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Full Length Article

Cost-savings accruable to removing value added tax from antiretrovirals in the South African private health sector

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ABSTRACT

Background: Despite the important and essential role that medicines play in any society, all medicines, including those identified as essential, are uniformly subjected to 14% value added tax (VAT), regardless of their therapeutic value in the private healthcare sector of South Africa. The aim of this article is to demonstrate the potential cost-saving attained from the removal of VAT from the private sector pricing of essential medicines, using antiretroviral treatment as an example.

Methods: An empirical analysis was undertaken to illustrate the potential cost-saving achieved by removing VAT from the Single Exit Price and the dispensing fee of essential medicines. This outcome was demonstrated by applying the methodology to an adult fixed dose combination 1st line antiretroviral regimen as well as to a group of 3rd line antiretroviral medicines.

Results: The potential saving for the lowest priced generic and originator 1st line antiviral regimen accrued to ZAR 693.84 and ZAR 1085.04 over a year respectively. Regarding the 3rd line antiretroviral drugs, results yielded an annual saving of ZAR 1678.68 (darunavir), ZAR 5741.04 (maraviroc) and ZAR 159.48 (rilpivirine).

Conclusions: Lobbying for the removal of VAT from the supply chain of medicines should be intensified. Policy development to monitor and recover lost government revenue through the removal of taxes should be explored.

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1. Introduction

As a middle-income country, South Africa faces similar healthcare challenges to other developing countries (Bulla et al., 2014; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). The country's residents are faced with a high disease burden, due largely to the HIV/AIDS pandemic, as well as to lack of essential healthcare resources and high medicine costs, which affect the availability, accessibility and affordability of essential medicines for a large percentage of the population (Cameron, Ewen, Ross-Degnan, Ball, & Laing, 2009; Gray & Matsebula, 2000).

Essential medicines can be defined as those that satisfy the priority health care needs of the population, being identified with careful consideration of disease prevalence, evidence of medicine efficacy and safety, and comparative cost-effectiveness (Department of Health, 2012). Furthermore, to improve service delivery and outcomes of the healthcare system, these medicines should be available at all times, in adequate quantities, in the appropriate dosage forms, with assured quality and adequate information, and at a price that individuals and communities can afford (Department of Health, 2012).

Medicine prices in the South African private sector are governed by the Single Exit Price (SEP) legislation. The SEP consists of the ex-manufacturer's price, this being the largest segment, a logistics fee of 10%–15%, this often being higher for essential medicines, and the standard 14% value added tax (VAT) (Ball, 2011; Bangalee & Suleman, 2015; Republic of South Africa, 1997). Dispensers are remunerated for their services through the additional charge of a dispensing fee, which is calculated on a legislated tiered framework contingent on the SEP of the medicine, and which also includes an additional VAT component.

The primary rationale for imposing taxes on society is the need for government to finance public expenditure (National Treasury, 2007). A well-designed and progressive tax system can promote both economic growth and social justice (Creese, 2011). Since its inception in 1991, VAT remains the second most important source of government revenue in South Africa, but as in most countries, its impact on income distribution is controversial (Jansen, Stoltz, & Yu, 2012).

During the early initiation of VAT in South Africa, it was maintained that its application without any exemptions was regressive. This, coupled with South Africa's previous political history and extremely skewed distribution of wealth, warranted an intervention that would protect public interest, in particular the poor. This led to the concessionary VAT treatment of a number of merit goods, such as certain food items, that are classified as essential foodstuff (Jansen et al., 2012). In order to attain merit goods status, one of the traits is that a commodity needs to be in the public interest as well as essential. Despite the important and essential role that medicines play in any society, all medicines, including those identified as essential, are uniformly subjected to 14% VAT, regardless of their therapeutic value. In addition, all essential medicines are taxed equally to cosmetic products, as well as other unregulated and items of unproven efficacy that are sold in pharmacies (Bate, Tren, & Urbach, 2006).

VAT on medicines ranges from zero in Brunei to 19% in Peru (The African Executive, 2005). A study conducted by Bate et al. (2006) identified a uniform relationship between tariffs and access to essential medicines, whereby increases in tariffs produced a corresponding decrease in essential medicine access and vice versa. As the economic viability and growth of any nation also depends on the health of its population, the removal of taxes on essential medicines is justified, as increased access to medicines would improve overall health and wellbeing.

In South Africa, many parties argue that VAT only operates in the private sector, and hence should not affect people accessing health care through the public sector. However, this ignores the fact that many users of the public health system purchase medicines from private pharmacies. With approximately only 16% of the South African population having access to medical insurance (OECD, 2011), the remaining 84% rely on the public sector, and make out-of-pocket purchases in the private sector due to medicine shortages in the public sector and to an inability to access public hospitals and clinics due to distance, time and cost constraints (Bate et al., 2006). Additionally the concerns about poor quality of services offered by public sector has also been shown to be a major barrier to access and has created a preference by the public for services in the private sector, which is largely funded out-of-pocket (Department of Health, 2011). Research has also shown that despite essential medicines being freely available in the public sector, the ease of access, privacy, confidentiality and short queues, generally attract patients, especially with sexually transmitted infections to seek treatment in the private sector (Chabikuli, Schneider, Blaauw, Zwi, & Brugha, 2002; Schneider, Blaaw, Dartnall, Coetzee, & Ballard, 2001). Equity in healthcare for all South African residents was an important key element during the development of the National Drug Policy (NDP), and implementing the Essential Medicines List (EML) was an important part of achieving the policy's objectives. Within this context, the EML should not operate solely in the public sector, but also serve the better interests of the population who use private sector health care services.

There has been much debate about the impact of removing VAT on the accessibility of essential medicines (The African Executive, 2005) in developing countries. In Nigeria, only 10% of the population have access to essential medicines, with taxes and tariffs on imports, including essential medicines, totalling 28%. In Brazil, 40% of the population have access to essential medicines through the public health sector, with a combined tax and tariff burden of 29% (Bate et al., 2006). Similar figures are evident in other developing countries, where high tariffs and taxes reduce the accessibility of medicines to the poorest members of the population, and exacerbate their poor health outcomes (The African Executive, 2005).

The aim of this paper is to explore the possible savings accrued from removing VAT from the private sector pricing of essential medicines, using antiretroviral treatment as an example. South Africa has the highest prevalence of HIV/AIDS in the world, with a reported 2.4-million people being infected in 2012, which is 1.2-million more than in 2008 (Malan, 2014). While several strides have been taken towards making

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