Death and Taxes

Government mark-ups on the price of drugs

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International Policy Network

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Introduction

Although increasing prosperity and medical innovation have led to huge rises in global life expectancy over the last century, access to medicines still remains a problem in many countries, particularly the poorest. According to the WHO, an estimated 30 per cent of the world population lacks regular access to existing drugs, with this figure rising to over 50 per cent in the poorest parts of Africa and Asia.[1] Within these populations, it is the poorest socio-economic groups that disproportionately suffer from a lack of access to existing medicines.[2]

The implications of this failure of public health policy on global mortality are profound – according to one study, over 10 million children die unnecessarily each year, almost all in low-income countries or poor areas of middle income countries, mostly from a short list of preventable diseases such as diarrhoea, measles, malaria and causes related to malnutrition.[3] (Black, 2003).

While access to medicines is a product of numerous factors such as health care systems, transport infrastructure and available healthcare personnel, much debate and public policy action has centred on the cost of drugs – the assumption being that because so many of the poor rely on out of pocket payments for healthcare, access will almost certainly increase if prices are reduced.

Consequently, many governments have enacted legislation to reduce the price of medicines. Such interventions include compulsory licenses for generic manufacture of patented drugs (Thailand, Canada, Brazil), legalised parallel trading (the European Union) and price controls on medicines (most OECD and increasing numbers of lower-income countries). While peer-reviewed research is yet to demonstrate if such measures actually improve health outcomes, the discourse has tended to understate the fact that governments themselves are amongst the biggest inflators of drugs prices, via tariffs and other taxes.

This paper is an attempt to quantify the extent to which governments mark up the price of medicines. The first part (and bulk) of the analysis focuses on tariffs imposed by governments on imported medicines and vaccines. The second part examines tariff rates on imported active ingredients, which are required for the domestic manufacture of medicines. This allows us to gauge the extent to which governments pursue protectionist industrial policy towards their domestic manufacturing industry. Additionally, tariffs on active ingredients will inevitably translate into higher prices for finished products.

The third section includes data on taxes and other mark-ups levied by governments aside from tariffs, including sales and value-added taxes. The fourth section concludes.

Methodology

Tariffs

In 2005, Richard Laing and Müge Olcay conducted an analysis on pharmaceutical tariffs for the World Health Organization,[4] which, given its official endorsement, makes it the most authoritative recent study on the topic. In order to demonstrate accurately how tariff levels have changed over time, we chose to emulate their methodology and apply it to the latest tariff data publicly available at the time of writing (Autumn 2009). This involved examining all pharmaceutical products, not just those on the WHO's Essential Medicines List, as is the case with certain other studies on the topic. The study therefore does not differentiate between on-patent and generic drugs.

As with the Laing and Olcay study, we obtained our data on tariff rates from the Trade Analysis Information System (TRAINS) which contains data compiled by the United Nations Conference on Trade and Development (UNCTAD). Using this data allowed us to calculate weighted tariff averages. Using weighted averages removes the risk of a very high tariff on a particular product imported in low volumes distorting the overall picture of tariffs within a country. In order to calculate the weighted averages, we obtained the latest available values of imports from the COMTRADE database, compiled by the United Nations Statistical Division.

Other studies on pharmaceutical tariffs, most notably that of Bate, Tren and Urbach (2005),[5] opted to calculate simple instead of weighted averages, reasoning that weighted averages may underestimate the impact of a certain tariff on medicine importation and therefore access. This reasoning has merits, so in order to take advantage of both approaches, we list here both weighted and simple averages. In any case, the differences between the two are minimal in most countries.

In order to calculate these averages, we followed the approach adopted by Laing and Olcay and extracted data relating to the 3003 (active ingredients) and 3004 (finished products) categories on the Harmonised Tariff schedule devised by the World Customs Organization. For each of these two categories, we examined items in their six digit sub-category.

We included the 3003 category (active ingredients), because these are important for domestic pharmaceutical manufacturing industries. Any government mark-up on these constituent parts will inevitably find their way to the end consumer in the form of higher prices, so it is important that these are monitored. This is especially the case given recent attempts on the part of intergovernmental agencies such as the World Bank to promote local drug production in lower income countries in order to meet local demand. However, we deemed medical products and equipment (bandages, gauze, machinery etc.) to be beyond the scope of the study. 136 countries were included in the study.

Taxes and other government mark-ups

Governments levy many different kinds of taxes on imported and locally manufactured drugs, including value-added taxes, sales tax, port charges, freight charges and other government taxes. While data relating to tariffs is systematically collected and stored in one repository by various agencies of the United Nations, the same is unfortunately not true for these other taxes. Data therefore has to be collated in a more ad hoc manner, through internet searches and through email correspondence with relevant local government officials. We readily acknowledge the shortcomings of this data, and hope to improve it gradually over time. Nevertheless, it should give an indication of the scale of future research that needs to be done on this important topic.

Disclaimer

As this data covers such a large geographical area, it is impossible to guarantee total accuracy. Countries may affect changes to their tariff rates and not notify intergovernmental bodies, for instance. Many governments do not post online precise information about their domestic levies in a transparent way. Other governments may only post this in their local language, making it difficult for English-speaking researchers to find.

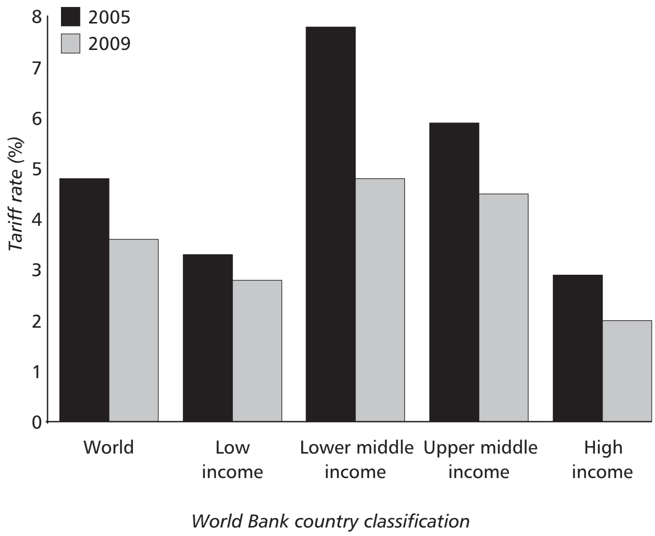
As this study is posted online, we encourage readers to alert us to any errors or omissions by emailing us at health@policynetwork.net. All online versions of this report will be altered accordingly upon verification. This data also forms the basis of our interactive website with world map at www.policynetwork.net/health.

Results

Tariffs

Finished pharmaceutical products (HS Code 3004)
The majority of medicines consumed in low income countries are imported from abroad. It is therefore good news that tariff rates on finished products seem be gradually on the decline in most regions since the 2005 study conducted by Laing and Olcay (Figure 1) However, tariff rates remain highest amongst lower- and upper-

Figure 1 **Weighted tariff averages on finished pharmaceutical products**



middle income countries (Figure 2). Many of these countries, including India and Iran, have local pharmaceutical manufacturing industries.

Although average tariff rates have fallen over the last five years, a majority of countries (54%) still apply import tariffs, albeit an improvement from 2005 when the figure was 61%. Notably, tariffs are lowest amongst the poorest and richest countries (Figure 2).

According to our research 14 countries have dropped their tariffs to zero since the last survey:

Ukraine	*Mauritius*
Seychelles	*Kenya*
Saudi Arabia	*Kuwait*
Rwanda	*Georgia*
Qatar	*Gabon*
Panama	*Croatia*
Oman	*Cameroon*

By contrast, a handful of countries retain punitively high tariff rates on imported medicines. The ten countries with the highest weighted tariff averages are listed in Figure 3.

This figure does not include certain countries for which we were unable to calculate the value of imports. These include Iran, which stands out as having an exceptionally high simple average tariff of 30.75%. Likewise, DCR Congo, an impoverished land-locked African nation with no significant domestic pharmaceutical industry imposes a simple average tariff of 11.67% on imported drugs. These represent significant mark-ups to sick patients.

Figure 2 **Global distribution of tariffs on finished pharmaceutical products (HS Code 3004)**

Tariffs rate (%)	*Number of countries (n=136)*	*Percentage of all countries*	*Low-income countries*	*Lower-middle income countries*	*Upper-middle income countries*	*High-income countries*
0	62	46%	16	13	12	21
0–5	32	24%	9	14	6	3
5.1–10	28	21%	5	9	12	2
10.1–20	13	10%	3	5	2	3
>20	1	1%	0	1	0	0
		MEDIAN=2%				

*All rates based on weighted average and applied tariffs. Where no weighted average is available, the simple average has been used

Sub-Saharan Africa (SSA) is notable for having amongst the worst health indicators in the world, and a very high burden of treatable and preventable disease. The levels of tariffs on imported medicines in the region therefore are of particular interest. Our data shows that just over half of the SSA countries for which we have data apply

Figure 3 **Top 10 highest tariff rates on finished pharmaceutical products**

Burundi	15.00%
Nigeria	14.81%
Tunisia	13.02%
Antigua and Barbuda	12.43%
Grenada	12.14%
Barbados	11.61%
Guyana	11.60%
Trinidad and Tobago	11.35%
Pakistan	10.56%
Jamaica	10.54%

Figure 4 **Tariff rates on finished pharmaceutical products in sub-Saharan Africa***

2008	Burundi	15%
2008	Nigeria	14.81%
2006	Djibouti	10%
2008	Zimbabwe	8.02%
2008	Sudan	7.13%
2008	Ghana	6.55%
2007	Central African Republic	5%
2007	Chad	5%
2007	Congo Rep.	5%
2007	Equatorial Guinea	5%
2008	Gambia	5%
2008	Ethiopia (excl. Eritrea)	3.76%
2006	Eritrea	2%
2006	Benin	0%
2008	Botswana	0%
2005	Burkina Faso	0%
2004	Cameroon	0%
2008	Cote d'Ivoire	0%
2005	Gabon	0%
2008	Kenya	0%
2008	Madagascar	0%
2008	Malawi	0%
2008	Mali	0%
2007	Mauritania	0%
2007	Mozambique	0%
2008	Namibia	0%
2007	Niger	0%
2008	Rwanda	0%
2008	South Africa	0%
2008	Uganda	0%
2008	Zambia	0%

*Weighted averages

tariffs on imported finished pharmaceuticals (Figure 4). It is notable that Zimbabwe, which has almost no local manufacturing capacity and very severe health problems, applies one of the larger tariffs. Similarly, Nigeria a country whose life expectancy at birth is an appalling 49 years (compared to the global average of 71) applies import tariffs of nearly 15%.

On the other side of the coin, many SSA countries are

Figure 5 **Tariffs on finished pharmaceutical goods in Low income countries outside SSA**

Year	*Country*	*Weighted average, %*	*Simple average, %*
2007	Nepal	n/a	12.71
2007	Lao P.D.R	n/a	9.38
2007	Bangladesh	8.32	5.83
2007	Vietnam	6.36	4.12
2008	Uzbekistan	5	5
2006	Yemen	3.64	4.69
2008	Afghanistan	2.5	2.5
2007	Myanmar	n/a	1.31
2007	Kyrgyz Republic	0	0

moving towards a zero tariff regime. Uganda, Tanzania and Kenya recently reversed their 10% tariff to become zero-rated, a welcome development in countries with such high disease burdens. Rwanda, Cameroon and Gabon similarly have abolished import tariffs on finished pharmaceutical goods. Outside of SSA, all lower-income countries apply pharmaceutical tariffs, with the exception of the Kyrgyz Republic (Figure 5).

Antibiotics

Infectious diseases are amongst the biggest killers in lower-income countries, mainly due to lack of access to clean water, proper sanitation, and clean sources of energy. Lower-respiratory infections and diarrhoeal diseases combined are responsible for 18.1% of deaths in lower-income countries.[6]

Many of these diseases are easily treatable with common antibiotics, the majority of which are not patented. However, governments in lower-income countries often single out these classes of medicines for particularly high tariffs (Figure 6). Nigeria is the worst offender amongst this group, with 20% tariff rates, despite having high rates of both poverty and infectious diseases.

Many countries classified as "middle-income" by the World Bank also have a high burden of infectious disease amongst poorer parts of their populations. Some of these countries levy exceptionally high tariffs on imported antibiotics such as Iran (68% on medicines

Figure 6 **Tariffs on antibiotics in a selection of low-income countries (HS 300410 & 300420)**

Country	*Containing penicillins or derivatives, %*	*Containing other antibiotics, %*
Nigeria	20	16.6
Burundi	15	15
Nepal	15	15
Congo Dem. Rep.	15	10
Djibouti	10	10
Ghana	10	10
India	10	10
Lao P.D.R	10	10
Sudan	10	10
Zimbabwe	10	10
Bangladesh	5	5
Central African Republic	5	5
Chad	5	5
Congo Rep.	5	5
Ethiopia (excl. Eritrea)	5	5
Gambia	5	5
Philippines	5	5
Afghanistan	2.5	2.5

containing penicillin and 52% on other antibiotics), Morocco (35% on each), and India (10% on each). These import duties represent a major tax on sick people, particularly children who carry the highest burden of infectious diseases.

Vaccines

Vaccine delivery programmes are one of the most cost-effective public health programmes available.[7] Despite this, many countries struggle to provide universal vaccinations for common childhood diseases such as measles, diphtheria and polio. It seems perverse in the extreme, then, that 40 countries still impose tariffs on imported vaccines (Figure 7). These include some extremely poor countries in sub-Saharan Africa, as well as wealthier countries such as India which nevertheless still suffer considerable health inequalities.

Active ingredients

Many lower and middle income countries have in the

Figure 7 **Tariffs on imported vaccines (HS code 300220)**

2008	Burundi	15%
2008	French Polynesia	15%
2005	Bhutan	10%
2007	Bolivia	10%
2008	Congo Dem. Rep.	10%
2006	Djibouti	10%
2008	Ghana	10%
2008	India	10%
2008	Sudan	10%
2008	Peru	9%
2008	Belarus	6.67%
2008	Pakistan	6.67%
2008	Russian Federation	6.67%
2007	Chile	6%
2008	Mexico	5.7%
2007	Central African Republic	5%
2007	Chad	5%
2008	Colombia	5%
2007	Congo Rep.	5%
2008	Ecuador	5%
2007	Equatorial Guinea	5%
2008	Gambia	5%
2007	Lao P.D.R	5%
2007	Lebanon	5%
2008	Maldives	5%
2007	Mongolia	5%
2008	Solomon Islands	5%
2008	Uzbekistan	5%
2008	Venezuela	5%
2006	Yemen	5%
2008	Iran	4%
2007	Indonesia	3.75%
2007	Afghanistan	2.5%
2008	Argentina	2.22%
2008	Brazil	2.2%
2008	Uruguay	2.2%
2007	Angola	2%
2006	Eritrea	2%
2008	Paraguay	1.67%
2007	Philippines	1%

Figure 8 **Weighted tariff averages on imported active ingredients (HS code 3003)**

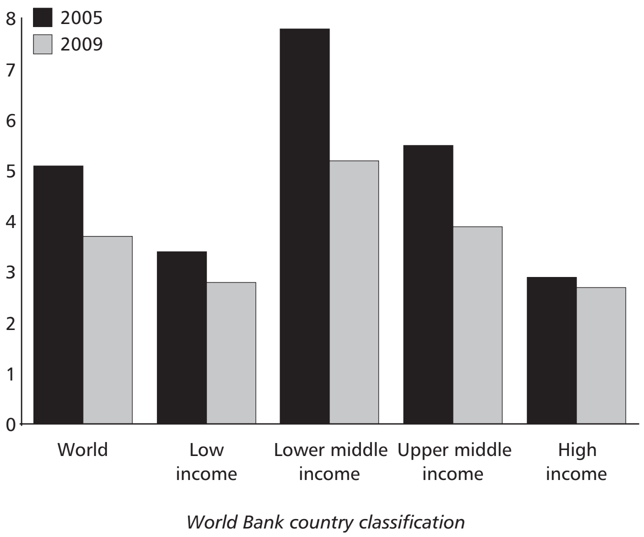


Figure 9 **Active ingredients (HS Code 3003)**

Tariffs rate (%)	*Number of countries (n=136)*	*Percentage of all countries**	*Low-income countries*	*Lower-middle income countries*	*Upper-middle income countries*	*High-income countries*
0	67	50%	16	15	14	22
0–5	29	21%	11	11	6	1
5.1–10	27	20%	4	10	10	3
10.1–20	11	8%	2	3	2	4
>20	2	1%	0	2	0	0

*Note: The percentages have been rounded.

** All rates based on weighted average and applied tariffs. Where no weighted average is available, the simple average has been used. Table does not include the EU as a whole, but does include certain EU countries within the number of countries.

past pursued a deliberate policy of protecting their local pharmaceutical manufacturing industries from international competition. They may do this in an attempt to achieve 'health security'; in other words, reducing reliance on imported products in an attempt to guarantee supply and minimise prices. This strategy may also be used for the purposes of industrial policy, wherein a country might seek to increase the importance of the pharmaceutical manufacturing sector for economic reasons.

Nevertheless, no country can ever hope to become self-sufficient in the active ingredients required to manufacture finished pharmaceutical goods – particularly the poorest countries, most of which have limited comparative advantage in producing such materials. For that reason, most countries with manufacturing capacity have to import active ingredients. If governments then add tariffs to these materials, it will necessarily add to the final retail price.

Half of the countries surveyed (69 of 138) impose tariffs on imported active ingredients. However, as with imported finished pharmaceutical products, tariff rates on ingredients are falling, down from a global weighted average of 5.07% in 2005 to 3.73% in 2009 (Figure 8). As Figure 9 demonstrates, lower- and upper-middle income countries impose the highest tariff rates on active ingredients, although lower-middle income countries have lowered tariffs considerably since the last survey. Particularly notable is Iran, which has dropped its tariff rate from 100% in 2003 to 34.5% in 2008 – a considerable change, but still extraordinarily high. Big reductions in tariffs have also taken place in Nigeria which dropped from 20% in 2002 to 13.6% in 2008 and Egypt, which fell from 4.17% in 2002 to 1.35% in 2008.

The majority of lower-income countries do not levy tariffs on active ingredients, but Zambia and Tanzania must be singled out for reducing the rate to zero from 1.1% and 10% respectively in 2003. In the lower-middle income category, Georgia and Ukraine have also abolished tariffs, from a rate of 5% and 1.92% respectively. The full list of countries which have abolished tariffs on active ingredients is as follows:

Zambia	*Mauritius*
Tanzania	*Panama*
Georgia	*Bahrain*
Ukraine	*Croatia*
Gabon	*Kuwait*
Macedonia	

Nevertheless, many countries still impose high tariff rates on imported ingredients. The ten countries with the highest weighted average tariff rates are represented in figure 10.

Figure 10 **Top 10 highest tariff rates on active ingredients (weighted averages)**

Iran	34.5%*
Morocco	23.08%
Burundi	15%
French Polynesia	15%
Nigeria	13.61%
Guyana	13.05%
Grenada	12.53%
Antigua and Barbuda	12.38%
Barbados	12.3%
Mexico	12.27%

*Simple average.

Absent from this list are Djibouti and Nepal, for whom there was insufficient data to calculate weighted averages. Their simple averages are 14.6% and 14.4% respectively.

It is possible that those countries which impose higher tariffs on finished goods than active ingredients do so for the purpose of protecting their local manufacturing industries. Only 25 countries structure their tariffs in this manner, but many of them do have domestic pharmaceutical manufacturing capacity, with Jordan, Pakistan and the Philippines being obvious examples (Figure 11). However, the difference in tariff rates between the two categories is frequently minimal and it is impossible with this data to determine for certain if a country is pursuing an industrial strategy.

Figure 11 **Countries which levy higher tariffs on finished medicaments than ingredients.**

Ingredients			*Medicaments*			
Year	*Country*	*Weighted average*	*Year*	*Country*	*Weighted average*	*Difference*
2007	Vietnam	0.8	2007	Vietnam	6.36	–5.56
2008	Ecuador	0	2008	Ecuador	5.44	–5.44
2007	Zimbabwe	3.03	2008	Zimbabwe	8.02	–4.99
2008	Belize	5.31	2008	Belize	10.26	–4.95
2008	El Salvador	0	2008	El Salvador	4.85	–4.85
2007	Jordan	0	2008	Jordan	4.13	–4.13
2008	Bosnia and Herzegovina	0	2008	Bosnia and Herzegovina	4.1	–4.1
2006	Tunisia	9.06	2006	Tunisia	13.02	–3.96
2008	Macedonia	0	2008	Macedonia	3.91	–3.91
2008	Belarus	5.66	2008	Belarus	9.45	–3.79
2008	Russian Federation	6.61	2008	Russian Federation	9.87	–3.26
2008	Colombia	5	2008	Colombia	7.74	–2.74
2007	Bangladesh	5.71	2007	Bangladesh	8.32	–2.61
2008	Guatemala	2.49	2008	Guatemala	4.83	–2.34
2007	Dominica	6.34	2007	Dominica	8.31	–1.97
2006	Jamaica	8.94	2006	Jamaica	10.54	–1.6
2007	Philippines	3	2007	Philippines	4.34	–1.34
2008	Egypt	1.35	2008	Egypt	2.58	–1.23
2008	Nigeria	13.61	2008	Nigeria	14.81	–1.2
2006	Yemen	2.83	2006	Yemen	3.64	–0.81
2008	Trinidad and Tobago	10.72	2008	Trinidad and Tobago	11.35	–0.63
2008	Pakistan	10	2008	Pakistan	10.56	–0.56
2008	Algeria	5	2007	Algeria	5.08	–0.08
2007	Antigua and Barbuda	12.38	2007	Antigua and Barbuda	12.43	–0.05

Value-added and other taxes and charges

In addition to tariffs on imported pharmaceutical products, many governments also levy a range of other taxes and mark-ups on medicines. Value-added tax is extremely common, as are sales taxes. Other duties include solidarity taxes, port charges and income taxes on local manufacturers. Value-added taxes range from 0% in Nigeria to 20% in Armenia. However, there is no central database where information on these charges is held, so research is necessarily *ad hoc*. Credible data is also limited by the fact that many governments are extremely opaque about such charges.

China provides a useful case study on how these various mark-ups can inflate the price of medicines. In addition to the tariff of 4%, the government levies a value-added tax of 17% and a sales tax of 5%. Local manufacturers of medicines must also pay a 15% income tax.[8] Importers face further complications in that they have to send their products to one of 18 designated ports. For products that are being imported for the first time to China, there are only three designated ports.[9]

Another example is Sudan, where the price of medicine is inflated by government levies to the tune of around 20% (including 10% customs duty, 1% Ministry of Defence duty, 1% pharmacy career fee, 2% quay charge & other charges).[10]

Many countries try to reduce the price of medicines by imposing price-controls and other forms of price regulation on medicines manufactured by the private sector. For instance, the Philippines recently enacted a ‘Cheaper Medicines’ act, which granted the government considerable power in setting medicines prices. However, the Philippine government itself charges a 4% tariff and 12% VAT on medicines, which represents a considerable mark-up. This is exacerbated by the fact that the government levies VAT on the first stage of the supply chain, which then inflates the price on which distributors and retailers base their mark-up.[11]

Although many countries exempt medicines from VAT, many poorer countries have extremely high VAT rates on medicines. Notable examples include Namibia (16.5%); Central African Republic (19%) and Benin (18%). A sample of various nations’ VAT and sales taxes on medicines appear in Figure 12.

Figure 12 **A selection of domestic taxes on medicines from different countries**

	VAT, %	*Other taxes*
Central African Republic	19	
Benin	18	
Burkina Faso	18	
Cote d’Ivoire	18	
Senegal	18	
Tanzania	18	
Brazil	17.5	
China	17	5% sales tax on domestic medicines; 15% corporation tax
Bangladesh	15	
Pakistan	15	16% sales tax on raw material and packaging
Zimbabwe	15	
Botswana	10	
Philippines	12	
Algeria	7	Customs fees of 2% & 0.4%
Djibouti	0	7% consumption tax
Tunisia	6	3% customs inspection tax
India	4	
Ghana	0	1% port inspection charge, 0.5% ECOWAS levy, 0.5% export development and investment levy
Angola	0	10% consumption tax

Conclusion

Although tariffs on medicines are declining, they still represent a major mark-up on the final price of medicines in many countries, particularly middle-income countries. Classes of drugs which include essential medicines such as antibiotics face steep tariffs that can add up to a fifth on the final price – and that’s before other government levies such as port charges, VAT and sales taxes. Because these taxes are largely paid by sick people or their families, they are highly regressive and should be abolished forthwith.

One of the ostensible purposes of tariffs is to raise money for governments, but tariffs on medicines fail to do this. According to the 2005 study by Laing and Olcay, medicine tariffs accounted for less than 0.1% of government revenue in 92% of the countries surveyed. Since then, tariff rates have generally dropped, implying that revenues from medicine tariffs are now even less significant. Their complete removal would therefore have minimal impact on overall government revenues.

As with the Laing and Olcay study, pharmaceutical tariffs in 2009 do not appear to be structured to protect the local industry from international competition, with the exception of one or two cases such as Vietnam and Ecuador. It would therefore not hurt domestic industries if tariffs were removed on both imported finished medicines and active ingredients. In the case of the latter, removing tariffs on the constituent parts of medicines would reduce manufacturing costs, allowing lower prices to be passed onto the consumer.

At the 2005 WTO Ministerial meeting in Hong Kong, the USA, Switzerland and Singapore proposed that all member states should move towards making all medicines tariff-free. There has been some progress towards meeting this laudable goal, even though many tariffs remain – albeit at generally lower levels than five years ago. However, there is some way to go until medicines remain free from taxation as they move from countries where they are manufactured to patients who need them in other countries.

A major lacuna in the research on government mark-ups on medicines relates to the domestic taxes levied beyond the point of importation. According to our initial research, this can add considerable sums to the final cost of medicines, in many cases more than tariffs. However, there is no international comparative research on this topic, partly due to the fact that there is no centralised database for such information. The creation of such a database would be a useful activity for the World Health Organization to undertake, so that we can gain a clearer picture of the extent to which governments price their own citizens out of treatment.

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According to the World Health Organization, an estimated 30 percent of the world's population lacks regular access to medicines, with this figure rising to over 50 percent in the poorest parts of Asia and Africa.

Governments have often blamed this on the price of medicines, and have responded with a number of market interventions such as price controls, compulsory licenses, and legalised parallel trading.

However, governments themselves are major contributors to the final retail price of medicines, through import tariffs and a range of domestic taxes. While such tariffs are gradually declining around the world, they are still as high as 15% – thereby acting as a tax on sick people.

This global study examines the latest data on drug tariffs for every country for which such information is available, and reveals import tariffs on imported medicines, active ingredients required for drug manufacture, vaccines and antibiotics. It also collates some initial data on domestic medicine taxes, such as Value Added Tax (VAT), sales taxes and port charges.

Import tariffs and taxes raise little revenue for governments, the poor are least able to afford them, and they hamper access to quality medicines. Those countries which retain such policies should take steps towards abolishing them completely.

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