money than the poor, but the poor tend to spend all their money, and since most spending goes on items that are subject to VAT or other indirect taxes, a larger proportion of income is taken in indirect taxation from the poor than from the rich. Tax can be the biggest single source of expenditure for those who live in poverty."

As will be explained below, the removal of VAT from medical products will have a negligible effect on state revenue. However, the poor – in this case, those diagnosed with HIV/AIDS – will have saved more than R60 per month in 2014, which is likely closer to R100 now. That, according to research done by

the FMF in 2014, could have bought a loaf of bread, six large eggs, a litre of milk, maize meal, and several bananas and pieces of chicken for a poor household.

For the wealthy and middle class, this situation is difficult to envision, however, removing the VAT from medicines might just mean the difference between life and death for South Africans living in abject poverty.

#### **4. State revenue will be virtually unchanged by removing VAT from medical products**

Unlike import duties and sin taxes, which ostensibly serve an identifiable public interest objective, value-added taxes on pharmaceuticals serve only to raise state revenue.

The government will thus be pleased to note that VAT on medicines represents a negligible amount of state revenue. In 2008 the pharmaceutical industry contributed around R741.64 million in VAT, which represents less than one percent (0.48%) of the total VAT collection for that year, which totalled R154.343 billion.

Whereas this is a virtually unnoticeable amount of state revenue, it is certainly noticeable and felt quite acutely by poor South Africans.

#### **5. Conclusion**

The FMF therefore recommends that a provision be inserted into section 11 of the Value-Added Tax Act which provides for a zero rating for all medicines being sold legally within South Africa.