

**VAT on medical supplies in South Africa:  
A critical analysis of whether the VATCOM's argument to  
standard rate medical supplies in 1991 still holds true**

**Dissertation presented in partial fulfilment of the requirements  
for the degree of Master of Commerce specialising in Taxation  
in the field of South African Tax**



**Department of Finance and Tax**

**Faculty of Commerce**

**University of Cape Town**

**By:** Cuan Hablutzel (HBLCUA001)  
**Supervisor:** Mr Rudi Oosthuizen  
**Date of Submission:** 14 March 2021  
**Resubmission:** 17 September 2021

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

## Plagiarism Declaration

### COMPULSORY DECLARATION:

1. This dissertation has been submitted to Turnitin (or equivalent similarity and originality checking software) and I confirm that my supervisor has seen my report and any concerns revealed by such have been resolved with my supervisor.
2. I certify that I have received Ethics approval (if applicable) from the Commerce Ethics Committee.
3. This work has not been previously submitted in whole, or in part, for the award of any degree in this or any other university. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works of other people has been attributed, and has been cited and referenced.

Student number	HBLCUA001
Student name	CUAN HABLUTZEL
Signature of Student	<div style="border: 1px solid black; padding: 2px; display: inline-block;">Signed by candidate</div>
Date:	14 March 2021

## Abstract

This paper aims to critically evaluate whether the existing VAT consequences on medical care services (and goods) is still relevant and valid given the developments within the South African economy since 1991, when VAT was first introduced in South Africa. Furthermore, this paper seeks to identify alternative VAT consequences that could be utilised if it is considered that the existing VAT consequences on medical care services and goods are no longer relevant and valid.

Medical services and goods currently receive no concessional VAT treatment. This is because, when VAT was first implemented in 1991, patients of lower- and middle-income classes used the State medical systems and hence only paid nominal VAT or no VAT on their medical services. Therefore, VAT did not significantly impact them. Furthermore, services which had higher input costs would be negatively affected by exempting these services from VAT. However, the private healthcare system has increased significantly since the adoption of VAT in 1991. In today's economy, the private sector accounts for over 50% of healthcare spending in South Africa (Department of Health, 2017:42). The majority of this, however, is funded via medical aid, and only 14% of this expenditure is recorded as occurring from out-of-pocket plans (RH Bophelo , 2017).

Therefore, the Value-Added Tax Committee's ("VATCOM's") reasoning for not zero-rating VAT on medical care services and goods in 1991, was because it only impacted a nominal amount of the economy as a result of people using the State's healthcare system and, hence, only having to pay nominal VAT. It needs to be questioned if this is still relevant and valid in today's more robust South African economy. This is as a result of the ever-increasing portion of the economy who are either required to pay for private medical services, are not covered by medical aid, or need to add on an additional 15% (National Treasury, 2018:11) on top of the already expensive cost of these services due to the standard-rating of VAT for these supplies in South Africa.

When South Africa first implemented its VAT Act it was based on the New Zealand model for General Sales Tax (Lang, et al., 2009: 264). Under the New Zealand GST model, healthcare services were standard-rated (New Zealand Government, 1985), hence providing reason as to why South Africa standard-rated medical services. However, Australia, who adopted GST in 2000, implemented healthcare as a GST free (zero-rated VAT) supply (Office of Parliamentary Counsel, 1999:98). Further to this, the United Arab Emirates, which is one of the most recent countries to introduce the VAT system into their economy, in 2018 (Deloitte, 2017:4), healthcare services from VAT (President of the United Arab Emirates, 2017:20). Additionally, the increased number of private healthcare institutions and the reliance on private medical care providers in South Africa (not to mention the fact that there is no concessional treatment, even though this healthcare system not only positively benefits patients receiving the healthcare and the South African Healthcare system, but also the South African economy as a whole) brings into question the validity and relevance of the current treatment of VAT on medical goods and services.

When the current consequences of the legislation do not fully fulfil the intentions of the Vat Act, the legislation needs to be reconsidered and the tax consequences thereof re-evaluated. The preferred alternative VAT treatment recommended is for medical services and supplies, as well as medical insurance, to be zero-rated. This will allow for a reduced cost of providing these goods and service. Furthermore, zero-rating will alleviate the competitive disadvantage that private medical care suppliers are placed under as result of the substantial government presence in the public healthcare

system. Additionally, it will decrease the burden of VAT being added to charges for medical services and goods, as well as decreasing the burden of VAT on medical insurance that is non-recoverable.

An alternative VAT treatment (should the zero-rated approach fail) would be to exempt the supply of medical care services and goods, or to tax the supply thereof at a reduced rate. However, the high input cost being “trapped” if it were VAT exempt (in addition to the high administration complexity under a reduced VAT rate system) results in standard-rating of supplies being recommended ahead of these other concessional VAT treatments.

## Table of Contents

<b>Plagiarism Declaration</b> .....	<b>1</b>
<b>Abstract</b> .....	<b>3</b>
<b>1. Introduction</b> .....	<b>6</b>
1.1. Background .....	6
1.2. Research question .....	7
1.3. Research method.....	7
1.4. Scope and limitations.....	7
1.5. Structure .....	8
<b>2. Critical Analysis of whether the current VAT treatment of medical care services and goods is still relevant and valid</b> .....	<b>9</b>
2.1. The South African government's reason for standard-rating medical care services and goods.....	9
2.2. Developments in the South African healthcare industry.....	11
2.3. Current VAT Treatment of medical care services and goods and medical insurance .....	13
2.4. The impact of private healthcare on the South African healthcare industry and the South African economy.....	15
2.5. Disadvantages of standard-rating medical care services and goods in South Africa .....	17
2.6. Conclusion.....	17
<b>3. Critical analysis of whether zero-rating medical care services and goods is a preferable alternative</b> .....	<b>19</b>
3.1. Analysis of when goods and services may be considered for zero-rating in South Africa .....	19
3.2. Analysis of whether medical care services and goods qualify for zero-rating in South Africa.....	19
3.3. The design of the Australian GST system compared to the South African VAT system .	20
3.4. Analysis of similarities of social, economic and State objectives for healthcare between South Africa and Australia.....	22
3.5. Australian government's rationale for zero-rating certain medical care services and goods .....	23
3.6. GST consequences for medical care services and goods in Australia.....	24
3.6.1. Medical care services and goods .....	25
3.6.2. Other health services .....	28
3.6.3. Other government funded health services .....	29

3.6.4.	Hospital treatment.....	29
3.6.5.	Medical aid and appliances and other health goods .....	29
3.6.6.	Drugs and other prescription medicine .....	30
3.6.7.	Private health insurance .....	31
3.7.	Analysis of the design of the United Arab Emirates VAT System compared to the South African VAT system .....	31
3.8.	Analysis of UAE healthcare economic considerations and State objectives.....	32
3.9.	Analysis of the VAT treatment of medical care services and goods in the UAE.....	33
3.10.	Recommendation .....	34
3.11.	Conclusion.....	36
<b>4.</b>	<b>Critical analysis of whether any other preferable VAT concessionary treatment on medical care services and goods exist and if they provide a better alternative .....</b>	<b>37</b>
4.1.	Analysis of exempting medical care services and goods from VAT in South Africa .....	37
4.1.1.	Argument for exempting medical care services and goods .....	37
4.1.2.	The case of the United Kingdom and European Union.....	38
4.1.3.	Disadvantages of exempting medical care services and goods in South Africa	38
4.2.	Analysis of applying a reduced VAT rate to medical care services and goods in South Africa.....	39
4.3.	Conclusion.....	40
<b>5.</b>	<b>Conclusion .....</b>	<b>41</b>
<b>6.</b>	<b>References .....</b>	<b>44</b>
<b>7.</b>	<b>Annexure .....</b>	<b>50</b>
7.1.	Annexure 1: Table of GST-Free other health services – Section 38-10 of the Australian GST Act .....	50
7.2.	Annexure 2: Schedule 3 of the Australian GST Act – medical aids and appliances .....	51

## 1) Introduction

### 1.1) Background

In 1991, when Value-Added Tax ("VAT") was introduced into South Africa, the Value-Added Tax Committee ("VATCOM") recommended that the supply of medical services and goods should be standard-rated. The primary reasons for standard-rating medical services were two-fold:

- 1) Services which have a higher input cost would be negatively affected by exempting these services from VAT
- 2) Patients of lower and middle classes would use the State medical systems and only pay nominal VAT or no VAT on their medical services, hence VAT thereon was not affecting them (VATCOM, 1991:31 )

Therefore, standard-rating VAT meant that input VAT could be claimed for services that had high input costs and secondly, the State would be able to receive income in the form of VAT from the wealthiest members of society who may choose to rather use the private medical system. Hence, standard-rating VAT in 1991, had a positive outcome on wealth redistribution for the economy.

However, the private healthcare system has grown significantly since the adoption of VAT in 1991. In today's economy, the private sectors medical healthcare schemes account for over 50% of spending in South Africa (Department of Health, 2017:42). Despite the fact that the majority of this is funded via medical aids, 14% of this expenditure is being recorded as occurring from out-of-pocket plans (RH Bophelo , 2017).

Over the years a larger proportion of the South African public have started using private healthcare. These private medical supplies are privately funded with the cost thereof being passed onto the public of South Africa. As the South African public's expenditure on private medical services increases, so will the public's out-of-pocket private medical expenditure. Therefore, it needs to be questioned whether VATCOM's reasoning for not zero-rating VAT in 1991 is still relevant and valid in this new South African economy, as VAT on medical services only impacts a nominal amount of the economy, due to the majority of the public using public healthcare. This is a consequence of the ever-increasing portion of the economy who are required to pay for private medical services that are not covered by their medical aid, and as a result needing to add on an additional 15% (National Treasury, 2018:11) on top of the already expensive cost of these services due to the standard-rating of VAT for these supplies in South Africa.

The South African VAT System that was first implemented was based on the New Zealand model for General Sales Tax ("GST") (Lang, et al., 2009: 264). Under the New Zealand GST model, healthcare services were also standard-rated (New Zealand Government, 1985), hence adding more reason as to why South Africa standard-rated its medical services. However, Australia, who adopted GST in 2000, implemented healthcare as a GST free (zero-rated VAT) supply (Office of Parliamentary Counsel, 1999:98). Further to this, the United Arab Emirates ("UAE"), which is one of the most recent countries to introduce the VAT system into their economy, in 2018, (Deloitte, 2017:4), zero-rated medical supplies from VAT (President of the United Arab Emirates, 2017:20). The above examples provide a solid foundation from which to question if zero-rating medical services in South Africa might be a better alternative.

Under the current South African VAT system, goods and services can either be taxable at the standard rate, zero-rated or exempt from VAT. Although this dissertation will not delve into whether South Africa should introduce a reduced rate of VAT for certain goods and services in South Africa, one needs

to question whether (if zero-rating medical services in South Africa is not the answer) a reduced VAT rate for medical services could provide some relief to the taxpayer, as compared to levying the standard 15% VAT.

The objective of this paper is to critically evaluate whether the present VAT treatment for medical goods and services is still relevant and valid, given the developments in the South African healthcare system. If the current treatment is found to no longer be valid, then this paper will explore and identify whether there is a preferable VAT treatment to be utilised.

## **1.2) Research question**

The fact that the majority of the South African population used the State healthcare system provided the basis for VATCOM's decision to standard-rate medical supplies in 1991. This decision was based on the reasoning that a standard-rating would allow input VAT to be claimed on the costs of the medical services, while output VAT could be kept to a nominal amount owing to the significant amount of State subsidies provided to the public healthcare system at the time.

However, the South African economy has since evolved significantly, with the private healthcare system growing significantly since 1991. As a result of this growth, there has been an increase in out-of-pocket expenditure in the private healthcare system, hence leading to output VAT thereon not being nominal, as these costs are not subsidised by the State.

In addition to this, many countries that have implemented VAT since 1991, with specific reference to Australia and the UAE, have either zero-rated or exempted medical services from VAT or GST.

Therefore, the research question is if the existing VAT treatment on medical supplies is still valid and relevant in the current South African economy? And, if not, is zero-rating medical supplies (as is done in Australia and the UAE) a preferable alternative to the present VAT treatment? Furthermore, do any other preferable VAT treatments of medical supplies exist and, if so, do any offer a better alternative?

## **1.3) Research method**

A doctrinal research methodology is utilised as the primary research method for this paper.

A critical analysis will be performed of the following:

- Various sections and sub-sections of the relevant legislation.
- Commentary and journals of experts in this field of research.
- Published document, reports, policies and guidelines by various national and international organisations in this field (including, but not limited to, the Australian, United Arab Emirates, New Zealand and South African governments and organisations).
- South African and international books on this field of study.

## **1.4) Scope and limitations**

This analysis will be limited to medical goods and services, medical insurance, and will also examine other areas of healthcare including, but not limited to, homecare, frail-care and disability support and services. In addition, although this dissertation will discuss the option of whether a reduced VAT rate

is a more appropriate VAT treatment compared to standard-rating, this research will not explore whether South Africa should introduce a reduced rate of VAT for certain goods and services.

Furthermore, the fiscal loss to the economy and government on the potential change in VAT consequences on medical care services and goods will not be considered in this paper. However, the importance and influence thereof in the consideration of any potential alteration to the VAT treatment on medical goods and services in South Africa is recognised.

## **1.5) Structure**

### **Chapter 2 – Critical analysis of whether the existing VAT consequences on medical services and goods is still relevant and valid?**

The current VAT treatment of medical care services and goods in South Africa (standard-rated) will be evaluated in this chapter. This chapter will look at the reasons VATCOM standard-rated medical services in South Africa, as well as evaluate how the evolution of the South African healthcare system results in VATCOM's reasoning around standard-rating medical services being out-of-date.

The chapter will then conclude if the existing VAT consequences on medical services are still relevant and valid in the current South African economy.

### **Chapter 3 – Critical analysis of whether zero-rating medical services is a preferable option**

This chapter will critically evaluate whether changing the VAT treatment on medical care services and goods in South Africa from standard-rated to zero-rated is a better alternative. In doing so, the paper will analyse whether medical care services and goods meet the conditions for zero-rating of supplies in South Africa.

Further to this, a critical evaluation of the Australian and UAE VAT consequences on medical supplies will be analysed. In doing so, the chapter will analyse their reasons for zero-rating medical services and if these reasons are valid and relevant in the South African economy.

A recommendation will be made as to whether zero-rating VAT on medical services in South Africa could be a preferable alternative to the existing VAT treatment on medical care services and goods in South Africa.

### **Chapter 4 – Critical analysis of whether any other preferable VAT concessionary treatment on medical care services and goods exist and if they provide a better alternative**

This chapter will briefly discuss and evaluate alternative VAT treatments for medical goods and services. This will include an analysis of whether a reduced VAT rate for medical services provides a feasible alternative to the current VAT treatment on medical goods and services in South Africa. Additionally, this chapter will analyse whether exempting medical goods and services provides a preferable option to standard-rating medical goods and services, if zero-rating is not an option.

To conclude, a recommendation will be made if any alternative VAT concessionary treatment on medical supplies could be feasible in South Africa.

## Chapter 5 – Conclusion

## **2) Critical analysis of whether the current VAT treatment of medical care services and goods is still relevant and valid**

The current VAT consequences on medical services and goods in South Africa will be evaluated in this chapter and the design and structure thereof will be evaluated. Accordingly, it will examine the initial VATCOM decision to not apply any concessional VAT treatment in South Africa and how the evolution of the activities in the healthcare industry of South Africa affected this decision. Further to this, a review of some of the instruments utilised to lessen the burden of VAT on South Africans will be discussed. Additionally, an analysis of the challenges faced by healthcare institutions and patients due to the current VAT treatment will be performed. This will include the disadvantages of applying no concession to medical services. This chapter will then conclude by considering whether the existing VAT consequences on medical goods services continues to be relevant and valid in the current South African economy.

### **2.1) The South African government's reason for standard-rating medical care services and goods**

It is imperative that one comprehends the aim of the of the VAT Act and understands the underlying basis for the decision reached on why medical care services and goods were standard-rated when VAT was first implemented. In doing so, one can analyse if the purpose of the legislation was attained and evaluate the validity of the current application thereof on the VAT treatment of medical services and goods in the current South African economy.

The 1991 Draft VAT Bill initially made provision that services supplied by a medical practitioner (as well other professions mentioned in the Draft Act) be exempt from VAT. The supply of goods and services necessary or incidental to the supply of a hospital or clinic was also to be exempted from VAT. The Supply of medicine not supplied in consultation and other medical equipment and aids were to be subject to VAT at the standard rate. However, the VATCOM made the representation that standard VAT consequences on medical services and medicine would result in equality between the different suppliers thereof, and had the additional advantage of reducing the administration costs associated with the proposed exemption (VATCOM, 1991: 48).

Therefore, the VATCOM recommended:

*“(i) The proposed exemption in clause 12(g) be withdrawn and all medical services and medicine be subject to VAT at the standard rate*

*(ii) Medical aid schemes be exempted from tax to the extent that they do not provide other taxable goods or services such as medicine” (VATCOM, 1991:51)*

The result thereof is the current VAT treatment for medical goods and services noted in the VAT Act where the supply of medical goods and services is standard-rated, and the supply of Medical Aid schemes is VAT exempt under Section 2 of the VAT Act.

The VATCOM representation received from all major organisations in the medical profession varied from pleas to zero-rate all medical services and goods to the standard-rating thereof. The administrative burden and inequities which result from applying VAT exemptions were made clear in the representation made to the VATCOM (VATCOM, 1991 48-49).

Medical practitioners and other professionals mentioned in the draft bill would have incurred GST in the past, but due to the broad base of VAT, many other services such as rental, rates and professional services would also have incurred VAT. If medical practitioners were VAT exempt, they would not be entitled to claim input tax credits. Additionally, medicine supplied during consultations had to be distinguished from medicine which could be used at any time. The consequence of this was the increase in administration complexity as well as concerns over this altering which medicine was prescribed (VATCOM, 1991: 49). Therefore, zero-rating was the preferred representation made by medical practitioners, as it was thought that it would provide them with the advantage of claiming input credits for their high input costs while still incurring the concessional output treatment. Alternatively, standard-rating of the supply was preferred to the draft bill's VAT exempt nature of medical services (VATCOM, 1991: 48-49).

The representation made by hospitals followed the same reasons made by medical practitioners, namely that the broader base of VAT would result in a greater number of goods and services being subject to VAT, hence increasing the costs which was very difficult to pass on to their patients. Additionally, there was the issue of an increase in administration costs and complexity with regards to distinguishing taxable and exempt supplies and the apportionment thereof for the purpose of input VAT. Therefore, hospitals likewise requested zero-rating as their preferred VAT consequence. However VAT exempt treatment was preferred to standard-rating if zero-rating was not possible, stating that this would be in the interest of their patients (VATCOM, 1991: 50).

The pharmaceutical industries representations focussed on the effect of VAT on the supply of medicine and the anomaly that existed under the draft bill due to different VAT treatment on medicine provided during consultation and elsewhere. The representation was that exemption for medical services should be removed and replaced with the standard-rating of all medical services and medicine. The reason for this was is that it would result in levelling the playing field for all suppliers of medicine as all medicine would be treated equally from a VAT perspective. Thus, there would be no discrimination against the place or circumstance of the supply. Additionally, it was argued that socio-economic patients pay a nominal amount for medical services and medicine received from the State and therefore the standard-rating of medical services and medicine would not affect them (VATCOM, 1991: 49-50).

Medical aid schemes made the representation that if medical services and medicines were taxed, then the medical schemes should also be subject to VAT. This would allow actual or deemed input credits to be allowed for payments made on behalf of members to medical practitioners and any other supply of medical services or medicine. However, the contrary argument thereto (which was the approach decided on) is that medical aid schemes are financial services and, if exempted, the loss of revenue therefrom would be minimal and would create the least amount of administration burden (VATCOM, 1991:50).

Although most representations made by organisations was for zero-rating of supplies (as this is the most preferential treatment), VATCOM noted that at the time the preferred treatment of medical services throughout the world was that they should be subject to VAT and that assistance to the needy be provided elsewhere. Furthermore, it was determined that the anomalies stated by the pharmaceutical industry would lead to the abuse of the VAT Act, and that the application thereof could not have been effectively controlled. Additionally, the compliance cost for both medical service providers and the Inland Revenue Service will increase under the concessional VAT treatment (VATCOM, 1991: 50-51).

The conclusion made by VATCOM stated that a blanket concessional treatment on medical services and medicine was not an effective or efficient way of assisting people who required State assistance for healthcare. Their argument in favour of this was that expenditure on medical services and medicine accounted for a modest portion of an individual's income. Additionally, individuals who do require State assistance with regards to healthcare are assisted through the public healthcare sector, where the financial position of the individual is accounted for in determining the amount they incur for the medical service received as well as for any medicine. Therefore, VATCOM believed that standard-rated VAT consequences for medical services and medicine would result in equality between the different suppliers thereof, as well as reducing the administration costs associated with the proposed exemption, and hence made their recommendation based hereon (VATCOM, 1991: 50-51).

## **2.2) Developments in the South African healthcare industry**

In order to critically evaluate whether the current VAT treatment on healthcare in the current South African environment is still relevant and valid, an understanding and analysis of the developments in the South African healthcare system since VATCOM's 1991 decision needs to be assessed.

The South African healthcare system is divided into a two-tier system along socio-economic lines. The South African government offers free healthcare to all citizens. However, the public also has the option to be treated at private hospitals and clinics (Delobelle, 2013: 161).

In 1988, the government released a White Paper indicating its intention to replace General Sales Tax with VAT (National Treasury, 2015:27). In a study conducted by Van den Heever on the South African healthcare system, it indicated that the number of private hospital beds increased from 10,936 in 1989 to 20,908 in 1998, and rose further to 31,067 in 2010. This was as a result of the increase in private hospitals during this period from 65 to 216 (van den Heever, 2012: 30). Simultaneously, the number of public sector hospital beds decreased by 25% from 117,842 beds in 1986 to 88,920 beds in 2010 (van den Heever, 2019: 11). The consequence thereof was a 184% increase in the number of private sector hospital beds during the first 20 years after South Africa decided to implement VAT, while the number of public healthcare beds was concurrently decreasing.

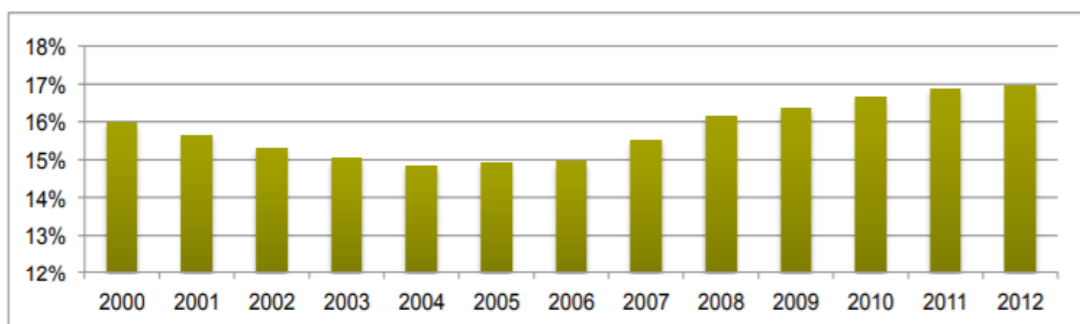
Furthermore, between the years of 1988 (when VATCOM's discussion around the VAT rules for various goods and services in South Africa began) and 1993, the number of 'for-profit' general hospital beds nearly doubled in this period alone (Coovadia, et al., 2009: 826). According to Coovadia et al (2009: 826), this expansion in the private healthcare system was due to the government policy of privatisation which was a result of the global economic trends of increasing the role for the private sector within healthcare. However, according to Ranchod, et al. (2017:102) additional factors also contributed, such as weak macro-economic conditions which placed constraints on South Africa's government budget and hence limited investment and funding into public hospitals. This constraint, together with the encouragement of the government for privatisation, led to specialists in the medical field migrating to the private sector and operating as independent practitioners.

The South African Apartheid government had the difficult task of trying to reform an inequitable healthcare system that was divided along racial and geographical lines, along with inequalities that started to develop between the private and public healthcare system. Under the ANC-led government, the public healthcare system's aim was to transform into a comprehensive, national service which addressed the previous inequalities and thus provided healthcare to previously disadvantaged members of the public. The government achieved partial success in this transformation, with the success thereof being limited by a multitude of factors, including a shortage of human resource capital,

poor leadership and management, an increased strain on the public health system caused by the AIDS pandemic, as well as limitations on the expenditure in the healthcare sector (Coovadia, et al., 2009: 829). These limitations of the public healthcare sector are emphasised by the fact that expenditure in the public healthcare sector has remained stagnant as a percentage of GDP (Econnex, 2013: 8), whereas private sector expenditure increased significantly.

Medical insurance schemes were first established in South Africa in 1889 to provide for the healthcare of white mine workers. These medical insurance schemes remained occupational or employer-based medical schemes and hence were not-for-profit schemes (Coovadia, et al., 2009: 826). In 1967, the introduction of the Medical Schemes Act was the first time medical mutual insurers could be recognised as separate entities. Until 1986, medical schemes were utilised almost exclusively for reimbursing tariffs charged by public hospitals and private professional fees. However, during the 1980's, multi-employer schemes became popular. In 1989, medical schemes were deregulated by removing all restrictions which related to risk-rating. Further deregulation occurred in 1994 which allowed integration between medical schemes and private healthcare providers (Soderlund, et al., 1998:3). This led to memberships in open schemes growing substantially to represent 70% of the industry by the end of 1999 (Rama & McLeod, 2001: 11). The increase in members in the medical insurance schemes between the period of 2000 and 2010 can be seen in figure 1 below.

**Figure 1: Medical scheme membership as a percentage of the population, 2000 – 2012**



Source: (Econnex, 2013)

Simultaneously to the deregulation of the medical insurance scheme industry, the worsening economic situation in South Africa increased the strain on funding of the public healthcare system. Coupled with the global trend towards privatisation, this led to the increase in private hospitals, which in turn led to the migration of expenditure by medical scheme members from the public sector to the private sector. In 1989, expenditure by medical schemes in the public sector health system accounted for 27% of scheme expenditure (Centre for Development and Enterprise, 2011:45), whereas in 2013 it counted for a mere 0.324% (Econnex, 2013: 14).

Although the deregulation of the medical insurance scheme industry was subsequently reversed in the 2000s, the membership base of these schemes remained in a strong position. During the period from 2000 to 2012, membership increased by 24%. However, when taking the increase in the population into account, medical insurance membership as a percentage of the population remained constant between 14.8 and 17% (Econnex, 2013:11). Therefore, there is a common misconception that the private healthcare system of South Africa only provides healthcare for approximately 16% of the South African population Econnex (2013:18). According to a report by Econnex (2013:18), if one takes into account the members of the public who access the private healthcare system sector through

“out-of-pocket expenditure”, it was projected (in 2012) that the private healthcare sector in South Africa caters for between 28% to 38% of the South African population. In addition to the public who utilise the private healthcare systems through medical scheme memberships or out-of-pocket expenditure, a portion of the public also utilises the private healthcare system through medical insurance, hence suggesting this number is even larger than 38% of the population (Econnex, 2013:19).

South Africa spent 9% of its GDP in 2017 on healthcare, which is 4% higher than the amount that the World Health Organisation recommends for a country of South Africa’s socio-economic status (Africa Health, 2019:1). In 2016, there was a total of 715 hospitals in South Africa, of which 280 were private. This increase of 35% since 2010 (Africa Health, 2019:2) indicates that the private healthcare system is still expanding in South Africa. The public sector contributed only 44% of total healthcare expenditure in 2016 (Africa Health, 2019:1), which indicates that the majority of healthcare expenditure is incurred in the private sector, and this is supported by the 2017 National Treasury data (Department of Health, 2017:42). Even with the proposed implementation of the National Insurance Act, public healthcare expenditure is only expected to increase to 52% of total healthcare expenditure by 2027 (Africa Health, 2019:3).

In 2017, the South African government announced their intention to move towards a unified healthcare system through the National Health Insurance scheme (NHI). The NHI is a healthcare financing system that is designed to combine finances to provide access to quality, affordable personal healthcare services for all South Africans based on their health needs, regardless of their socio-economic status. The implementation of the NHI policy will result in a substantial structural re-organisation in both the public and private healthcare systems. Universal health cover under the NHI will ensure that the public has access to comprehensive healthcare through both private and public providers (Department of Health, 2017:8-9). Through the implementation of the NHI, a greater portion of the South African population will have access to the private healthcare sector, hence increasing the role that the private healthcare sector will play in providing healthcare in South Africa. Therefore, this brings to the forefront any additional costs on these services (in the form of VAT) as well as any competitive disadvantages that may exist between the private and public healthcare system.

### **2.3) Current VAT treatment of medical care services and goods, and medical insurance**

There is no VAT concession or relief for medical goods or services in the Value-Added Tax Act (“VAT Act”). Hence, VAT is imposed on medical goods and services in accordance with S7(1)(a) of the VAT Act.

Section 7(1)(a) of the VAT Act states that, except for the various exemptions and concessions provided under the Act, where a vendor supplies goods and services in the furtherance of their enterprise, such goods and services will be subject to VAT at the standard rate (South African Government, 1991:33). Currently, the standard VAT rate is 15% (National Treasury, 2018:11).

Section 9 of the VAT Act specifies the time that the goods or services become subject to VAT. Medical goods and services provided to the general public are not subject to any of the specific time of supply rules (under Section 9), therefore the goods or services are deemed to take place at the earlier of the time the invoice is issued or the payment of the consideration is received. Section 10 of the VAT Act determines the value of the supply of medical goods and services, and this is deemed to be the amount

of consideration that the general public will be liable to pay for the supply (South African Government, 1991:41-48).

A medical aid scheme is defined as an organisation that is governed by a board of trustees and registered with the Council for Medical Schemes, in accordance with the Medical Schemes Act of 1998. A medical Scheme's role is:

*“the business of undertaking liability in return for a premium or contribution—*

*(a) to make provision for the obtaining of any relevant health service;*

*(b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service;*

*and (c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme”*  
(South African Government, 1998:131)

The Long-Term Insurance Act of 1988, defines “Health policy” as:

*“a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health even”* (South African Government, 1998:10)

Section 2 of the VAT Act deems certain activities to be financial services. Section 2(1)(i) of the VAT Act states that:

*“The provision, or transfer of ownership, of a long-term insurance policy or the provision of reinsurance in respect of any such policy”*

Section 2(2)(v) goes on to define a “long-term insurance policy” as:

*“any policy of insurance issued in the ordinary course of carrying on a long-term insurance business as defined in Section 1(1) of the Long-Term Insurance Act, 1998”*

Therefore, as a medical scheme is defined as a “health policy” in terms of Section 1(1) of the Long-Term Insurance Act, medical schemes meet the definition of a “financial service” as it is a “long-term insurance policy” (South African Government, 1991: 26-28).

Section 12 of the VAT Act makes provision for certain goods and services to be exempt from VAT imposed under Section 7(1). Vendors of VAT exempt goods and services do not have to charge output VAT on their supply, however, they are concurrently not able to claim the input VAT credits on the purchase of standard rate VAT supplies that they use in the furtherance of their business. The supply of financial services is VAT exempt under Section 12(a) of the VAT Act. Therefore, as medical schemes are classified as a “financial service” under Section 2(1)(i), no VAT is charged on the supply of medical schemes by registered medical scheme providers. Due to the VAT exempt nature of financial services, medical schemes are not able to claim input VAT credits but also cannot charge output VAT. Medical goods and services are not subject to any VAT concessions and are instead subject to VAT at the standard rate of 15% and, because medical schemes are in the business of providing cover for healthcare issues, medical schemes will therefore be required to incur the costs of the full input VAT consequence on the medical goods and services provided to their customers due to their exempt nature.

Medical scheme premiums are calculated on statistical and mathematical formulae that calculate how much it would cost the providers to cover a group of people in the medical scheme. The main cost for these providers to calculate is the cost of medical goods and services that the collective group of customers will require (Pitacco, 2017). As these supplies have input VAT consequences that will not be able to be claimed due to the exempt nature of medical schemes, the cost of the medical scheme to the consumer is indirectly and significantly impacted by the 15% VAT consequence of the supply of medical goods and services.

#### **2.4) The impact of private healthcare on the South African healthcare industry and the South African economy**

The imposition of tax on society is for the government to finance public expenditure (National Treasury, 2015:35). Worldwide, public sector spending is used to achieve public objectives, with one of these objectives globally being access to universal health cover. Public sector spending also redistributes funds through social security benefits and public services. Public healthcare spending in OECD countries (except USA and Mexico) represents the highest portion of spending on healthcare (Public Services International Research Unit, 2014:32). Research has shown that healthcare systems based on private expenditure are found to be more expensive, while still producing worse results than systems based on public financing. This is because private spending results in healthcare being less affordable to the general public (Hall, May 2014:32-33). An example thereof can be found in a study completed by Tacke & Waldmann (2013: 3246), in which the authors concluded that an increase in public healthcare correlates significantly to lower infant mortality rates. Conversely, an increase in private healthcare spending is shown to have the opposite effect as it is associated with a higher infant mortality rate. In accordance with a report compiled by Hall (May 2014:27) on the need for public spending, Hall groups the issues associated with private healthcare spending into four categories, namely:

- 1) Affordability – private providers charge for a service thereby prejudicing the poor as they can afford less of the services offered than the rich.
- 2) Selectivity – private healthcare operators target the rich and the wealthy areas rather than the areas with the greatest need for healthcare.
- 3) Over-Treatment – private healthcare companies oversell services that are profitable instead of the services that are required and most beneficial.
- 4) Catastrophic expenditure – the poor risk being catapulted into “catastrophic expenditure” due to ill-health (Hall, May 2014:28-31).

However, recent health reforms in the world trend towards an increased responsibility of the private sector in delivering medical care services. This is specifically true in low- to middle-income countries who are utilising the private sector to improve quality and deliver value for money (Hanson, et al., November 2008:233). The arguments presented for the private sector in healthcare are due to a monopoly public sector healthcare, resulting in inefficacy and the belief that the utilisation of a mix of private and public sector in the delivery of healthcare improves efficiency and injects competition (Propper & Green, 1999:1). In a study performed by Loevinsohn and Harding (2005: 679), it was discovered that private sectors were able to operate on a larger scale, be more cost-effective, and increase the coverage of medical care in poor and remote areas. In South Africa, the private healthcare system assists in alleviating the strain placed on the public healthcare system due to overcrowding and the under-resourcing faced by the public healthcare sector (Maphumulo & Bhengu, 2019:4).

Since the implementation of the VAT system in South Africa, VAT remains the second most important source of government income. Creese (2011: 5) argues that a well-designed tax system can promote social justice and economic growth, however, the initial VAT regulations, which presented a broad-based system with no exemptions or concessions, were, in fact, regressive in nature. Due to public pressure, South Africa's skewed distribution of wealth and political history, the South African broad-based VAT system was altered to include concessionary treatment of several merit goods (Jansen & Calitz, 2015). One of the traits of a merit good is that it is seen to be essential and in the public interest (Bangalee & Suleman, 2017:151). However, despite the essential role medical services play in society, medical services and supplies (regardless of their status) are standard-rated in South Africa.

There is a strong consensus in South Africa that VAT only affects the private sector. Therefore, VAT on medical goods and services should not impact the general public's access to healthcare through the public sector. This, however, disregards the reality that numerous people who access the public healthcare system also utilise the private healthcare sector (Bangalee & Suleman, 2017:151). A report published by the (Department of Health, 2011: 4) notes that only 16.2% of the South African population have access to private health insurance, implying that 84% of the population are required to make out-of-pocket purchases when utilising the private healthcare sector. This 84% will be driven to use the private healthcare system due to medicine shortages and an inability to access public health institutions due to distance, time and cost constraints (Bangalee & Suleman, 2017:151). Furthermore, there are concerns that the poor quality of the public sector services act as a barrier and, hence, creates an increased preference for private healthcare (Department of Health, 2011: 6). Therefore, the private healthcare system performs a vital role in assisting the government (and the public healthcare system) to fulfil their responsibility to provide healthcare to all South Africans. Additionally, the private healthcare system is a pivotal player in the South African economy. The key impacts of the private healthcare sector are:

- Employment – It was projected that in 2013 there were around 7,529 general practitioners, 6,726 specialists and 77,569 nurses employed by the private healthcare sector, as well as an estimated 3,527 dentists and 2,964 pharmacists. There are also many additional workers outside of healthcare providers who are employed in the private healthcare industry. Furthermore, the employment from upstream and downstream value chain linkages from the private health care department is extensive.
- Investments and Taxation – The private healthcare sector plays a pivotal role in ensuring investment into South African through the means of profit-making and ensuring a healthy return on capital. In 2012, the combined market capitalisation of the three largest hospital groups was R83.688-billion. These companies distributed their wealth between employees, re-investment, maintenance and expansion of capital, capital providers and government. All this distribution of wealth would have a substantial multiplier effect on the South African economy. These companies also created R 1.651-billion in taxation for the government to utilise to meet their public objectives.

Furthermore, Medical Schemes had total assets of around R55.4-billion and a net surplus (after consolidation) of R 3.7-billion in 2012. These funds are invested into cash or cash equivalents, bonds, debentures, equities, insurance policies and properties – creating a substantial multiplier effect on the South African economy. Additionally, many of the large pharmaceutical groups supplying the South African healthcare industry are listed (or based) in South Africa. Hence, increasing the taxation revenue of the South African Government as well as increasing the multiplier effect of these investments in South Africa.

- Education – All three of the big hospital groups (Netcare, Mediclinic and Life) as well as medical insurance companies have undertaken to fund the training of specialists and nurses in South Africa due to the lack of resources available. Furthermore, practitioners are in short supply at all levels. The private healthcare sector has been playing a leading role to try and solve this issue through trying to train more medical practitioners at a quicker rate. Through this, the private sector is helping to alleviate the capacity strain on the public healthcare system in South Africa due to a shortage of trained healthcare workers.
- International Linkages - The South African private healthcare sector utilised and leveraged its reputation in the global market. Accordingly, the private healthcare sector has implemented the following internal activities, all of which positively impact the South African economy due to an inflow of money into these companies which are based in South Africa. These activities include:
  - Private hospital groups winning tenders to provide health services internationally.
  - Private medical schemes exporting some of their ideas to other countries.
  - South African private healthcare sector expanding into other countries.
  - Substantial foreign investment into South Africa being attracted by the private healthcare sector.
  - Increase in Medical Tourism.

(Econnex, 2013: 37 -53)

## **2.5) Disadvantages of Standard-Rating medical care services and goods in South Africa**

In order to analyse the validity of standard-rating VAT on medical services and goods in South Africa, one needs to assess the negative impact that standard-rating has on these supplies.

The standard-rate VAT consequences on medical supplies and services results in the private healthcare sector having to charge more for goods and services. This is as a result of them needing to charge the patients an additional 15% due to the output VAT consequences. Furthermore, as health insurance schemes are VAT exempt, the imposition of VAT on medical goods and services has an adverse effect on the pricing of these medical schemes, thereby making them more expensive. This increased cost of medical services will be passed on to the members of the medical insurance schemes as the insurance scheme is not able to claim this input VAT deduction due to the exempt nature of the service. Therefore, the imposition of VAT on medical supplies increases the price of medical insurance for the general public. The increase in cost of medical insurance will result in fewer members of the South African public using the private healthcare industry as they either cannot afford it or are not willing to pay the higher prices. The consequence thereof is an increased strain on the already stressed public healthcare system as these members of the public would utilise the public sector for healthcare as a compromise.

## **2.6) Conclusion**

Currently there is no concessional VAT treatment available for medical care services and goods under the VAT Act. Hence, medical care goods and services incur standard-rated VAT consequences in South Africa. The root cause of this is that most of the healthcare was financed through the government and

hence any increase in the cost would be financed by the increase in cost to the State. Over the years, the number of private medical care providers and the reliance of the South African public and healthcare system thereon has increased substantially. However, no consumption tax concessions were provided to these healthcare providers, even though they positively benefitted not only the patients receiving the healthcare and the South African healthcare system, but also the South African economy.

Due to the substantial change in the South African healthcare environment since the implementation of VAT, the standard-rating of medical supplies and goods under the current environment does not fully fulfil the intentions of the VAT Act. Hence, the VAT treatment on medical supplies needs to be reconsidered and the tax consequences thereof re-examined. The remainder of this paper will analyse and examine alternative concessional VAT treatments for medical care goods and services in South Africa.

### **3) Critical analysis of whether zero-rating medical care services and goods is a preferable option**

An analysis of whether zero-rating medical care services and goods is a more suitable VAT treatment than the current standard-rate treatment applied in South Africa will be completed in this chapter. The assessment thereof will examine whether medical services meet the conditions for zero-rating of supplies in South Africa.

Furthermore, an analysis of the Australian and United Arab Emirates (UAE) tax treatment of medical care services and goods will be performed and their basis for the zero-rating will be compared to the South African economy's social and State objectives to see whether it can be applied to South Africa.

#### **3.1) Analysis of when goods and services may be considered for zero-rating in South Africa**

The political and economic climate of South Africa was significantly different at the inception of the VAT Act to the current climate in South Africa today. It is essential to understand the motivation and rationale as to why certain goods and services were given a concessional treatment. In doing so, one needs to evaluate whether the change in circumstances that we see in today's economy and society justifies a change in the VAT treatment of medical care services and goods.

VATCOM recommended a broad-based, ideal VAT system in South Africa with no concessions or relief measures. The idea behind restricting concessions and relief to a minimum was that the disadvantaged population would be supported significantly outside of the VAT system, thereby compensating the poor for the negative effects of VAT. However, pressure from affected factions, combined with the State's failure to provide such support to the disadvantaged in order to offset the negative impacts from VAT, resulted in various concessions being introduced. Consequently, the VAT system currently functioning in South Africa is a more differentiated and complex system with a smaller base than what was intended by the VATCOM (National Treasury, 2015:4).

Zero-rating of goods and services was introduced as one of the relief measures used to mitigate the regressive negative effect of the VAT system (Judghaw, 2018:25). Specific goods and services were zero-rated in order to produce a more equitable VAT system, thereby reducing any inequalities. According to Jansen and Calitz (2017: 57), zero-rating is also an instrument that can be used to combat the effect of poverty. Furthermore, when certain items are considered politically desirable, these goods may be zero-rated to encourage consumption thereof (Kearney, 2003:40).

Under the South African VAT system, zero-rated items allow the supplier to claim input VAT on supplies consumed in their production but not have to charge output VAT thereon. Whereas, exempt supplies result in no input or output VAT consequences. Therefore, zero-rating is the most favourable VAT treatment under the South African VAT system (National Treasury, 2007:60).

#### **3.2) Analysis of whether medical care services and goods qualify for zero-rating in South Africa**

The Davis Tax Committee of 2015 (which was established to make recommendations to the Minister of Finance on the tax policy framework) advocated that zero-rating and exemptions of goods and

services should be reduced as far as possible. The Davis Tax Committee based this decision on the view of the OCED (Hagemann, et al., 1987) and Mirrlees Review (Crawford, et al., 2010: 275-362) which supported the idea that a broad-based single VAT rate is ideal.

The VAT concession needs to be evaluated against the South African Government's policy considerations with regards to VAT. One of the main considerations to note in relation to the various concessions in the VAT policy is with regards to the neutrality of the VAT System. Neutrality in the VAT system is based on the idea that the VAT system should not competitively disadvantage anyone through discriminating between goods or services, impacting the various options of production and distribution or interfering with market distributions of resources (National Treasury, 2007: 59). As mentioned under chapter 2, the supply of medical care is standard-rated in terms of the VAT Act, however, an effective exemption is applied hereon to the Department of Health and provincial hospitals as they are not required to be registered VAT Vendors (National Treasury, 2007: 80). Therefore, as the public sector will not be required to pay VAT as they are not registered as a VAT vendor, the VAT treatment thereon can be seen as VAT exempt as they do not have to charge output VAT but, at the same time, obviously cannot claim the input VAT credits. The result thereof is that the private sector is placed at a competitive disadvantage because the public sector receives preferential treatment due to them not having to register as a VAT vendor.

Concessionary VAT treatment of goods and services is generally provided to treat the regressive nature of VAT, but the status of goods or services as a merit good is also used to determine whether a supply could be subject to preferential VAT treatment. Medical care services and goods are deemed to be in the public's interest and essential to the nation. Therefore, the poorer members of society should be relieved from paying VAT on these supplies. Although public sector health is effectively exempt from VAT due the Department of Health and the provincial hospitals not being VAT vendors, as well as the government subsidizing public sector health, the reality (as discussed under chapter 2) is that many South Africans are being forced to utilise the private sector due to overcrowding and under-resourcing faced by the public healthcare sector in South Africa (Maphumulo & Bhengu, 2019: 4). Therefore, members of society are being disadvantaged due to the standard-rated nature which requires providers to charge output VAT on goods and services. Additionally, in accordance with a study performed by the National Treasury, the zero-rating of medicine would be in line with government's policies on healthcare and would also be in line with further efforts by the Department of Health to decrease the cost of medicines (National Treasury, 2007: 98).

Medical care is a basic human right and vital to the well-being and running of a country and its economy. The current VAT system can be seen as not adhering to the policy of neutrality as medical care is a merit good and the standard-rated treatment thereon is disadvantaging members of society through the additional costs associated with VAT and competitively disadvantaging the private healthcare sector as a result of the effective exemption applied to the Department of Health and to all provincial hospitals. Therefore, medical care goods and services should qualify for zero-rated concessionary treatment with regards to the VAT Act of South Africa.

### 3.3) The Design of the Australian GST system compared to the South African VAT system

Australia's General Sales Tax ("Australian GST") is defined as:

*"broad-based tax of 10% on most goods, services and other items sold or consumed in Australia"* (Australian Taxation Office, 2018)

Thereby making it very similar in nature to that of the South African VAT System. The Australian GST system, like the South African VAT system, is based on the New Zealand system. However, the Australian system also adopts concepts from several other VAT systems. The result thereof is that the Australian VAT system is more territorial than the South African and New Zealand systems, but more worldwide than the EU and Canadian systems (as well as other) VAT Systems<sup>1</sup>. The Australian GST System imposes GST on "taxable supplies", which is defined as a supply made for consideration in the course or furtherance of an enterprise by a registered person and the supply is "connected with Australia".

The Australian GST System obtains its authority and power to tax a person based on where the operations of an "enterprise" is situated and carried on. In determination thereof, the system hinges on the "permanent establishment" idea that is utilised in their Income Tax system (Lang, et al., 2009: 269).

In accordance with Section 5 of the A New Tax System (Goods and Services Tax) Act 1999, the supply will be "connected with Australia" if the supply of the goods is:

- Delivered in or made available in Australia.
- Exported out of Australia.
- Imported into Australia.
- In the case of Real Property, the real is situated within Australia.
- In the case of anything else, the "thing" is
  - Completed in Australia; or
  - Supplied through an enterprise (or permanent establishment) carried on in Australia; or
  - If the supply is neither performed in Australia nor supplied through an enterprise carried on in Australia, and the "thing" is a right or option to acquire another "thing" and the supply of the "thing" would be connected (Office of Parliamentary Counsel, 1999).

The method used by the Australian GST system to address the source of the supply with regards to the "anything else" rule, which includes the supply of services, has a direct link to the structure of the source of supply rules used in the worldwide method of imposing indirect tax and VAT (Lang, et al., 2009: 269 - 270).

South Africa's VAT operates on a modified worldwide system. Within this system, vendor's are required to levy VAT on all supplies connected with their enterprise, wherever the supply occurs (Lang,

---

<sup>1</sup> A worldwide VAT system is described as one where the country can presumptively tax all of the person's supplies – regardless of where it is made, whereas a territorial VAT System is one where the country imposes VAT on taxable supplies made within the taxing country only (Lang, et al., 2009: 264).

et al., 2009:264). Hence, the source of the supply is not a decisive factor in determining the imposition of VAT in South Africa. Once an enterprise has carried on sufficient business in South Africa so that they need to be registered for VAT, the goods supplied by the entity are deemed to be made within South Africa – regardless of their actual location or the source of the supply and where it is being performed.

Therefore, it becomes clear that the South African VAT System and the Australian GST system are quite similar in nature – although the structure of their indirect Tax system may differ.

### **3.4) Analysis of the similarities in social, economic and State objectives for healthcare between South Africa and Australia**

The similarities between social, economic and State objectives for healthcare in Australia and South Africa needs to be determined and examined in evaluating the approach of zero-rating medical services and supplies in South Africa.

The Constitution of the Republic of South Africa (1996) places an obligation on the nation for the progressive realisation of socio-economic rights – including healthcare. Section 27 of the Constitution provides:

- “(1) Everyone has the right to have access to –*
- (a) health care services, including reproductive health care;*
  - (b) sufficient food and water; and*
  - (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.*
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.*
- (3) No one may be refused emergency medical treatment.” (The Constitutional Assembly , 1996:27)*

In order to guarantee the South African public’s right to healthcare, the South African Department of Health established the public hospital system in South Africa (as discussed in Chapter 2). To finance the cost of providing healthcare to all citizens, the Department of Health is lobbying for the implementation of National Health Insurance (NHI) as they believe that the right to healthcare should not depend on your wealth and income status, nor your geographical location, and hence are trying to apply a more equitable healthcare system in South Africa (Department of Health, 2017 :8-9).

The Australian Bill of Rights provides an almost identical right for all Australians to receive healthcare. Article 23 of the Australian Bill of Rights states:

- “(1) Every person has the right to an adequate standard of living, including:*
- (a) sufficient food and water; and*
  - (b) clothing and housing; and*
  - (c) access to health care services; and*
  - (d) access to social security, including if they are unable to support themselves and their dependants, appropriate social assistance.*

(2) *No one may be refused emergency medical treatment.*

(3) *The Commonwealth or State Government will take reasonable legislative and other measures to provide for the progressive realisation of each of these rights.*” (The Parliament of the Commonwealth of Australia, 2019: 27)

Australia operates a two-tiered healthcare system (like South Africa). The public healthcare system provides free or low-cost medical treatment as well as a private sector for those who elect to not use the public healthcare system. One of the main ways the Australian government finances the public healthcare system is through a Medicare Universal Healthcare Scheme (“Medicare”) that was established in 1984. Medicare is a single-payer scheme that covers the medical costs of all Australians and permanent residents using a public hospital. A Medicare levy (which is currently 2%) is charged on the taxable income of Australian Tax Residents over a certain income threshold. This is used to fund the cost of running Medicare. Furthermore, higher income earners who do not have appropriate private health insurance will pay a Medicare Levy Surcharge in addition to the Medicare Levy (Australian Taxation Office, 2020).

Australia spent roughly \$185.4-billion on healthcare goods and services in 2017-2018. This equates to around 10% of GDP being spent on healthcare. Of the \$185.4-billion spent on healthcare, the government contributed around 66%. Government health spending represented 24.4% of the Australian government’s budget (Australian Institute of Health and Welfare, 2019: iv), hence making health the Australian government’s second-largest sector by expenditure (Morrison & Cormann, 2017: 6-7). In comparison, South Africa’s expenditure on healthcare as a percentage of GDP was 9% in 2017. Additionally, healthcare is the South African Government’s third biggest expenditure sector, with 14% of its budget being allocated and spent on healthcare (National Treasury Republic of South Africa , 2019:8). The South African private sector contributed significantly more to overall healthcare expenditure, with the South African private sector providing the majority of healthcare expenditure in 2016 (Africa Health, 2019:1).

### **3.5) Australian Government rationale for zero-rating certain medical care services and goods**

Australia underwent a tax reform in 1998, a key Section of this reform was the implementation of a broad-based indirect tax (GST) to replace the wholesales tax system that was in operation (House of Representatives, 1998). In the Australian Treasury’s policy document *“Tax Reform: not a new tax, a new tax system”*, the policy document stated that *“most health, education and childcare services”* were to be excluded from the base that made up GST. (The Honourable Peter Costello, 1998: 16).

The Government’s rationale for making most healthcare and hospital services GST free is that this sector has substantial government involvement through regulations and subsidies. This results in many health services being provided free of direct charge, resulting in only a fraction of the total cost of the services being paid by the patient. Therefore, applying taxes on these health services will result in the private healthcare system being placed at a competitive disadvantage due to its heavy reliance on direct fees from patients to cover the cost of the services (The Honourable Peter Costello, 1998: 93). Due to this competitive disadvantage, the Australian Treasury made the decision that most healthcare services should be GST zero-rated, stating:

*“The cost of providing health care and insurance will fall as a result of the Government's indirect tax reforms as input taxes will be systematically removed from the sector.”* (The Honourable Peter Costello, 1998: 93)

This is consistent with the Committee's Terms of Reference (Tax Consultative Committee, 1998:2), which recommended that the GST reform be framed in a manner which ensured that:

*“... the tax system minimises any discrimination between private and public provisions of goods and services in the GST-free areas”* (Tax Consultative Committee, 1998:2)

The Australian Treasury received many submissions that reasoned that health is a “public good” and therefore argued for even greater concessions than were initially proposed by the government. The Committee recognised the ‘merit’ argument proposed in the submission but decided to concentrate on the government's guidelines as the ‘merit’ argument went beyond the guidelines as established in the Terms of Reference (Tax Consultative Committee, 1998: 26).

The Committee deemed it desirable to base the decision on the scope of GST-free health goods and services on existing definitions where possible. The reason for this was that they believed that this would result in the government receiving recommendations which would have been more “readily transferable” into legislation. It would also have the effect of assisting the stakeholders in effectively understanding the recommended scope of what healthcare goods and services should be zero-rated. However, the committee was also aware of areas within the healthcare system where they needed to make allowances for the changing nature of healthcare goods and services (Tax Consultative Committee, 1998: 26).

The committee also decided that the services (and goods) itself needed to be deemed GST-free rather than giving blanket GST-free concession to institutions. The reason thereof was to alleviate institutions that generally delivered these GST-free healthcare services from expanding their scope of supply into areas that should not be given GST-free treatment (Tax Consultative Committee, 1998: 26).

### **3.6) GST consequences of medical care services and goods in Australia**

In line with the Treasury of Australia's introduction of GST in *“Tax Reform: not a new tax, a new tax system”*, the GST laws contained in *A New Tax System (Goods and Services Tax) Act 1999* (GST Act) treat medical services as GST-free. The result thereof is that the supplier of these medical services will not be required to impose GST on the supply but will still be allowed to claim input tax credits for GST charged on expenditure it makes in carrying on its enterprise (Australian Taxation Office, 2020).

The Australian GST Act does provide for the exclusion of certain medical services (or ancillary medical services) which do not meet the specific requirements of the legislation to be GST-free and hence will be taxed as standard or exempt supplies under the GST Act. In addition to this, due to the Tax Consultative Committees decision to make specific medical services GST-free and not provide a blanket GST-free concession to healthcare services, not all supplies and goods provided by healthcare providers are indeed GST-free (Tax Consultative Committee, 1998: 26). Therefore, healthcare providers need to examine the validity of each individual good and service they make and sell on an individual basis to determine its correct GST consequence.

### 3.6.1) Medical care services and goods

Section 38-7(1) of the GST Act states that “a supply of a medical service is GST-free”.

A medical service is defined in Section 195-1 as:

- “(a) a service for which Medicare benefit is payable under Part II of the Health Insurance Act 1973; or
- (b) any other service supplied by or on behalf of a \*medical practitioner or \*approved pathology practitioner that is generally accepted in the medical profession as being necessary for the appropriate treatment of the \*recipient of the supply.” (Office of Parliamentary Counsel, 2014: 527)

In accordance with *Part II Section 10(1) and (2) of the Health Insurance Act 1973*, a Medicare benefit is defined as:

“(1)Where, on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person, Medicare benefit calculated in accordance with sub-section (2) is payable, subject to and in accordance with this Act, in respect of that professional service.”

“(2) A benefit in respect of a service is:

- (a) in the case of a service provided:
  - (i) as part of an episode of hospital treatment; or
  - (ii) as part of an episode of hospital-substitute treatment in respect of which the person to whom the treatment is provided chooses to receive a benefit from a private health insurer;
    - an amount equal to 75% of the Schedule fee; or
    - (aa) in the case of a service to which paragraph (a) does not apply and that is prescribed by the regulations for the purposes of this paragraph—an amount equal to 100% of the Schedule fee; or
    - (b) in any other case—an amount equal to 85% of the Schedule fee.” (Office of Parliamentary Counsel, 2020: 46)

To summarise, if medical expenditure is incurred within Australia to an eligible person in respect of hospital treatment, hospital substitute treatment, or is prescribed by regulation, the service and hence expenditure will constitute a Medicare Benefit *under Part II of the Health Insurance Act 1973* and will, therefore, be zero-rated in accordance with the Australian GST Act.

A “medical practitioner” in the GST Act refers to the *Health Insurance Act 1973*. *The Health Insurance Act 1973*, defines a “medical practitioner” in Part I, Section 3(1) as:

“... a person registered or licensed as a medical practitioner under a law of a State or Territory that provides for the registration or licensing of medical practitioners but does not include a person so registered or licensed:

- (a) whose registration, or licence to practise, as a medical practitioner in any State or Territory has been suspended, or cancelled, following an inquiry relating to his or her conduct; and

- (b) *who has not, after that suspension or cancellation, again been authorised to register or practise as a medical practitioner in that State or Territory.*" (Office of Parliamentary Counsel, 2020: 7)

An approved pathology practitioner (like Medical Practitioner) refers to the *The Health Insurance Act 1973*. *The Health Insurance Act 1973*, defines an approved pathology practitioner in *Part I, Section 3(1) as a person:*

*"whom there is in force an undertaking given by the person, and accepted by the Minister, under Section 23DF".* (Office of Parliamentary Counsel, 2020: 2)

Hence, in order to be an approved pathology practitioner, one needs to apply and be accepted by the Health Care Minister.

Furthermore, to meet the requirements under Section 195(1)(b) of the Australian GST Act, the supply must also be:

*"generally accepted in the medical profession as being necessary for an appropriate treatment".*

There is no definition of "generally accepted" and the Australian Taxation Office's ("ATO") issue logs are inconclusive on the matter - noting that it is ultimately the decision of the medical profession to determine what services are "generally accepted" (Australian Medical Association, 2000:5). Nevertheless, a treatment is considered necessary if the health professional is using their professional skills to assess the patients' health, work out a course of action to preserve, restore or improve the patient's wellbeing to the best of their training, and to supply a treatment that is generally accepted as being appropriate by their profession (Whitby, 2000: 129).

Provisos to the zero-rating of medical services under Section 38-7(1) are laid out in Section 28-7(2) of the GST Act. In accordance with Section 38-7(2), a supply of a medical service as defined is not GST-free if:

- (a) *it is a supply of a \*professional service rendered in prescribed circumstances within the meaning of regulation 14 of the Health Insurance Regulations made under the Health Insurance Act 1973 (other than the prescribed circumstances set out in regulations 14(2)(ea), (f) and (g)); or*
- (b) *it is rendered for cosmetic reasons and is not a \*professional service for which medicare benefit is payable under Part II of the Health Insurance Act 1973.*" (Office of Parliamentary Counsel, 1999: 98)

Section 38-7(2)(a) requires that in order for the supply of a medical service not to be GST-free, the supply needs to be rendered in prescribed circumstances in accordance with *"regulation 14 of the Health Insurance Regulations made under the Health Insurance Act 1973"*:

- (1) *Unless the Minister otherwise directs, Medicare benefits are not payable in respect of professional services rendered in prescribed circumstances.*
- (2) *Each of the following shall be taken to be professional services rendered in prescribed circumstances:*

- (a) *professional services rendered in relation to the provision of chelation therapy (that is to say, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) otherwise than for the treatment of heavy-metal poisoning;*
- (b) *professional services rendered in association with the injection of human chorionic gonadotrophin in the management of obesity;*
- (c) *professional services rendered in relation to the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;*
- (d) *professional services rendered for the purpose of, or in relation to, the removal of tattoos;” (Cosgrove, 2019: 8-9)*

Additionally, Section 38-7(1)(a) states that services are excluded from “*regulation 14 of the Health Insurance Regulations made under the Health Insurance Act 1973*” if they are rendered under (2)(ea), (f) or (g). These sub-sections of the regulation state:

- “(ea) *professional services rendered for the purposes of, or in relation to, the removal from a cadaver of kidneys for transplantation;*
- (f) *professional services rendered for the purposes of, or in relation to:*
  - (i) *the transplantation of a thoracic or abdominal organ, other than a kidney, or of part of an organ of that kind; or*
  - (ii) *the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or of a part of an organ of that kind;*  
*if the services are rendered to a patient of a hospital;*
- (g) *professional services rendered for the purpose of administering microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used immediately before or during the therapy”. (Cosgrove, 2019: 9)*

The Australian GST Act does not define the phrase “cosmetic reason”. Therefore, the ATO considers the term to take on its ordinary meaning as defined in the Macquarie Concise Dictionary as:

- “(v) *serving to beautify: imparting or improving beauty, especially of the complexion:*
  - w) *designs to effect a superficial alteration while keeping the basis unchanged”.*
- (Australian Taxation Office, 2013)

In accordance with the ATO issuance on medical services rendered for cosmetic reasons, the ATO states a service is rendered for cosmetic reasons if it is principally performed for the purpose of improving one’s personal appearance and hence has no medical or reconstructive purpose. However, procedures performed for reconstructive or medical reasons do not meet the requirements of Section 38-7(2)(b) and hence have zero-rated GST consequences (Australian Taxation Office, 2013).

Further to making certain medical goods GST-free, the Australian GST-Act deems the supply of goods as GST-free under Section 38-7(3) if:

- “(a) *it is made to an individual in the course of supplying to him or her a \*medical service the supply of which is GST-free; and*
- (b) *it is made at the premises at which the medical service is supplied”.* (Office of Parliamentary Counsel, 1999: 98)

It is evident from the above that medical services and goods are explicitly defined in the Australian GST system, and hence it is restrictive in terms of which medical services and goods do qualify for GST-free treatment. Due to the limiting nature of the definition, the Australian GST Act further defines the various sub-sections in health and their requirements for having a zero-rated GST consequence. The remainder of this sub-chapter will explore the various sub-sections that are applicable to medical services and goods.

### 3.6.2) Other health services

Health services that are not defined as medical services in Section 38-7 of the Australian GST Act may still be GST-free if they meet the criteria established under Section 38-10 of the Australian GST Act. Additionally, a supply under Section 38-10 may not always be made to a patient but can also be made to another business. Section 38-10 allows for a supply to be GST-free if all the below applies:

- It is a listed health service<sup>2</sup>.
- The service is made by a recognised health professional or they provide assistance (under specific conditions).
- The service is generally accepted as being necessary for the appropriate treatment of the patient (Australian Taxation Office, 2020).

Section 195-1 defines a recognised professional as:

- “(a) the service is supplied in a State or Territory in which the person has a permission or approval, or is registered, under a \*State law or a \*Territory law prohibiting the supply of services of that kind without such permission, approval or registration; or*
- (b) the service is supplied in a State or Territory in which there is no State law or Territory law requiring such permission, approval or registration, and the person is a member of a professional association that has uniform national registration requirements relating to the supply of services of that kind; or*
- (c) in the case of services covered by item 3 in the table—the service is supplied by an accredited service provider within the meaning of Section 4 of the Hearing Services Administration Act 1997.” (Office of Parliamentary Counsel, 1999: 534)*

Furthermore, Section 38-10(5) zero-rates services supplied by ambulances during treatment.

It can be evidenced that Section 38-10 follows the same principles established under Section 38-7 where the supply needs to be performed by a recognised professional in that field, the service must be generally accepted as necessary and the treatment must be appropriate. Therefore, Section 38-10 allows for healthcare services that are deemed to be merit goods for society to have the same zero-rated GST treatment that is applied to medical services. In doing so, the Tax Consultative Committee made provisions for GST-free treatment within areas of the healthcare system where allowances needed to be made due to the changing nature of healthcare goods and services (Tax Consultative Committee, 1998: 26).

### 3.6.3) Other government-funded health services

Section 38-15 of the Australian GST Act makes provision for a supply to be GST-free if:

---

<sup>2</sup> Refer to Annexure 1 for health services listed under Section 38-10 of the Australian Tax Act as GST-free.

- “(a) it is a supply of a health service in connection with a supply that is GST-free because of Section 38-7 or 38-10; and
- (b) the supplier receives funding from the Commonwealth, a State or a Territory in connection with the supply of the health service; and
- (c) the supply of the health service is of a kind determined in writing by the Health Minister”. (Office of Parliamentary Counsel, 1999: 100)

Through the insertion of this sub-section in the GST Act, the Australian Treasury and Tax Committee is able to further alleviate any competitive disadvantages faced by the private health sector when compared to the public health sector in providing these services as discussed in Section 3.5 of this paper.

#### **3.6.4) Hospital treatment**

Hospital treatment is defined in Section 195-1 of the Australian GST Act as the definition thereof in the *Private Health Insurance Act 2007*, wherein Hospital Treatment is defined as:

- “(1) Hospital treatment is treatment (including the provision of goods and services) that:
  - (a) is intended to manage a disease, injury or condition; and
  - (b) is provided to a person:
    - (i) by a person who is authorised by a \*hospital to provide the treatment; or
    - (ii) under the management or control of such a person; and
  - (c) either:
    - (i) is provided at a hospital; or
    - (ii) is provided, or arranged, with the direct involvement of a hospital”.

(Office of Parliamentary Counsel, 2021: 86)

If the supply meets the definition above, the supply will be zero-rated in accordance with Section 38-20 of the Australian GST Act, unless the supply made in the hospital meets the requirements established in Section 38-7(2) as discussed under 3.6.1 of this paper.

#### **3.6.5) Medical aids and appliances and other health goods**

Health goods that are not defined as medical supplies in Section 38-7 (3) of the Australian GST Act may still be GST-free if they meet the criteria established under Section 38-45 or Section 38-47 of the Australian GST Act. Section 38-45 allows for a medical aids and appliances that satisfy the conditions set out in the Section to be GST-free at all points in the supply chain. In accordance with Section 38-45, medical aids and appliances are to be GST-free if the three conditions listed below are met:

- 1) The medical aid or appliance is listed in schedule 3<sup>3</sup> to the GST Act or in the GST regulation.
- 2) The medical aid or appliance is designed specifically for people who are disabled or ill.
- 3) The medical aid or appliance is commonly utilised among members of the public who are not disabled or ill. (Australian Taxation Office, 2020)

---

<sup>3</sup> Refer to Annexure 2 for Schedule 3 of the Australian GST Act

Additional to the GST-free consequences under Section 38-45, Section 38-47 gives the Health Minister of Australia discretion in determining which other health goods are to be declared zero-rated.

Section 38-45 and 47 both include a proviso that if both the recipient and the supplier agree, the supplies are not treated as a GST-free supply. According to the ATO, the reason for this is the simplification of administering GST as manufacturers may supply a range of GST-free and taxable goods to a retailer and don't want the administrative burden of identifying the GST status of every product (Australian Taxation Office, 2020).

### 3.6.6) Drugs and prescription medicine

The Australian GST system specifically makes provisions for the zero-rating of medicine and the preparations thereof in Section 38-50. Section 38-50(1) defines the general requirements in which a drug or medical preparation is GST-free. Section 38-50(1) states:

- “(1) A supply of a drug or medicinal preparation is GST-free if the supply is on prescription and:
- (a) under a State law or a Territory law in the State or Territory in which the supply takes place, supply of the drug or medicinal preparation is restricted, but may be supplied on prescription; or
  - (b) the drug or medicinal preparation is a pharmaceutical benefit (within the meaning of Part VII of the National Health Act 1953).” (Office of Parliamentary Counsel, 1999: 105)

In accordance with a public ruling issued by the ATO, Section 38-50(1)(a) allows for the zero-rating of drugs that are specified in Schedules 4 and 8 of the *Standard for the Uniform Scheduling of Medicines and Poisons* that are only available on prescription. Whereas, paragraph (b) covers the zero-rated treatment of “Pharmaceutical Benefits Scheme” medicine which is supplied as prescription based pharmaceutical benefit as defined in *Part VII of the National Health Act* (Australian Taxation Office, 2019).

Section 38-50 (2) makes provision for the GST-free treatment of medicine and drugs that can only be supplied by a medical practitioner, dentist or pharmacist. Section 38-50(2) states:

- “(2) A supply of a drug or medicinal preparation is GST-free if, under a \*State law or a \*Territory law in the State or Territory in which it is supplied, the supply of the drug or medicinal preparation to an individual for private or domestic use or consumption is restricted but may be made by:
- (a) a \*medical practitioner, \*dental practitioner or pharmacist; or
  - (b) any other person permitted by or under that law to do so.” (Office of Parliamentary Counsel, 1999: 106)

Furthermore, Section 38-50(5) allows for the zero-rated treatment of small packet (less than 25) painkillers containing aspirin, paracetamol or ibuprofen which are intended to be taken by mouth. Whereas, sub-section (6) makes provision for medicine and drugs which are supplied under the “*Special Access Scheme*” and permits new drugs which are still to be approved in Australia for supply, to be supplied to patients who have life-threatening or other serious illnesses (Australian Taxation Office, 2019).

However, Section 38-50(7) provides a proviso to when drugs are not GST-free as it states:

- “(7) A supply of a drug or medicinal preparation covered by this Section is GST-free if, and only if:*
- (a) the drug or medicinal preparation is for human use or consumption; and*
  - (b) the supply is to an individual for private or domestic use or consumption.”*

(Office of Parliamentary Counsel, 1999: 107)

Therefore, medicines and drugs provided to animals or drugs supplied by a wholesaler will be standard-rated.

### **3.6.7) Private health insurance**

To ensure that the private health sector was not at a competitive disadvantage, the Australian GST Act additionally made provision for the zero-rated treatment of the supply of private health insurance under Section 38-55(1) of the Australian GST Act. Private medical insurance is defined in Section 195-1 of the Australian GST Act as:

*“Insurance provided under a contract of insurance that was entered into by a private health insurer (within the meaning of the Private Health Insurance Act 2007) in the course of carrying on health insurance business”* (Office of Parliamentary Counsel, 1999: 107)

The *Private Health Insurance Act 2007* requires the insurer to be registered with the *Private Health Insurance (Prudential Supervision) Act 2015*. Section 38-55(2) additionally makes concessional GST-free treatment available for ambulance insurance cover.

The Australian GST treatment of Private health insurance is consistent with the GST treatment of health services under Subdivision 38-B of the Australian GST Act and is not consistent with the GST treatment of other insurance policies in Australia. Life Insurance is input-taxed because they involve a substantial component of savings and are hence are a financial service in nature. Therefore, life insurance is treated consistently with financial services under the Australian GST (Australian Veterinary Journal, 1999: 756). Whereas all other insurance is fully taxable in accordance with the GST Act (Australian Taxation Office, 2019).

### **3.7. Analysis of the design of the United Arab Emirates VAT system compared to the South African VAT system**

The United Arab Emirates (“UAE”) implemented a Value-Added Tax (VAT) system in January 2018 (Deloitte, 2017: 4). Consequently, they became one of the latest countries in the world to adopt a consumption tax-based system. The UAE VAT system was a new source of tax implemented in the UAE as it did not replace any pre-existing sales tax (The Institute of Chartered Accountants of India, June 2018: 21). This contrasted the South African VAT system which was adopted as a substitute for the General Sales Tax system (Go, et al., 2005: 2). VAT was introduced into the UAE to provide the government with a new source of funding which would be used to provide high quality public services and help the government transition the economy away from its dependence on oil and hydrocarbons (UAE, 2020).

The UAE is a Member State of the Gulf Cooperation Council (GCC). Hence the implementation of VAT in the UAE was due to their adherence of the GCC Framework for common law and the requirement for all Member States to implement VAT. The GCC's VAT framework states that all Member States need to apply a consumption-based VAT model. (The Institute of Chartered Accountants of India, June 2018:7). A consumption-based VAT model is the most widely used VAT model globally. The South African VAT system is likewise based on the consumption model, as ultimately the consumer in the final stage of production ends up paying the tax (Go, et al., 2005:2).

The UAE VAT System (in accordance with the GCC Framework) applies the destination principle as the basis for the taxing of supplies - although some deviations from the destination principle with regards to where services are made have been noted. A destination based taxing system allows the UAE to tax all goods and services that are consumed in the UAE – irrespective of their country of origin (The Institute of Chartered Accountants of India, June 2018:3). The design of the South African VAT system follows a modified destination approach with respect to taxing imports and exports, where imports of goods and related services are taxed at the border, whereas exports of goods and related services are zero-rated. Additionally, some imported services are taxed to the recipient under a reverse charge rule (Lang, et al., 2009:261).

Furthermore, the UAE operates a broad-based single rate VAT system, with GCC members having agreed to charge VAT at a fixed rate of 5% with a few exceptions and exemptions made on certain goods and services (Deloitte, 2020: 1). As mentioned previously (refer to 3.1), South Africa's VAT Act is also a broad-based VAT system with various tax concessions due to pressure from affected groups.

Therefore, even though the structure and rules of the South African and UAE VAT systems may differ, it becomes apparent that the two systems are similar in nature.

### **3.8. Analysis of the UAE healthcare economic consideration and State objectives**

The UAE has a comprehensive government funded health system, which is complemented by an ever-increasing private sector. The UAE offers a two-tiered health system. Healthcare is regulated at both a federal and emirate level because of UAE's governing structure. Emirati nationals are able to access the public hospitals at free to little cost whereas non-nationals will have to incur more costs for healthcare and generally use private health facilities (Embassy of the United Arab Emirates, 2020).

In the Emirate of Dubai and Abu Dhabi, employers and sponsors are required to provide health insurance coverage for their employees. This, coupled with the high medical costs and the increasing number of expatriates in the UAE, has resulted in a significant increase in the number of people living in the UAE that has health insurance (U.S - U.A.E Business Council, 2018). The result thereof is the number of private hospitals in 2014, being 71, was more than double the number of government hospitals, which sat at 33 (U.S - U.A.E Business Council, 2014). In comparison to South Africa, there is a heavier reliance on the private sector in the UAE, as South Africa has only 280 private hospitals out of a total of 715 in 2017. However, there is an upward trend of private hospitals and healthcare in South Africa, as the number of private hospitals has increased by 4% since 2012. Additionally, UAE's healthcare accounted for 6.89% of the total expenditure per the fiscal budget for the 2020 fiscal year (United Arab Emirates Ministry of Finance, 2020), which is only 2.11% less than South Africa allocated to healthcare in 2017.

### 3.9. Analysis of the VAT treatment of medical care services and goods in the UAE

The Member States of the GCC agreed that certain sectors, in accordance with certain conditions and provisions, may be exempted or zero-rated as determined by the Member State. The healthcare sector was included as one of these sectors. Article 31 made provision for medicine and medical equipment to be zero-rated in accordance with unified provisions proposed by the Committee of Ministers of Health and approved by the Financial and Economic Cooperation Committee (Cooperation Council for the Arab Gulf States (GCC), 2017: 11-12). It is this that sets the basis for UAE's VAT principles as established in *Federal Decree-Law No. (8) of 2017 on Value Added Tax* (President of the United Arab Emirates, 2017).

Article 35 of the *Federal Decree-Law No. (8) of 2017 on Value Added Tax (UAE VAT Act)*, provides for the zero-rating of certain supplies of goods and services. Within this article, sub-section (14) zero-rates:

*“The supply of preventive and basic healthcare Services and related Goods and Services according to what is specified in the Executive Regulation of this Decree-Law.”* (President of the United Arab Emirates, 2017: 19)

Therefore, the supplier of these healthcare services will not be required to charge VAT on the supply but is still allowed an input tax credit for VAT charged on expenditure made in carrying on its enterprise.

Although not defined in the *Federal Decree-Law No. (8) of 2017 on Value Added Tax*, Article 41 of the *Cabinet Decision No. (52) of 2017 on the Executive Regulations of the Federal Decree-Law No (8) of 2017 on Value Added Tax* defines “healthcare” as:

*“any Service supplied that is generally accepted in the medical profession as being necessary for the treatment of the Recipient of the supply including preventive treatment.”* (Maktoum, 2017: 28)

Furthermore, the Cabinet's decision elaborates in Subsection (2) that a supply of the healthcare services is zero-rated on the condition that the supply:

- a) *Be made by a healthcare body or institution, doctor, nurse, technician, dentist, or pharmacy, licensed by the Ministry of Health or by any other competent authority.*
- b) *Relate to the wellbeing of a human being”.* (Maktoum, 2017: 28)

Article 41(3) of the *Cabinet Decision No. (52) of 2017 on the Executive Regulations of the Federal Decree-Law No (8) of 2017 on Value Added Tax* provides for a proviso for the zero-rating of healthcare services, stating:

- 3. *‘Healthcare services’ do not include any of the following:*
  - a. *Any part of a supply that relates to staying in or attending an establishment the principal purpose of which is to provide holiday accommodation or entertainment such that any healthcare service is incidental to the provision of the accommodation or entertainment.*

- b. *Elective treatment for cosmetic reasons other than prescribed by a doctor or medical professional for treating or prevention of a medical condition” (Maktoum, 2017: 28)*

This is similar to the Australian GST Act which limits the zero-rating of healthcare services to certain conditions and specifications (refer to chapter 3.6). Furthermore, proviso 3(b) is a very similar proviso to the one provided in the Australia GST Act which states that medical services for cosmetic reasons will be prohibited from the zero-rated concession applied to healthcare as it has no medical benefit.

In line with the provisions of *Unified Common VAT Agreement of the States of the Gulf Cooperation Council (GCC)*, the *Cabinet Decision No. (52) of 2017 on the Executive Regulations of the Federal Decree-Law No (8) of 2017 on Value Added Tax* provides for the zero-rating of health goods if the health goods are the supply of any pharmaceutical products in Article 41(4)(a), or medical equipment in Article 41(4)(b). Furthermore, to ensure cohesion between goods used in the supply of healthcare services and the zero-rated nature of the supply itself, the UAE VAT Act under Article 41 (4)(c) zero-rates:

*“Any other Goods not covered by paragraphs (a) and (b) of this Clause which are supplied in the course of supplying a Person with zero-rated healthcare services that are necessary for the supply of such healthcare services.” (Maktoum, 2017: 29)*

Although, under Article 41 the supply of preventative and basic healthcare is zero-rated, the supply of health insurance is not included in Article 41, nor is it included Article 45 of the Federal Decree-Law No. (8) of 2017 on Value Added Tax. Additionally, health insurance does not meet the requirements under Article 41 of the Cabinet Decision No. (52) of 2017 on the Executive Regulations of the Federal Decree-Law No (8) of 2017 on Value Added Tax and, hence, is not an exempt supply. Therefore, health insurance is taxed as a standard-rate supply in accordance with the UAE VAT Act (Federal Tax Authority (UAE), 2020). The standard-rated nature would generally allow the health insurance companies to claim input VAT credits against the output VAT that would need to be paid. However, due to the underlying inputs into health insurance being the medical care that is zero-rated under Article 41 of the *Cabinet Decision No. (52) of 2017 on the Executive Regulations of the Federal Decree-Law No (8) of 2017 on Value Added Tax*, the health insurance companies will be required to charge output VAT on the supply of health insurance, thereby increasing the cost of the health insurance product due to the costs of VAT (Maktoum, 2017).

### **3.10. Recommendation**

The recommendation is that the VAT treatment of medical care services and goods and medical insurance in South Africa be reconsidered and that the current standard-rated and exempt supply rules be changed so that both are considered a zero-rated supply. This will allow the competitive disadvantage that the private medical care suppliers are placed under, due to substantial government involvement in public healthcare through regulations and subsidies, to be alleviated. In line with medical care being zero-rated, medical insurance should also be zero-rated. This follows the approach utilised by the Australian GST system where the treatment of private health insurance is consistent with health services and not in line with other insurance policies.

Furthermore, applying the zero-rated treatment to medical care services and goods should allow medical care providers to free-up additional funding (due to not having to charge output VAT). This could and should be used to decrease the cost of medical care to the public. Additionally, the zero-rating of medical insurance will allow medical insurers to decrease insurance premiums as the burden of 'trapped' input VAT will not have to be passed onto patients.

In order to reduce concerns of the possible exploitation of the VAT system by medical suppliers and insurers, the Australian decision to not provide a blanket GST-free treatment to medical care but rather deeming the medical services and goods itself GST-free is recommended for South Africa. This should help alleviate institutions that generally delivered such healthcare services expanding their scope of supply into areas that should not be given zero-rated VAT treatment.

With regards to deciding whether to base the legislation of zero-rating medical care on the Australian GST Act or the UAE's VAT Act, the recommendation is that the updated South African legislation be based on the Australian legislation for the following reasons:

- The South African healthcare system has more in common with the Australian system. The South African Bill of Rights are very similar to the Australia Bill of Rights in that it provides for all people to receive healthcare. Australia also operates a two-tiered system, with healthcare being one of the largest funded sectors by the government, as well as South Africa and Australia spending thereon being between 9% and 10% of their GDP, both of which is above the OCED average. Furthermore, with the South African healthcare system moving towards the NHI scheme, the Australian GST system has provisions within their GST Act to ensure that the private sector is not placed at a competitive disadvantage under their healthcare system. These include the zero-rating of private medical insurance and other government-funded health services, as well as ensuring zero-rating of services for which a Medicare benefit is payable.

On the other hand, although the UAE operates a two-tiered system, the citizens of the UAE do not share the same Bill of Rights, nor is the public healthcare sector the major sector servicing the medical needs of the public with regards to healthcare. The heavy reliance on the private sector for healthcare is evident in the UAE VAT Act. The UAE VAT Act has no provisions for alleviating a competitive disadvantage that may exist between the public and private healthcare sectors after the zero-rating of "preventative and basic healthcare".

- The Australian GST Act is more an established legislation and was also implemented to replace the already existing wholesales sales tax. Whereas, the UAE VAT Act was implemented in 2018 as a first-time consumption-based tax system in the UAE, and hence not enough time has lapsed for any amendments to be passed to rectify any shortcomings of the UAE VAT Act. Additionally, the Australia GST Act is more specific and provides more detailed legislation providing specific requirements for hospital, medical aids, medical appliances, medical drugs and medical preparation. This more specific guidance effectively helps alleviate the concerns of potential exploitation of the VAT system by medical suppliers.
- One of the concerns with the South African VAT legislation with regards to medical care is that medical insurance is exempt, thereby creating "trapped" input tax credits as medical insurers pass on the cost to consumers. The Australian GST system treats medical insurance consistently with the treatment of healthcare, hence resulting in zero-rated concessional

treatment, regardless of whether they access private medical care via insurance or out-of-pocket expenditure. On the other hand, the UAE VAT legislation requires health insurance to be standard-rated. This results in a situation where health insurance companies will be required to charge output VAT on the supply of health insurance, thereby increasing the cost of the health insurance product due to the cost of VAT.

### **3.11. Conclusion**

The Australian GST system and the UAE VAT system provide greater beneficial treatment for medical services and goods than the current South African VAT system. Neither system provides blanket zero-rated concessional treatment to medical care institutions, but instead zero-rates specific medical care services and goods.

The Australian GST system and the UAE VAT system may seem distinctive from the South African VAT system in terms of regulation and the base thereof, however both systems are modern VAT systems with considerable characteristics in relation to the worldwide position on VAT which is similar to the South African position. Additionally, all three nations operate a two-tiered healthcare system. Hence, both the Australian and UAE systems provide valuable framework on VAT legislation and consequences which may be adopted by the South African VAT legislation with regards to medical care and insurance.

The Australian and South African state intentions and objectives with regards to health are similar in terms of accessibility to healthcare as well the fact that Australia is currently implementing a Medicare system which has similarities to the proposed NHI system of South Africa. Furthermore, the established nature of the Australian GST legislation (and the fact that the Australian GST Act is more specific and provides more detailed legislation) suggests that the Australian GST legislation should be used as a base for the consideration of an amendment to the South African legislation with regards to zero-rating medical services and goods.

In conclusion, it is recommended that the zero-rating of medical services and goods as well as medical insurance should be considered. This will allow for a reduced cost of providing these goods and services and alleviate the competitive disadvantage that the private medical care suppliers are placed under due to substantial government involvement in public medical care. Furthermore, it will decrease the output VAT burden on medical services and goods as well as the burden of non-recoverable VAT on medical insurance.

#### **4) Critical analysis of whether any other preferable VAT concessionary treatment on medical care services and goods exist and if they provide a better alternative**

The standard-rated VAT treatment utilised by South Africa and the zero-rated VAT treatment utilised by Australia and the UAE are not the only possible VAT treatments for medical care services and goods. This chapter will analyse alternative VAT treatments that exist for healthcare systems. Additionally, recommendations are made on the validity of these VAT treatments on medical care services and goods.

##### **4.1. Analysis of exempting medical care services and goods from VAT in South Africa**

###### **4.1.1) Argument for exempting medical care services and goods**

VAT exempt supplies allows the supplier not to account for output VAT on the supply of their goods and services. However, the supplier is also not allowed to claim a credit for input VAT for amounts paid on expenditure in carrying on that supply.

A broad-based, single-rate VAT system is widely recognised as a regressive tax system as VAT targets those with lower disposable income more than those with higher disposable income (Tamaoka, 1994: 69). This regressive nature of VAT is generally against the equality and fairness objective included in a country's social policy. Therefore, in order to reduce the regressive nature of VAT, reduced VAT Rates or VAT exempt categories were provided for, allowing some progressive structure to VAT (Konstantinos, 2016: 8). Assigning concessional treatments to merit goods was a way for government to support equity through redistribution.

One of the most cited reasons for the exemption of VAT on healthcare is the fairness between different income groups in society (de la Feria, 2015: 19). Vertical equity refers directly to the regressive nature of VAT as it burdens low-income sectors of the public the most. Many products exhibit low price elasticity, resulting in the demand for these products or services not fluctuating much with a change in price. It was found that spending on these items (which includes medicine and healthcare) comprises the biggest portion of low-income household expenditure (Konstantinos, 2016: 9) – making the case for the concessional treatment thereof.

Furthermore, exempting VAT on medical services and goods has the added advantage of reducing the cost of the specific items that yield a positive externality. By applying exemptions hereon, it can be considered as an approach to encourage and increase the consumption of these merit goods (de la Feria & Krever, 2013:22). Due to the nature of healthcare and the fact that a healthy workforce increases wealth, along with the fact that vaccines limit the exposure of diseases to other people, healthcare is seen as a positive externality (Mankiw, 2017: 3). According to Borowiecki & Navarrete (2018: 329), the concessional treatment of these goods correlates with the theory that the free market cannot account for these positive externalities, hence obstructing the effectiveness of these goods and services and, therefore, providing motive and reason for government intervention through various policies, including exempting these goods from VAT (Konstantinos, 2016: 11).

Exempting supplies provides a better economic and administrative alternative to concessional VAT treatment, in comparison to zero-rating the supply. According to Le (2003:24), zero-rating has increased in complexity due to the intensified audits and refunds that are associated with a zero-rated

system. This is a result of suppliers of zero-rated items being able to claim a credit for input VAT. Therefore, zero-rating is less financially profitable to the State than exempting the supply. Hence, exemptions provide the government with a less costly option both administratively and revenue wise than zero-rating the supply.

#### **4.1.2) The case of the United Kingdom and European Union**

VAT was introduced in the United Kingdom in 1973 when the UK joined the European Union (“EU”) and replaced the existing Purchases Tax system. The sixth European VAT directive established common VAT rules for Member States of the EU. The harmonisation of VAT across the Member States of the European Union has been recognised for some time as an integral part of the creation of the single European Market. Under Article 13 of the Sixth Directive, exemptions to VAT provided for certain activities that were in the public’s interest (Council of the European Union, 1977: 13.6.77). Additionally, the majority of delegations at the Sixth Directive meeting on the 13<sup>th</sup> of July 1989 agreed that medical care should be exempt under Article 13 or deemed out of scope of VAT (VAT Committee, 2020: 53). Therefore, Article 13 of the sixth directive exempts certain medical care that falls under the following:

*“b) hospital and medical care and closely related activities undertaken by bodies governed by public law or, under social conditions comparable to those applicable to bodies governed by public law, by hospitals, centres for medical treatment or diagnosis and other duly recognized establishments of a similar nature;*

*(c) the provision of medical care in the exercise of the medical and paramedical professions as defined by the Member State concerned”.*

The United Kingdom implemented this medical exemption into their *Value Added Tax Act 1994* (‘UK VAT Act’) where, under Section 31(1), it states that a supply is exempt if is included and defined in Schedule 9 of the UK VAT Act. Group 7 of the 9<sup>th</sup> schedule includes the VAT exemptions that apply to the supply of healthcare goods and services (UK Public General Acts, 1994).

#### **4.1.3) Disadvantages of exempting medical care services and goods in South Africa**

Despite VAT exemptions being commonplace in the world, there are multiple issues associated with providing exemptions. Cnossen (2003: 437) argues that the rationale for VAT exemptions lies in the history of their implementation and not in the underlying economic nor administrative logic as discussed in 4.6.1. These generally lead to the over-taxation of businesses and the under-taxation of consumers.

Exemptions tend to erode the tax base of the country’s revenue services as a result of exemptions narrowing the tax base. This is especially prevalent in the traditional EU-style VAT system. The modern VAT system style which uses broad-base VAT with a low, single standard rate and less concessions and exemptions (with references specifically to New Zealand system) scored the highest in the VAT revenue ratio <sup>4</sup> (Charlet & Owen, 2010: 945). A study performed by Le (2003: 4) states that implementing exemptions into the VAT system induces a “cascading effect” when the exempt supply

---

<sup>4</sup> The VAT Revenue Ratio by the OCED in Consumption Tax Trends 2008 as:

“the ratio between the actual VAT revenue collected and the revenue that would theoretically be raised if VAT was applied at the standard rate to all final consumption:  
VAT Revenue Ratio = (VAT revenue)/([consumption – VAT revenue] x standard VAT rate)” (OCED, 2008)

is not at the end of the supply chain and hence is not consumed by the consumer. This makes the system economically inefficient (Le, 2003: 50).

Furthermore, in a study completed by Dietl, et al. (2011:21), it was found that VAT exemptions positively affects profits of exempt operators and degrades profits of rated operators, thereby providing a competitive advantage to the exempt operators' relative position, and resulting in an unlevel playing field. VAT exemption also increases the administration issues for the tax authority and compliance complexities for the taxpayer (Charlet & Owen, 2010: 944). This is caused when a supplier produces both exempt and taxable supplies and hence is required to apportion their inputs between these two categories of supplies.

#### **4.2. Analysis of applying a reduced VAT rate to medical care services and goods in South Africa**

An unfavourable alternative would be to apply a reduced VAT rate to medical services and goods. The argument in favour thereof is that a reduced rate system is more efficient and equitable. The efficiency argument attempts to reduce dead-weight loss through altering VAT rates on goods and services. This is due to the belief that VAT rates should be set inversely proportional to the supply's own elasticity of demand. With regards to this, it is argued that when reduced rates are applied to goods and services predominantly consumed by the poor, it will help reduce the regressive nature of VAT (Le, 2003: 35).

A reduced VAT rate system is utilised as part of the EU VAT system. Under this system, Member States may utilise up to two reduced VAT rates, in addition to zero-rating and exempting supplies. These reduced rates may not be lower than 5%. The reduced rate must be fixed so that the VAT therefrom is such that the input VAT can be deducted in full in accordance with Article 98 and 99 of the EU VAT Directive (Council of the European Union, 1977: 347/23 & 347/24). The use of reduced rates is limited to certain supplies. The supply of medical care that does not meet the definition of being exempt under Article 13 (see 4.1) but meets the definition and requirements set out in the following subsections of Article 98, may be taxed at a reduced rate:

- “(3) pharmaceutical products of a kind normally used for health care, prevention of illnesses and as treatment for medical and veterinary purposes, including products used for contraception and sanitary protection;*
- (4) medical equipment, aids and other appliances normally intended to alleviate or treat disability, for the exclusive personal use of the disabled, including the repair of such goods, and supply of children's car seats”. (Council of the European Union, 1977: 347/23 & 347/24)*

A reduced VAT rate as an alternative will allow healthcare providers in South Africa to significantly reduce the cost of their final products (due to the VAT portion being decreased), while still allowing healthcare providers to claim the VAT incurred in the supply of healthcare

However, The Davis Tax committee argued that reduced VAT rates are a poor tool for directing aid to the poorer households in the economy, as the best-case scenario is that the rich receive just as much benefit as the poor. And, at worst, the rich actually get more benefit in absolute monetary value terms than the poorer households (The Davis Tax Committee, July 2015: 26). A study performed on VAT charged on basic foods (which accounts for a major share of the total consumption of the poor) found that, although the subsidy as a result of the reduction in the VAT rate was meant to benefit the poor, it resulted in the rich benefitting more therefrom. This was due to the rich spending a larger absolute

monetary amount on the items than the poor, and hence they gain more from the subsidy than the poor (Le, 2003: 37-38).

Furthermore, a reduced VAT rate requires increased bookkeeping costs for businesses due to the complexity with regards to the different VAT rates to be applied. This in turn increases administration costs for the tax authorities as they would be required to collect more information in order to assess the VAT positions of companies (Le, 2003: 35). In a study performed by Tait (1988), at least 17 pieces of information are required if the number of positive rates triple. This is compared to nine pieces of information required under a single-rate system with zero-rating and exemptions only as concessions. Additionally, reduced rates and rate differentiations can hinder the optimal collection of VAT, hence providing extensive opportunities for fraud through the potential misclassification of products, therefore adversely impacting public revenue, which could have been allocated to social policy (Polomarkakis, 2016: 15). Additionally, the complexity in accurately measuring the effectiveness of the subsidy on distribution of income among the different income groups makes it an ineffective tool in the redistribution of income, and hence undermines the reason for the reduced VAT rate (Le, 2003: 38).

#### **4.3. Conclusion**

Other alternative concessional VAT treatments exist if zero-rating medical care is not the preferred replacement for the current standard-rating treating of medical care services and goods.

Exempting the supply of medical care (a method used in the UK VAT System) will allow the South African Government to support equality through the redistribution of income which occurs with exempting merit-goods. It will also encourage the positive externalities that can be seen through increased consumption thereof. Additionally, VAT exemptions will provide a better economic and administrative alternative to zero-rating. However, exemptions tend to erode the tax base of the revenue services by narrowing the tax base and it has the potential to induce a “cascading effect” into the system, making the system economically inefficient. This is combined with exemptions creating a competitive advantage to the exempt operators’ and increased VAT administration and costs.

The other alternative method, using reduced rates, provides a solution to reducing deadweight loss in the economy by allowing VAT rates to be inversely proportional to a goods’ own elasticity of demand, as well as providing a solution to combat the apparent regressive nature of VAT. This method also allows healthcare providers to significantly reduce the cost of their final products while still allowing healthcare providers to claim the VAT used in the supply of the healthcare and reducing the impact of this on the cost of their supplies. However, studies have found that reduced VAT rates are a poor tool for directing aid to the poorer households in the economy, as well as increasing the administration complexity and burden with regards to VAT bookkeeping.

To conclude, the South African VAT system is leveraged off the New Zealand VAT system (Lang, et al., 2009: 264). The New Zealand system is seen as the quintessence of a broad-based, single-rate system and is the system supported by OCED as it enables substantial income to be utilised by authorities, while at the same time decreasing tax administration costs for governments and compliance costs for businesses (Charlet & Owe, 2010: 944). Therefore, taking the above into consideration, exempting or applying a reduced VAT rate on the supply of healthcare in South Africa seems to be a regressive step in achieving the objectives of VAT.

## 5) Conclusion

Medical care services and goods currently receive no concessional VAT treatment. The main reason for this is that it was believed patients of lower- and middle-classes would make use of the State medical systems and hence only pay nominal or no VAT on their medical services. Therefore, VAT on medical care services and goods would not significantly affect them. Additionally, services which have higher input costs due to the increased base under VAT (compared to the old GST system) would be negatively affected by exempting these services from VAT. However, the private healthcare system has increased considerably since the adoption of VAT in 1991.

Over the years, a larger proportion of the South African public has started using private healthcare. All the necessary private medical supplies are privately funded, with the cost thereof being passed onto the South African public. Under standard-rating of medical care services and goods, medical services and goods providers will be required to charge output VAT at 15% on the supply of medical services and goods. This results in a portion of this cost being passed onto consumers, with a significant increase in the cost of medical services and goods. Additionally, medical aid schemes are currently VAT exempt in terms of Section 12(a) of the VAT Act, and this results in medical schemes not being able to claim input VAT credits, as well as not being required to charge output VAT. Due to the fact that medical goods and services are not subject to any VAT concessions, and hence are subject to VAT at the standard rate of 15%, medical schemes will therefore be required to incur the costs of the full input VAT consequence on the medical goods and services provided to their customers, due to their exempt nature. Hence, this effectively increases the input costs of providing medical insurance.

The private healthcare system has increased significantly since the adoption of VAT in 1991. In today's economy, the private sector provides healthcare for over 50% of spending in South Africa (Department of Health, 2017). Although government uses the imposition of VAT on medical care services and goods to fund the public sector, which in turn helps assist with funding the public healthcare system, recent health reforms in the world are trending towards an increased role of the private sector in delivering medical care services. Furthermore, the inability of the general public to access public healthcare due to distance and time constraints, as well as concerns around the poor quality of the public sector services, has resulted in the increase in the significance of the role that the private healthcare sector plays in South Africa with supporting the State to fulfil their responsibility to provide healthcare to the South African public.

The validity and relevance of there being no concessional treatment on medical services and goods needs to be questioned. Hence, the validity of standard-rating medical services and goods needs to be questioned, the intentions and objectives of the VAT Act needs to be analysed, thus resulting in the legislation needing to be re-analysed and the tax consequences thereof re-evaluated.

The concessional VAT treatment of zero-rating medical care services and goods is an alternative VAT treatment that has been adopted in both Australia and in the UAE and can be applied to the South African VAT Act. The Australian GST Act does not provide a blanket GST-free concessionary treatment to the institution itself but rather deems the services and goods itself as GST-free. Whereas under the UAE system, the supplier of these preventative and basic healthcare services will not be required to charge VAT.

At the outset, both the Australian GST system and the UAE VAT system may be distinctive, however both systems (and South Africa) utilise a modern VAT/GST System with important characteristics of a worldwide position. Additionally, both countries (like South Africa) operate a two-tiered healthcare system, with Australia sharing a similar Bill of Rights requirements for healthcare as well as the similar

socio-economic position when it comes to the funding of healthcare by the State. As a result, both countries provide invaluable insight on the potential VAT consequences and legislation that could be implemented by the South African VAT legislation in terms of medical care services and goods.

It is recommended that consideration be given to the changing of the VAT treatment on medical care as well as medical insurance in South Africa from being a standard-rated supply and an exempt supply respectively, to being zero-rated supplies. This will allow the competitive disadvantage that the private medical care suppliers are placed under due to government involvement in public medical care to be alleviated. In line with medical care being zero-rated, medical insurance should also be zero-rated. This follows the approach utilised by the Australian GST system, where the treatment of private health insurance is consistent with health services and not in line with other insurance policies. Furthermore, this should reduce the cost of providing these goods and services and hence alleviate the competitive disadvantage that the private medical care suppliers are placed under. Additionally, it will decrease the output VAT burden and the burden of non-recoverable VAT on medical insurance.

To reduce concerns about the possible manipulation of the VAT system by medical suppliers and insurers, the Australian GST legislation's decision to not provide a blanket GST-free treatment to the medical care industry, but rather deeming the medical services and goods itself GST-free) is recommended. This should help alleviate institutions that generally delivered such healthcare services by expanding their scope of services (and goods) provided into areas that should not be given zero-rated VAT treatment. Additionally, the updated South African legislation should be based on the Australian legislation, as the economic, social and State objectives of South Africa are more aligned with the Australian healthcare system as well as the fact that the Australian GST Act is more established and the provisions thereof align the VAT consequences of medical insurance VAT with that of medical care services and goods.

Other alternative concessional VAT treatments exist if zero-rating medical care services and goods is not a preferred alternative. Exempting the supply of medical care will allow the South African Government to support equality through the redistribution of income and encourage the positive externalities that are seen through increased consumption of healthcare. VAT exemptions additionally provide a better economic and administrative alternative than zero-rating. However, exemptions tend to erode the tax base of the revenue services by narrowing the tax base and have the potential to induce a "cascading effect" into the system, hence making the system economically inefficient. Furthermore, it creates a competitive advantage to the exempt operators as well as increasing VAT administration and costs.

The other alternative method, reduced VAT rates, provides a solution to reducing deadweight loss in the economy by allowing VAT rates to be inversely proportional to a goods' own elasticity of demand and provides a solution to combat the apparent regressive nature of VAT. This method also allows healthcare providers to significantly reduce the cost of their final products, while still allowing those healthcare providers to claim VAT in relation to the supply of healthcare and, thereby, reducing the impact of this on the cost on their supplies. However, studies found that reduced VAT rates are a poor tool for directing aid to the poorer households in the economy, as well as the fact that reduced rates increase the administration complexity and burden with regards to VAT bookkeeping.

Therefore, to conclude, it is recommended that it should be considered that all medical services and good as well as medical insurance be zero-rated. This will allow for a reduced cost of providing these goods and services and hence alleviate the competitive disadvantage that the private medical care suppliers are placed under due to substantial government involvement through regulations and

subsidies in the supply of public medical services and goods. Additionally, it will decrease the burden of output VAT being charged on medical services and goods and the burden of non-recoverable VAT on medical insurance. If zero-rating is not possible, then it is recommended to retain the current standard-rated VAT treatment on the supply of medical services and goods ahead of other concessional VAT treatments due to the numerous disadvantages associated with the alternative con

## 6) References

- Africa Health, 2019. *Industry Insights: South Africa Healthcare Market Overview*, s.l.: Africa Health.
- Australian Institute of Health and Welfare, 2019. *Health Expenditure Australia 2017-2018*, Canberra: The Australian Institute of Health and Welfare.
- Australian Medical Association, 2000. *Goods and Services Tax: Business Skills for*, s.l.: Australian Medical Association.
- Australian Taxation Office, 2013. *1.b. \*Medical services rendered for cosmetic reason*. [Online] Available at: <https://www.ato.gov.au/Business/GST/In-detail/GST-issues-registers/Health-Industry-Partnership---issues-register/?page=31> [Accessed 13 October 2020].
- Australian Taxation Office, 2018. *GST*. [Online] Available at: <https://www.ato.gov.au/business/gst/>
- Australian Taxation Office, 2019. *GST and insurance*. [Online] Available at: <https://www.ato.gov.au/Business/GST/In-detail/Your-industry/Financial-services-and-insurance/GST-and-insurance/> [Accessed 30 October 2020].
- Australian Taxation Office, 2019. *Issue 3. Section 38-50 Drugs and medicinal preparations*. [Online] Available at: <https://www.ato.gov.au/Business/GST/In-detail/GST-issues-registers/GST-Pharmaceutical-Health-Forum---issues-register/?page=26> [Accessed 20 October 2020].
- Australian Taxation Office, 2020. *GST-free sales*. [Online] Available at: [https://www.ato.gov.au/business/gst/when-to-charge-gst-\(and-when-not-to\)/gst-free-sales/](https://www.ato.gov.au/business/gst/when-to-charge-gst-(and-when-not-to)/gst-free-sales/) [Accessed 9 November 2020].
- Australian Taxation Office, 2020. *Medical aids and appliances*. [Online] Available at: <https://www.ato.gov.au/business/gst/in-detail/your-industry/gst-and-health/?page=7#RepairstoGSTfreemedicalaidsandappliances> [Accessed 15 October 2020].
- Australian Taxation Office, 2020. *Medicare levy*. [Online] Available at: <https://www.ato.gov.au/Individuals/Medicare-levy/> [Accessed 12 September 2020].
- Australian Taxation Office, 2020. *Other health services*. [Online] Available at: <https://www.ato.gov.au/business/gst/in-detail/your-industry/gst-and-health/?anchor=Otherhealthservices1#Otherhealthservices1> [Accessed 13 October 2020].
- Australian Veterinary Journal, 1999. GST and its effect on Insurance. *Australian Veterinary Journal*, 77(11), p. 756.
- Bangalee, V. & Suleman, F., 2017. Cost-savings accruable to removing value added tax from antiretrovirals in the South African private health sector. *Health SA Gesondheid*, Volume 22, pp. 150-156.

- Bate, R., Urbach, J. & Tren, R., 2005. Still Taxed to Death: An Analysis of Taxes and Tariffs on Medicines, Vaccines and Medical Devices. *RePEc*.
- Borowiecki, K. J. & Navarrete, T., 2018. Fiscal and economic aspects of book consumption. *Journal of Cultural Economics*, Volume 42, pp. 309-339.
- Centre for Development and Enterprise, 2011. *Reforming Healthcare in South Africa: What Role for Private Sector*, s.l.: CDE.
- Charlet, A. & Owen, J., 2010. An International Perspective on VAT. *Tax Notes International*, 59(12), pp. 943 - 954.
- Cnossen, S., 2003. Is the VAT's Sixth Directive becoming an anachronism?. *Bulletin for International Fiscal Documentation*, 43(12), pp. 434-442.
- Cooperation Council for the Arab Gulf States (GCC), 2017. *The Unified VAT Agreement for The Cooperation Council for the Arab States of the Gulf*, s.l.: Deloitte.
- Coovadia, H. et al., 2009. The Health and Health System of South Africa: Historical Roots of Current Public Heal Challenges. *Lancet*, Volume 374, pp. 817-834.
- Cosgrove, H. S. P., 2019. *Health Insurance (General Medical Services Table) Regulations 2019*, Canberra: Governor-General of the Commonwealth of Australia.
- Council of the European Union, 1977. *Sixth Council Directive 77/388/EEC of 17 May 1977 on the harmonization of the laws of the Member States relating to turnover taxes - Common system of value added tax: uniform basis of assessment*, s.l.: s.n.
- Crawford, I., Keen, M. & Smith, S., 2010. Value Added Tax and Excises. In: *Dimensions of Tax Design: The Mirrlees Review*. Oxford: Oxford University Press, pp. 275-362.
- Creese, A., 2011. *WHO/HAI project on medicine prices and availability review series on pharmaceutical pricing policies and interventions*, s.l.: Working paper 5: Sales taxes on medicines; World Health Organisation.
- de la Feria, R., 2015. Blueprint for Reform of VAT Rates in Europe. *Intertax*, 43(2), pp. 155-172.
- de la Feria, R. & Krever, R., 2013. Ending VAT Exemptions: Towards a Post-Modern VAT. In: *VAT Exemptions: Consequences and Design Alternatives*. s.l.: Wolter Kluwer, pp. 3-36.
- Delobelle, P., 2013. The health system in South Africa. Historical perspectives and current challenges. In: W. CC, ed. *South Africa in Focus*. s.l.: Nova Science Publishers, pp. 159-206.
- Deloitte, 2015. *Request for Change: Pertaining to Value-Added Tax treatment in respect of Educational Services*, s.l.: Unpublished.
- Deloitte, 2017. *Value Added Tax (VAT) in the GCC: Frequently asked questions Vol 2*, s.l.: Deloitte.
- Deloitte, 2020. *The impacts of the introduction of Value-Added Tax in the UAE*, s.l.: Deloitte.
- Department of Health, 2011. *National Health Insurance in SouthAfrica: Policy paper*, s.l.: Department of Health.
- Department of Health, 2017. *National Health Insurance Policy*, s.l.: Department of Health.

- Econnex, 2013. *The South African Private Healthcare Sector: Role and Contribution to the Economy*, s.l.: Econnex.
- Embassy of the United Arab Emirates, 2020. *Health Care*. [Online] Available at: <https://www.uae-embassy.org/about-uae/health-care> [Accessed 3 November 2020].
- Federal Tax Authority (UAE), 2020. *VAT Treatment on Selected Industries*. [Online] Available at: <https://u.ae/en/information-and-services/finance-and-investment/taxation/valueaddedtaxvat#:~:text=At%20the%20end%20of%20each,the%20taxable%20person's%20VAT%20liability>. [Accessed 2020 November 3].
- Go, D. S., Kearney, M., Robinson, S. & Thierfelder, K., 2005. *An Analysis of South Africa's Value Added Tax*, Washington DC: World Bank .
- Hagemann, R., Jones, B. & Montador, R., 1987. *Tax Reform in OECD Countries: Economic Rationale and Consequences*, Paris: ECD Publishing.
- Hall, D., May 2014. *Why we Need Public Spending: A Report for the EPSU & PSI by The Public Service International Research Unit*, s.l.: EPSU.
- Hanson, K. et al., November 2008. Is Private Health Care the Answer to the Health Problems of the World's Poor?. *PLoS Medicine*, 5(11), pp. 1528 - 1532.
- House of Representatives, 1998. *Bills Digest No. 92 1998-99 A New Tax System (Income Tax Laws Amendment) Bill 1998*, s.l.: Department of the Parliamentary Library.
- Jansen, A. & Calitz, E., 2015. *How effective is VAT zero rating as a pro-poor policy?*. [Online] Available at: <http://www.econ3x3.org/article/how-effective-vat-zero-rating-pro-poor-policy>
- Jansen, A. & Calitz, E., 2017. Considering the Efficacy of Value-Added Tax Zero-Rating as Pro-Poor Policy: The Case of South Africa.. *Development Southern Africa*, 34(1), p. 56–73.
- Judghaw, D., 2018. *Is the Value-Added Treatment for Educational Services Still Valid? Is Zero-Rating a Better Alternative? Are there any other alternative VAT Treatment available?*, Cape Town: (Unpublished).
- Kearney, M., 2003. *Restructuring Value-Added Tax in South Africa*. [Online] Available at: <https://repository.up.ac.za/bitstream/handle/2263/27705/00front.pdf?sequence=1&isAllowed=y>
- Konstantinos, A. P., 2016. The European VAT Oxymoron: A pragmatic solution for welfare, especially in times of crisis?. *Journal of International & Comparative Social Policy*, 32(3), pp. 220-234.
- Lang, M., Melz, P., Kristoffersson, E. & Ecker, T., 2009. *Value Added Tax and Direct Taxation: Similarities and Differences*. Washington D.C: IBFD.
- Le, T. M., 2003. *Value Added Taxation: Mechanism, Design, and Policy Issues* *Value Added Taxation: Mechanism, Design, and Policy Issues*, Washington DC: World Bank .
- Loevinsohn, B. & Harding, A., 2005. Buying results? Contracting for health. *Lancet*, Volume 336, pp. 676-681.

Maktoum, M. b. R. A., 2017. *Cabinet Decision No. (52) of 2017 on the Executive Regulations on the Executive Regulations*, s.l.: United Arab Emirates.

Mankiw, N. G., 2017. *The Special Characteristics of the Market for Healthcare*. s.l.:Harvard University.

Maphumulo, W. T. & Bhengu, B. R., 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, 42(1).

Morrison, T. H. S. & Cormann, S. t. H. M., 2017. *Budget 2017-18: Budget Strategy and Outlook Budget Paper No. 1*, s.l.: Commonwealth of Australia.

National Treasury Republic of South Africa , 2019 . *Budget Review 2019* , s.l.: National Treasury Republic of South Africa .

National Treasury, 2007. *The VAT Treatment of Merit Goods and Services*, s.l.: s.n.

National Treasury, 2015. *VAT Treatment of Merit Good and Services*, s.l.: s.n.

National Treasury, 2018. *2018 Budget Speech*, Petoria: National Treasury.

New Zealand Government, 1985. *Goods and Services Tax Act 1985*. As Amended 7 August 2020 ed. Wellington: New Zealand Government .

OCED, 2008. Value Added Taxes Yield, Rates and Structure. In: *Consumption Tax Trends 2008: VAT/GST*. Paris: OCED, p. 67.

OCED, 2011. *Health at a glance 2011: OECD indicators*, s.l.: OCED Publishing.

Office of Parliamentary Counsel,, 2020. *Health Insurance Act 1973*. Canberra: Commonwealth of Australia.

Office of Parliamentary Counsel, 1999. *A New Tax System (Goods and Services Tax) Act 1999) No 55 of 1999 as amended*. Canberra: s.n.

Office of Parliamentary Counsel, 2020. *Health Insurance Act 1973 No. 42, 1974 Compilation No. 113*. As amended up to Act No. 74, 2020 ed. Canberra: Office of Parliamentary Counsel.

Office of Parliamentary Counsel, 2021. *Private Insurance Act 2007 No. 31, 2007*. Canberra: s.n.

Office of Parliamentry Counsel, 2014. *A New Tax System (Goods and Services Tax) Act 1999*, Canberra: Office of Parliamentry Counsel.

Pitacco, E., 2017. *Health Insurance: Products and Basic Actuarial Models*. [Online] Available at: [http://aktuari.math.pmf.unizg.hr/docs/Health\\_Ins.pdf](http://aktuari.math.pmf.unizg.hr/docs/Health_Ins.pdf) [Accessed 1 Novemeber 2020].

Polomarkakis, K. A., 2016. The European VAT Oxymoron: A pragmatic solution for welfare. *Journal of International and Comparative Social Policy*, 32(3), pp. 220-234.

President of the United Arab Emirates, K. b. Z. A. N., 2017. *Federal Law No. 8 of 2017 on VAT*. Abu Dhabi: United Arab Emirates Government.

President of the United Arab Emirates, K. b. Z. A. N., 2017. *Federal Law No. 8 of 2017 on VAT*. Abu Dhabi: United Arab Emirates Government.

Propper, C. & Green, K., 1999. *A larger role for the private sector in health care?: A review of the arguments*, Bristol: Centre for Market and Public Organisation; Unvirsity of Bristol.

- Public Services International Research Unit, 2014. *Why we need public spending: A report for EPSU and PSI*, s.l.: Public Services International Research Unit.
- Rama, P. & McLeod, H., 2001. *A Study of Trends in Medical Schemes in South Africa: 1974 to 1999*, Cape Town: Centre for Acturial Research (A research unit of Univeristy of Cape Town).
- Ranchod, S. et al., 2017. South Africa's hospital sector: Old divisions and new developments. *South African Health Review*, 2017(1), pp. 101 - 110.
- RH Bophelo , 2017. *A glimpse into the South African healthcare industry*. [Online] Available at: <https://www.rhbophelo.co.za/news/latest-news/page/2/> [Accessed 17 March 2020].
- Soderlund, N., Schierhout, G. & van den Heever, A., 1998. Private Health Sector Care: Techincal Report to Chapter 13 of the 1988 South African Health Review. *Health System Trust*, pp. 141-157.
- South African Government, 1991. *VALUE-ADDED TAX ACT NO. 89 OF 1991*. As Amended in 2016 ed. Petoria: South African Government.
- South African Government, 1998. *Long Term Insurance Act, 1998 (Act No. 52 of 1998)*. As Amended in 2014 ed. Petoria: South African Government.
- South African Government, 1998. *MEDICAL SCHEMES ACT NO. 131 OF 1998*. As Amended 2004 ed. Petoria: Sou African Government.
- Tacke, T. & Waldmann, R., 2013. Infant mortality, relative income and public policy. *Applied Economics*, 45(22), pp. 3240-3254.
- Tamaoka, M., 1994. The Regressivity of a Value Added Tax: Tax Credit Method and Subtraction Method — A Japanese Case. *Fiscal Studies*, 15(2), pp. 57-73.
- Tax Consultative Committee, 1998. *The Report of the Tax Consultative Committee*. [Online] Available at: <https://treasury.gov.au/sites/default/files/2019-03/tcc.pdf>
- The Constitutional Assembly , 1996. Chapter 2: Bill of Rights. In: *Constitution of the Republic of South Africa*. Petoria: s.n., pp. 5-21.
- The Davis Tax Comittee, July 2015. *First Interim Report on Value-Added Tax for the Minister of Finance*, s.l.: The Davis Tax Comittee.
- The Honourable Peter Costello, M. o. t. C. o. A., 1998. *Tax Reform: not a new tax, a new tax system*, s.l.: Commonwealth of Australia.
- The Institute of Chartered Accountants of India, June 2018. *Background Material on UAE - VAT Federal Decree Law (No. 8) 2017*, Agra: The Publication Department on behalf of the Institute of Chartered Accountants of India.
- The Parliament of the Commonwealth of Australia, 2019. *Australian Bill of Rights Bill 2019*. Canberra: House of Representatives.
- Theron, C., 2015. *VAT must rise- An unpopular solution to a very real problem..* [Online] Available at: <https://www.theteacher.co.za/2017/03/vatmustrise/> [Accessed 18 July 2020].

U.S - U.A.E Business Council, 2018. *The U.A.E. Healthcare Sector*, Washington D.C.: U.S.-U.A.E. Business Council.

U.S - U.A.E Business Council, 2014. *The U.A.E. Healthcare Sector*, Washington D.C.: U.S.-U.A.E. Business Council.

UAE, 2020. *Value Added Tax (VAT)*. [Online]

Available at: <https://u.ae/en/information-and-services/finance-and-investment/taxation/valueaddedtaxvat>

[Accessed 2 November 2020].

UK Public General Acts, 1994. *Value Added Tax Act 1994*. s.l.:s.n.

United Arab Emirates Ministry of Finance, 2020. *The federal budget for fiscal year 2020 amounts to AED 61.35 billion*. [Online]

Available at:

<https://www.mof.gov.ae/en/resourcesandbudget/federalbudget/pages/budget2020.aspx>

[Accessed 03 11 2020].

van den Heever, A., 2012. *Review of Competition in the South African Health System: Produced for the Competition Commission*, Petoria: Competition Commission.

van den Heever, A., 2019. *National Health Insurance Policy Bill Review: Expert review of the National Health Insurance bill submitted by the Minister of Health to Parliament in 2019 for submission to Parliament as a response to the request for public comment*, s.l.: Wits School of Governance.

VAT Committee, 2020. *GUIDELINES RESULTING FROM MEETINGS: Up until 3 November 2020*, s.l.: s.n.

VATCOM, 1991. *The Report of the Value-Added Tax Committee (VATCOM)*, Cape Town: Government Printer.

Verhoef, G., 2006. From Friendly Society to Compulsory Medical Aid Association: The History of Medical Aid Provision in South Africa's Public Sector. *Cambridge University Press: Social Science History*, 30(4), pp. 601-627.

Whitby, C., 2000. First do no Harm: GST and Health Care Services. *Revenue Law Journal*, 10(1), pp. 119 - 137.

## 7) Annexure

### 7.1. Annexure 1: Table of GST-Free other health services – Section 38-10 of the Australian GST ACT

<b>Health services</b>	
<b>Item</b>	<b>Service</b>
1	Aboriginal or Torres Strait Islander health
2	Acupuncture
3	Audiology, audiometry
4	Chiropody
5	Chiropractic
6	Dental
7	Dietary
8	Herbal medicine (including traditional Chinese herbal medicine)
9	Naturopathy
10	Nursing
11	Occupational therapy
12	Optometry
13	Osteopathy
14	Paramedical
15	Pharmacy
16	Psychology
17	Physiotherapy
18	Podiatry
19	Speech pathology
20	Speech therapy
21	Social work

(Office of Parliamentary Counsel, 1999)

## 7.2. Annexure 2: Schedule 3 of the Australian GST Act – medical aids and appliances

Note 1: GST-free supplies of medical aids and appliances are dealt with in Section 38-45.

Note 2: The second column of the table is not operative (see Section 182-15).

<b>Medical aids and appliances</b>		
<b>Item</b>	<b>Category</b>	<b>Medical aids or appliances</b>
1	Cardiovascular	heart monitors
2		pacemakers
3		surgical stockings
4	Communication aids for people with disabilities	communication boards and voice output devices
5		communication cards
6		page turners
7		eye pointing frames
8		software programs specifically designed for people with disabilities
9		printers and scanners specifically designed for software and hardware used by people with disabilities
10		switches and switch interfaces
11		mouth/head sticks/pointers
12		alternative keyboards
13		electrolarynx replacements
14		speech amplification/clarification aids
15	Continence	urine/faecal drainage/collection devices

16		waterproof covers or mattress protectors
17		absorbent pads for beds and chairs
18		disposable/reusable continence pads, pants and nappies required for continence use (excluding nappies for babies, sanitary pads or tampons)
19		enuresis alarms
20		incontinence appliances
21		hospital/medical/continence deodorising products
22		waterproof protection for beds and chairs
23		sterile plastic bags
24		electric bag emptiers
25		enemas, suppositories and applicators
26		urinals and bedpans
27		penile clamps
28	Daily living for people with disabilities	customised eating equipment for people with disabilities
29		customised toothbrushes for people with disabilities
30		dentures and artificial teeth
31		environmental control units designed for the disability of a particular person
32		computer modifications required for people with disabilities
33		—medical alert devices
34	Diabetes	finger prickers
35		alcohol skin wipes

36		test strips
37		needles and syringes
38		glucose monitors
39	Dialysis	home dialysis machines
40	Enteral nutrition	enteral nutrition and associated delivery equipment
41	Footwear for people with disabilities	surgical shoes, boots, braces and irons
42		orthotics
43	Hearing/speech	hearing aids
44		visual display units specifically designed for deaf people, or for people with a speech impairment, to communicate with others
45		telephone communication devices specifically designed to allow deaf people to send and receive messages by telephone
46		batteries specifically designed specifically for use with hearing aids
47		visual/tactile alerting devices
48		interactive and broadcast videotext systems
49		closed caption decoding devices
50		external processors for cochlear implants
51	Home modifications for people with disabilities	bidet/bidet toilet attachments
52		special door fittings relating to the disability of a particular person

53	Mobility of people with disabilities— motor vehicles	special purpose car seats
54		car seat harness specifically designed for people with disabilities
55		wheelchair and occupant restraint
56		wheelchair ramp
57		electric/hydraulic wheelchair lifting device
58		motor vehicle modifications
59	Mobility of people with disabilities— physical: bedding for people with disabilities	manually operated adjustable beds
60		electronically operated adjustable beds
61		hospital-type beds
62		customised bed rails for people with disabilities
63		bed cradles
64		bed restraints
65		bed poles and sticks
66		pressure management mattresses and overlays
67		backrests, leg rests and footboards for bed use
68	Mobility of people with disabilities— physical: orthoses	spinal orthoses
69		lower limb orthoses

70		upper limb orthoses
71		pressure management garments and lymphoedema pumps
72		callipers
73		corsets (surgical)
74		handsplints and cervical collars
75		mandibular advancement splints
76	Mobility of people with disabilities—physical: positioning aids	alternative positional seating corner chairs
77		alternative positional seating abduction cushions or long leg wedges
78		alternative positional seating modifications
79		standing frames
80		standing frames or tilt table modifications
81		side lying boards
82		night-time positioning equipment modifications
83	Mobility of people with disabilities—physical: prostheses	artificial limbs and associated supplements and aids
84		mammary
85	Mobility of people with disabilities—physical: seating aids	postural support seating trays

86		electrically operated therapeutic lounge/recliner chairs specifically designed for people with disabilities
87		cushions specifically designed for people with disabilities
88	Mobility of people with disabilities—physical: transfer aids	manual, electric, ceiling track or pool hoists specifically designed for people with disabilities
89		hoist slings
90		goosenecks
91		transfer boards
92		transfer sheets, mats or belts
93		stairlifts
94		portable stair climbers
95		monkey rings for people with disabilities
96	Mobility of people with disabilities—physical: walking aids	crutches
97		walking sticks—specialised
98		walking frames—standard adult
99		walking frames—standard child
100		walking frames—specialised
101		walking frame modifications
102		specialised ambulatory orthoses
103		specialised ambulatory orthosis modifications

104		quadrupod and tripod walking aids
105	Mobility of people with disabilities—physical:  wheelchairs and accessories	wheelchairs, motorised wheelchairs, scooters, tricycles, spinal carriages and other goods for the carriage of people with disabilities
106		accessories associated with wheelchairs, motorised wheelchairs, scooters, tricycles, spinal carriages and other goods for the carriage of people with disabilities
107		battery chargers for wheelchairs, scooters, tricycles, spinal carriages and other goods for the carriage of people with disabilities
108		stair-aid apparatuses designed for carrying people with disabilities in wheelchairs up or down stairs
109	Pain relief delivery systems	syringe drivers
110		patient control analgesia
111	Personal hygiene for people with disabilities	bathboards or toilet seats for people with disabilities
112		bath supports
113		shower chairs or stools
114		shower supports
115		shower trolleys
116		mobile shower chairs
117		commodes
118		commode cushions
119		commode pans

120		toilet frames
121		toilet supports
122		self-help poles
123	Respiratory appliances	ventilators
124		continuous positive airway pressure (CPAP) appliances
125		respiratory appliance mask assemblies—complete
126		respiratory appliance mask assemblies—components
127		respiratory appliance accessories
128		sleep apnoea machines
129	Respiratory appliances—other products for those with breathing difficulties:	peak flow meters
130		nebulisers
131		spacers
132		vaporisers
133		respirators
134		air pumps
135		bottled oxygen and associated hardware
136		oxygen concentrators
137		breathing monitors
138		ventilators

139	Safety helmets specifically designed for people with disabilities	safety helmets specifically designed for people with disabilities
140	Skin	Jobst suits
141		transcutaneous nerve stimulator machines
142	Stoma	stoma products including all bags and related equipment for patients with colostomies and ileostomies
143		
144		electronic reading aids
145		talking book machines (and parts) specifically designed for people with a vision impairment
146		enlarged text computer monitors for people with a visual impairment
147		Braille note takers
148		Braille printers and paper
149		Braille translators (hardware and software)
150		money identification equipment
151		auditory/tactile alerting devices
152		sonar canes
153		reading magnification devices (excluding magnifying glasses)
154		artificial eyes
155		lenses for prescription spectacles
156		prescription contact lenses
157		ultrasonic sensing devices specifically designed for use by people with a vision impairment
158		viewscan apparatus specifically designed for use by people with a vision impairment
Vision		tactile or Braille books, magazines or newspapers

(Office of  
Parliamentary Counsel, 1999)