

SALES TAXES ON MEDICINES

WHAT IS THE BASIS FOR THIS POLICY BRIEF?

WHO/HAI Review Series on Pharmaceutical Pricing Policies and Interventions.

Working paper 5:

Sales taxes on medicines by Andrew Creese.

www.haiweb.org/medicine-prices/policy/index.html



As part of the joint World Health Organization (WHO)/ Health Action International (HAI) Project on Medicine Prices and Availability, a series of in-depth reviews have been published on pharmaceutical policies and interventions that may improve medicine availability and affordability. This policy brief summarises the key points from the review on sales taxes and the effects of changes in tax policy on access to medicines, which included a systematic literature review.

Page references to the review paper are given in parentheses.

SUMMARY CONCLUSIONS

What is the main case for reducing or eliminating taxes on medicines?

Taxes on medicines can account for a substantial share of medicine prices. They are regressive. They reduce utilisation, particularly by the poor and elderly, and reduce compliance with cost-effective preventive and chronic disease treatment regimes. It makes political, economic and social sense to advocate for a “healthy tax strategy” combining elimination of taxes on some medicines with increases in taxes on unhealthy products and behaviour.

What are the main arguments against eliminating medicine taxes?

Taxes are necessary for governments to provide vital public functions and services, including health services.

Medicine taxes can be an important source of revenue. Privileged tax treatment for one sector or type of product can be difficult to defend.

Should taxes be reduced or eliminated on all medicine prices?

No. An optimal tax system would treat different medicines differently. A case can be made for cutting taxes on essential medicines – life-saving products, cost-effective chronic disease medicines and medicines with important public health benefits – but not for “lifestyle” medicines and many over-the-counter products.

Is the same “healthy tax strategy” appropriate for all countries?

No. Countries differ in the share of revenue lost from cutting medicines taxes and gained from increasing

taxes on various unhealthy products. Constraints on administrative and enforcement capacity in low- and middle-income countries (LMICs) also need to be considered.

Are there any complementary policies that should accompany medicine tax reductions?

Price monitoring and analysis is needed to ascertain if tax cuts benefit consumers through corresponding price reductions. Consumers are more likely to benefit if there are complementary policies to stimulate competition where feasible and regulate prices where competition is ineffective.

Taxes commonly make up 20-30% of the final price people pay for medicines (1). Reducing or removing taxes on medicine sales may reduce prices and improve access. The objectives of design of the tax system can be summarised as “to raise money from individuals and the private sector in as efficient, equitable and administratively least costly fashion as possible”. Designing a tax system requires balancing these objectives. The percentage of public revenue raised from medicine taxes appears to be small at 0.03-1.7% of total tax revenue in the sample of country data analysed for the review. (p.21) However, effective tax systems are needed to provide adequate public financing for health services, including financing of medicines to ensure access for the poor. With this in mind, the review looked at whether there is a case for “taxing differently” to improve access to medicines while maintaining or increasing tax revenue. (p. xiii-xiv)

Direct and indirect taxes in countries with different income levels

Richer countries raise more tax than poor countries as a share of their gross domestic product (GDP). LMICs typically raise a larger share of revenue through *indirect* taxes which are levied on goods and services such as sales taxes and value-added taxes (VAT), compared to richer countries, which raise relatively more *direct* taxes that are levied on the income of individuals and companies. There has been a global trend to replace tariffs on imports and sales taxes with VAT to make the tax system more efficient. Direct taxes can be related to income and so made more or less progressive – meaning that the ‘better off’ pay a larger share of their income in taxes than the poor. But LMICs may have weak capacity to administer income taxes. Indirect taxes are usually regressive – meaning that low-income people pay a larger share of their income in tax than richer people – but can be easier for LMICs to collect. The regressivity of indirect taxes can be reduced by exempting some goods consumed by poorer households from tax or taxing them at a lower rate. (pp.4-7)

How do different countries tax medicines?

Among 30 European countries with VAT typically with standard rates between 15-25%, five apply a zero VAT rate to some or all medicines. A further 21 countries apply a lower tax rate (ranging from 2.1-11%) to some or all medicines. Where countries apply lower or zero rates only to some medicines, this is usually for prescription medicines or publicly reimbursed medicines, while over-the-counter (OTC) or non-reimbursable medicines are taxed at the standard rate. In the USA, 34 out of 50 states exempt prescription medicines from sales tax or apply a zero rate. Some states also exempt non-prescription medicines. In other states, medicines are commonly exempt from any local government surtaxes on the general state sales tax rate. (pp.9-11)

Medicines taxation in LMICs is less systematically documented. A 2003 study of 57 LMICs found that customs duties accounted for a third of total taxes applied to medicines and found VAT rates on medicines varying from 0% to over 20% (1). The WHO/HAI database (2) on medicine prices shows that in 23 countries where medicines are taxed, the range of tax rates is from approximately 2.9-34%. Ten countries in the dataset report zero VAT or sales tax rates on medicines. The database includes analysis of the component shares of the final retail price accounted for by taxes and other components. Domestic taxes such as VAT or sales tax are the third largest component in the medicines price in many countries after the manufacturer’s selling price and distribution mark-ups. In general, tariffs are a small and falling share of the final price of medicines. Some LMICs have complex taxation arrangements for medicines. India, for example, has two national taxes on most medicines and in addition state governments impose sales taxes. The final impact of tax on retail price is between 13-24%. Medicines sold in the public and private sectors are sometimes taxed differently. Some countries have a variety of additional local charges such as community or local government charges, stamp duty, pharmacy career fees, statistics fees, research fund levies and industrial promotion fund fees. (pp.12-16)

An important difference between high-income countries and LMICs in the impact of medicine taxes on access is the fact that almost all upper income countries have universal or near universal health insurance or public health system coverage, which finances a substantial share of the cost of prescription medicines. In low-income countries, on average around 48% of health spending is out-of-pocket, and the average is several percentage points higher in lower-middle-income countries. Spending on medicines is commonly a high share of out-of-pocket spending. (p.16)

What effect do reductions in medicines taxes have on prices and availability?

The experience with tax options for medicines and the effects of tax changes on medicines is not well documented. There is a large body of evidence from upper income countries and some from LMICs (3) about the effects of prices for health care, including medicines prices, on demand and utilisation of services, which is relevant. Most of these are studies of user fees and prescription charges rather than tax changes, but in a wide range of circumstances, tax changes should result in corresponding prices changes.

An international review of prescription charges concluded that “user charges are a regressive form of health-care finance, requiring the poor to pay more as a proportion of their income than the rich... Poorer people reduced their use of prescription drugs even when co-payment levels were very low”(4). Studies of how much demand for medicines responds to price changes (the “price elasticity of demand”) have been carried out in upper-income and LMIC settings. These studies find that medicines, like many other “necessities” have a positive price elasticity less than one – which means that a given percentage increase in price can be expected to result in a smaller percentage reduction in demand or vice versa. Eliminating a 25% tax on

prescription medicines could be expected to increase demand by some 5-15%, if LMIC consumers have comparable price responsiveness to upper income country consumers. Some groups of people, including the poor and the elderly, are more responsive to price changes than others. Responsiveness to price may be lower for medicines for urgent or life-threatening conditions than for some preventive and chronic disease medicines and lifestyle medicines. USA evidence shows that a 10% increase in prescription medicine prices leads to poorer compliance and more frequent discontinuation of treatment, delays in chronically ill patients starting treatment and increased use of health care for chronic conditions (5, 6). (pp. 17-18)

Complementarity with other policies

Tax changes in some circumstances may not be passed on to consumers fully as corresponding changes in prices. Monopoly suppliers of medicines or cartels may already be charging prices that are as high as the market will bear, and may not be able to increase prices when taxes are imposed without losing revenue, nor face any incentive to cut prices following tax cuts. Policies to increase competition, where feasible, and regulate prices where necessary may be needed in such situations to ensure consumers benefit from any reductions in taxes on medicines.¹ (pp.18-19)

Removing tax on medicines may not always be effective on its own THE CASE OF PERU

Peru removed indirect taxes on a range of on-patent cancer medicines and anti-retrovirals in 2001, but little change in retail prices was observed as a result. This may indicate that suppliers had monopoly power and faced no incentive to cut prices. Unless complementary policies were to be put in place – for example, an appropriate form of price regulation for on-patent prescription medicines – eliminating taxes would reduce tax revenue without benefiting patients or public funders of health services (7). (pp. 18-19)

What challenges have been encountered in making the case for medicines tax reductions and how can public health advocates best make the case for tax reductions?

Ministries of Finance tend to oppose tax cuts or exemptions for medicines for several reasons. Governments may stand to lose substantial revenue if medicines taxes are cut. In 57 LMICs studied, VAT revenue on imported medicines alone averaged US\$11.6 million per country, but ranged up to US\$123 million in Brazil and an estimated US\$1 billion in India. Additionally, special cases for tax exemptions for one sector may create precedents for other sectors to lobby for the same privilege. Taxes

on medicines are relatively easy to collect because record-keeping – especially for prescription medicines – is generally better than for many goods. As well, it can be argued that some non-essential medicines are not very different from other commodities in their effect on equity. (pp. 21-22)

A case can be made for tax reductions or exemptions for essential medicines based on the general principles for tax design. Taxes on essential medicines can be shown to be inequitable: the poor and the sick pay a higher share of medicines taxes relative to their income than the rich and healthy. In countries that are unable or unwilling to protect the poor and sick from health care costs through

1. Other policy reviews and policy briefs in this series discuss some forms of price regulation, regulation of mark-ups and competition policy.

public health systems or social health insurance, taxing essential medicines may not only create a barrier to achievement of priority health development goals such as the MDGs for poverty reduction and health, it can also be inefficient. Ill health reduces human capital, reducing their ability to learn, produce and consume. Taxing cost-effective essential medicines thus taxes economic potential. Increased utilisation of medicines for prevention and for management of chronic illnesses can also achieve savings in costs of hospitalization. (pp.23-24)

Public health advocates may be more successful in making the case for cuts in taxes on medicines if they also support the government's efforts to introduce and enforce other forms of tax collection that are more efficient, in particular, taxes on unhealthy products and behaviour, such as excises on tobacco, alcohol and unhealthy foods high in fat, sugar (e.g. taxes on sugary soft drinks) or salt. There may be a stronger case for a "healthy tax strategy" that combines tax cuts with tax increases than for simply cutting medicines taxes. (pp.25-27)

EXAMPLE The case for a healthier tax strategy in India

In India, the 5% VAT, plus other taxes charged, increases prices and reduces the consumption of essential medicines. Medicine sales in 2009 were reported to be US\$19 billion. VAT revenue alone on medicines would yield almost US\$1 billion. At the same time, tobacco consumption in India reduces life expectancy by an average of 6-10 years. The 38% excise tax on tobacco yields nearly 3% of India's tax revenue, but research has shown that India under-taxes tobacco by not adjusting the excise tax for inflation. Doubling the tobacco excise tax would raise an additional \$3.1 billion in additional revenue each year – enough to allow a complete waiver of VAT on medicines while still allowing a \$2 billion increase in annual government revenue. It would in addition save 3.4 million lives a year (8). (pp.25-26)

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