Taxing essential medicines – a sick tax that hinders access to treatment

While various policies and strategies that negatively impact on medicine prices are often scrutinised, there is one that is rarely discussed yet widely applied - governments imposing taxes and duties on essential medicines - thereby adding to the enormous burden borne by their citizens who have the misfortune of being poor and sick.

Table 1 lists examples of taxes and duties currently applied to medicines in the private sector. Import duties, value added tax (VAT) and other government-imposed duties and charges on medicines can significantly increase the final price patients pay. To illustrate this, in Mongolia, if the government removed taxes on medicines the price of a 30 tablet pack of imported omeprazole 20mg in private pharmacies could fall from 7,134 tugrig (US$5.91) to 5,850 tugrig (US$4.85). If the Philippines government removed the 12% VAT applied to medicines, the price of 10 cc-trimoxazole 480mg tablets (generic) purchased in the private sector could fall from 14.90 to 13.30 Philippine pesos.

Such savings are significant where millions of people live in poverty. A few governments have abolished some taxes on medicines in recent years e.g. in Tajikistan 20% VAT was removed, and the Sudanese government abolished a 1% Ministry of Defence duty and a 1% Pharmacy Career Fund charge on medicines. However, in both countries, other taxes and government charges remain.

A 2005 study by Olcay and Laing on import tariffs (customs duty) on medicines found that 61% of the 153 countries where data was available applied duties on finished pharmaceutical products. In 86% of the countries, the rate was 10% or less.

A 2003 European Commission study on duties and taxes on essential medicines, in 57 developing countries, used to treat major communicable diseases found that for finished products VAT ranged from 0-20% with an average of 10%. This was higher than the average rate in EU countries. It is often stated that governments impose taxes and duties to protect local manufacturers or generate revenue. The Olcay and Laing study found import tariffs generally did not appear to be structured to protect local manufacturers and for over 90% of the countries, the revenue generated by these duties (on active pharmaceutical ingredients as well as finished products) amounted to less than 0.1% of national GDP. The Jordan Food and Drug Administration announced in 2008 that exempting customs duties and sales tax on medicines will have limited negative effects on the country’s treasury but will help improve the affordability of treatments. While customs duties on all imported medicines were subsequently abolished, 4% sales tax is still applied to medicines in Jordan.

When attempting to improve treatment affordability, governments tend to focus interventions on the manufacturer’s selling price, mark-ups in the supply chain and other causes of high prices. What they should also do is lead by example and remove all taxes, duties and other government-imposed charges on medicines, then monitor the impact to ensure patients benefit from lower prices.

Government taxes and duties on essential medicines targets the sick, who are least able to pay, in order to generate revenue for government expenditure. This is an inappropriate policy.

Table 1. Examples of taxes, duties and other government charges on medicines in the private sector

<table>
<thead>
<tr>
<th>Country</th>
<th>Type and amount of charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Salvador</td>
<td>Customs duty 5%(^1) VAT 13%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>VAT 10%</td>
</tr>
<tr>
<td>China</td>
<td>Customs duty 20-40%(^2) VAT 17%</td>
</tr>
<tr>
<td>Peru</td>
<td>Import tax 9%(^3) IGV (VAT) 19% (includes municipal promotion tax 2%)(^4)</td>
</tr>
<tr>
<td>Philippines</td>
<td>VAT 12%</td>
</tr>
<tr>
<td>Yemen</td>
<td>Drug Support Fund Lot 1% Customs duty 5% General tax 5%</td>
</tr>
</tbody>
</table>

1. Not applied to medicines imported from some countries.
2. Some medicines exempt.

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1. Based on data and the situation in a 2004 medicine price study by the ministry of health www.haiweb.org/GlobalDatabase/survey_result/Main.htm
PRICING NEWS

Medicine prices and availability in Latin America

Towards the end of 2008, four groups from Health Action International - Latin America & the Caribbean (Asociación Acción Internacional para la Salud) concurrently undertook medicine price and availability surveys: Colombia, Ecuador, Bolivia and Nicaragua. In the public sector medicines were available free of charge in Ecuador and Nicaragua but not Bolivia. In Colombia, there isn’t a distinct public sector in the classical sense, as 70-80% of the population is covered by health insurance which is accessed through either public and/or private outlets.

In Bolivia, where patients have to pay for medicines in the public sector, a person on a low wage, such as the lowest paid unskilled government worker, would have to work at least half a day to pay for a course of the antibiotic amoxicillin or for a month’s course of atenolol for hypertension. However for some conditions and medicines, it could be as much as 3 days’ work for a month’s treatment for diabetes using metformin, or almost 3 days for a beclometasone inhaler for asthma. Whilst medicine prices in the public sector were lower than in the private sector, it was found that they were only 24% lower.

Originator brands (OB) were rarely found in the public sector (Figure 1). The availability of essential generic medicines (LPG) ranged from an average of 32% in Bolivia [with relatively little variation between outlets demonstrated by the vertical line displaying the amount of variation (as the standard deviation)]; to 45% and 63% in Ecuador and Nicaragua respectively (both of which had a greater amount of variation in availability than Bolivia). In Bolivia, Ecuador and Nicaragua, medicines were much more available in the private sector than in the public sector. In the private sector across all four countries (Figure 2), generics were much more available than originator brands – however originator brands were comparatively more available and closer to the availability of generics in Colombia and Ecuador (and more available than in Bolivia and Nicaragua). In all of the countries the variation in availability [demonstrated by the vertical line displaying the amount of variation (as the standard deviation)] was similar and fairly wide.

Originator brand medicines were 2.4 – 6.5 times the price of the lowest priced generics – this brand premium being lowest in Bolivia and Ecuador at 2.4 times the generic price, to 4.7 times in Nicaragua and 6.5 times the generic price in Colombia.

Requiring less than one day’s wage for a family’s medicines requirements can be deemed as affordable. In Table 1, the number of days’ work required to purchase a treatment course in the private sector is presented across the four countries. Depending upon the condition, medicine and/or where the originator brand or lowest priced generic is purchased, the lowest paid unskilled government worker may have to work a significant amount of time to purchase one course of treatment for one person with one condition. A course of amoxicillin for a respiratory tract infection would require around half to one day’s work across all the countries – and two to six times more work should the originator brand be purchased. For diabetes using glibenclamide, between about half a day’s wage for the generic in Colombia and Ecuador to 1.1 day’s wages in Bolivia, and 7 days’ wages for the originator brand in Nicaragua would be required each month. Treatment for hypercholesterolemia using simvastatin would require a minimum of 3.1 days’ wages each month (for the generic in Ecuador) of the low paid worker and up to 15.7 days’ wage for the originator in Nicaragua – clearly unaffordable in all cases regardless of whether the originator brand or generic is used.

Table 1. Number of days work required to purchase treatments in the private sector (lowest paid unskilled government worker)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medicine</th>
<th>Dose</th>
<th>Bolivia OB</th>
<th>Colombia OB</th>
<th>Ecuador OB</th>
<th>Nicaragua OB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>LPG</td>
<td>LPG</td>
<td>LPG</td>
<td>LPG</td>
</tr>
<tr>
<td>respiratory tract infection</td>
<td>amoxicillin</td>
<td>3 x per day</td>
<td>0.8</td>
<td>2.7</td>
<td>0.4</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(21)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hypertension</td>
<td>atenolol</td>
<td>1 x per day</td>
<td>1.1</td>
<td>5.2</td>
<td>0.8</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(30)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>captopril</td>
<td>2 x per day</td>
<td>2.1</td>
<td>0.3</td>
<td>3.6</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(60)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diabetes</td>
<td>glibenclamide</td>
<td>2 x per day</td>
<td>1.1</td>
<td>0.3</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(60)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>metformin</td>
<td>2 x per day</td>
<td>4.5</td>
<td>4.1</td>
<td>5.6</td>
<td>1.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(60)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hypercholesterolemia</td>
<td>simvastatin</td>
<td>1 x per day</td>
<td>15.1</td>
<td>3.6</td>
<td>8.0</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(30)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>asthma</td>
<td>beclometasone</td>
<td>1 x 200 doses</td>
<td>2.8</td>
<td>3.7</td>
<td>0.7</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>inhaler</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In Nicaragua, prices in the Venta Social de Medicamentos (VSM) outlets (not-for-profit retail outlets) were overall 44% lower than prices in the private sector, however many treatments are still out of reach for those with low incomes.

For more detail on each of the studies, the full country reports are available at www.haiweb.org/GlobalDatabase and the data will soon be available on the Medicine Prices database at www.haiweb.org/GlobalDatabase.

1. For those medicines found in both public and private sectors; only one originator brand medicine was found in both sectors.
2. For matched pairs of medicines, comparison includes only those medicines where both originator and generic versions of the medicine were found.
3. For those medicines found in both private and VSM sectors.

**Colombia**

Our medicine price policy gives total freedom to manufacturers to determine prices, and there is absolutely no transparency about price components. The result is high priced originator brand medicines, which have large market shares. Our regulatory framework is weak, our regulatory authorities fragile.

Since 2006, price controls (albeit weak) have been applied to a medicine if it is the only one in a therapeutic class, leaving competitive market forces to determine prices for other medicines. But what we have are originator brands that are heavily advertised and commonly used, often priced at 60 times more than the cheapest generic equivalent. We also have the problem of new medicines on the market with no therapeutic advantage over existing alternatives but at much higher prices.

Miguel Cortes and Francisco Rossi, HAI Colombia

**Bolivia**

After two decades of lobbying, the government has finally approved a new constitution that recognises people’s right to health, with key articles intended to ensure access to healthcare for everyone, including access to medicines. The challenge now is to ensure these intentions are translated into concrete actions with positive outcomes.

A new approach is needed for the National Health System, with more efficient and effective management of resources, universal coverage, new medicines regulations (including price regulations), less vertical programmes, and greater focus on risk prevention, health promotion and rational medicine use.

While these reforms will take years or even decades to fully implement, at least there is now a legal framework on which to act. But there is much work to be done.

Oscar Lanza, HAI Bolivia

**Nicaragua**

The ministry of health spends only US$2 per capita on medicines resulting in poor availability in public sector outlets, where medicines are much more affordable than in the private sector. This is a serious problem in a country where 45% live on less than US$2 a day and social security covers less than 10% of the population. Because of the global and national economic crisis, it is unlikely that the ministry’s budget for buying medicines will increase in the next year or so. Improving supply chain management and promoting rational medicine use will achieve only modest improvements in medicine availability.

One of the strategies identified to improve access in the short-term is to strengthen a network of nonprofit retail outlets run by NGOs that currently provide low priced quality essential medicines to about 15% of the population living in rural and poorer urban areas. Increasing this network would complement ministry of health efforts to improve medicine availability and fill a need while social security coverage increases. Reforming the legal framework would be needed but this alternative nonprofit drug supply system could really make a difference.

Benoit Marchand, HAI Nicaragua
**São Tomé and Príncipe Survey results**

São Tomé and Príncipe is a small country off the west coast of Africa (population approx. 200,000) with a weak economy and 54% of the population living on less than US$1 a day. As with many other low income countries, Saotomeans are affected by the high price of medicines and the lack of social insurance protection.

In 2008, price and availability data were collected for 50 medicines across the country’s 7 regional health districts. Sampling included 32 public sector medicine outlets and all 9 private retail pharmacies. Procurement prices of generics varied across the 3 central procurement stores despite the medicines all being purchased from a single source international supplier. Whilst procurement prices were generally reasonable, overall the government charged a high mark-up (119%) resulting in high patient prices in public sector facilities. In the private retail pharmacies, prices were extremely high for both originator brands and lowest priced generics (54 and 14 times the international reference prices respectively). Private sector prices of generics were over 400% more than public sector prices. The overall availability of generics was poor in both the public and private sector (55% and 24% respectively). Geographical inequities were found across districts, both in terms of price, availability and affordability. Treatments for various acute and chronic conditions are unaffordable for the majority of Saotomeans. In the public sector, the lowest paid unskilled government worker (on US$ 1.25 a day) requires up to 2.4 days salary to buy a month’s treatment for chronic conditions. In the private sector, for some conditions, over 30 days wages is required to purchase 30 days’ treatment. For example, 48 days’ wages are needed to purchase a month’s supply of simvastatin for hypercholesterolaemia – clearly an impossible situation.

The investigator, Joana Martinho do Rosário, proposes the development and implementation of a National Medicines Policy that addresses medicine affordability and availability issues including improving procurement and supply chain management (including investigating the benefits of a national pooled procurement system across the public and private sector), implementing price regulations, eliminating taxes and duties on all essential medicines across all sectors, and increasing government financing of medicines.

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**Philippines**

**Poor access to diabetes care**

In the Philippines, diabetes is becoming a major public health concern (currently the 9th leading cause of mortality). Recent interviews, by investigator Michiyu Higuchi, with diabetes patients, healthcare providers, health officers and administrators about access to diabetes care revealed patients prioritized diabetes care according to their finances and whether they had symptoms; consultation with a doctor and laboratory tests were more likely to be dropped than medication. Over 70% of the 160 patients interviewed said they had given up some form of diabetes care at some point in the past because they could not afford it. About 40% of the patients reported they had been hospitalized in the last year due to their diabetes.

Many patients took their medication intermittently, mainly, but not exclusively, due to financial constraint. In addition to the median monthly medicine cost of 750 PHP (US$16), patients reported other significant costs e.g. transportation to the clinic, loss of daily wage of patient and/or companion. Median out-of-pocket costs for one hospitalization totaled 8580 PHP (US$186). With a daily minimum wage of 362 PHP (US$8), and 43% of the population living on less than US$2 a day, these expenditures can have a devastating effect on households. It is not surprising, therefore, that a large proportion of patients said they borrowed money or pawned assets to pay diabetes-related costs.

Many diabetes medicines were unavailable at public facilities and patients in remote areas were forced to travel long distances to purchase medicines due to poor availability, even in the private sector. Some diabetes patients believed that they needed to buy expensive products from private pharmacies. The availability of laboratory tests was also inadequate; blood glucose testing was unavailable at some hospitals and rural health units, and glycosylated haemoglobin tests were only available at a few sites in each province (at a median price of 688 PHP or US$15).

The government’s promotion of low-priced medicines may not be achieving the desired results as some doctors reported that they doubt the quality of low-priced diabetes medicines. The Bureau of Food and Drugs needs to be strengthened in order to assure the quality of medicines. Other recommendations included the promotion of regular check-ups and continuous medication, improved public sector procurement and supply of diabetes medicines, improved access to tests, and the expansion of PhilHealth (public health insurance) in terms of enrolment and the provision of an outpatient diabetes care benefit (including medication and tests).

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**Contact**

Interested in learning more about medicine prices or conducting a survey? Then contact the pricing project’s coordinators:

- **Health Action International (HAI) Global**
  - Overtoom 60/III
  - 1054 HK Amsterdam
  - The Netherlands
  - T (+31-20) 683 3684
  - W www.haiweb.org/medicineprices

- **Margaret Ewen**
  - E marg@haiweb.org

- **Martin Auton**
  - E martin@haiweb.org

- **Serena Fasso**
  - E serena@haiweb.org

- **World Health Organization (WHO)**
  - Avenue Appia 20
  - CH-1211 Geneva 27
  - Switzerland

- **Alexandra Cameron**
  - T (+41-22) 791 3785
  - E cameron@who.int

- **Dele Olawale Abegunde**
  - T (+41-22) 791 2826
  - E abegunde@who.int

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