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Medicinal Malpractice: Improving Drug Access and Reducing Corruption

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Current global efforts to improve access to medicines in the developing world have hit a major roadblock. Too often, the medicines do not reach the impoverished sick because governments of many poor countries impose substantial tariffs, taxes, and customs duties on imported drugs. These fees make drugs more expensive and encourage corruption, making the delivery process from port to patient more difficult. While donations from governmental aid agencies can often neutralize the effects of such tariffs, private-donor organizations from these countries cannot. Some drug-donating groups are fed up with the abuse of their philanthropy and may no longer help countries extracting bribes, which could be fatal for the millions of people for whom affordable, lifesaving medicines remain out of reach. Governments should eliminate tariffs and other impediments to the importation of medicines.

Nowhere in the world are the effects of poor health-care systems as visible and pervasive as in impoverished countries. Many patients no longer bother to seek care because qualified staff are frequently absent and doctors regularly run out of necessary drugs. Ironically, the much-needed drug shipments are often just miles away, sitting in ports while onerous customs clearance regulations are "worked out."

Currently, the World Health Organization (WHO) reports that two-thirds of the world's population—and 80 percent of Africans—do not have adequate access to drugs. Attention to this problem is, of course, nothing new, reappearing on the agendas of World Health Assemblies, G8 summits, and World Trade Organization meetings. In these forums, governments are repeatedly urged to "increase access to medicines, in accordance with the health needs of people, especially those who can least afford the costs."[1]

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At the turn of the century, low life expectancies and high disease rates—even for those illnesses that had supposedly been eradicated—impelled world leaders to identify underlying factors that could explain why, in an era of such unprecedented medicinal innovation and economic development, millions of people still go without adequate health care. Some spirited activists pointed to pharmaceutical companies, which did not always sell drugs to poorer countries at prices they could afford. Such charges soon sounded hollow as more and more pharmaceutical companies responded by tiering their prices (with the lowest prices in the poorest countries), and in some cases donating essential drugs. The international donor community was also accused of being far too "stingy." Since then, many nations—notably the United States—have drastically increased their aid budgets.

The solution to the medicine-access crisis in poor nations today goes far beyond browbeating pharmaceutical companies and a parsimonious donor community; domestic policy failures in recipient countries must also be addressed.

Government Inaction in Africa

Many poor countries impose tariffs on medicines and medical devices. The Democratic Republic of Congo, Nigeria, and Zimbabwe, for instance, impose tariffs of about 8 percent on pharmaceutical products and active ingredients in pharmaceuticals. Other countries, such as India and Morocco, impose tariffs that are double that. Some countries even tax drugs and health-care products that are donated for free, and others have high taxes on all medical products without exception; cases in point are South Africa and Armenia, which maintain a 14 percent and 20 percent value-added tax (VAT), respectively. But how exactly do tariffs restrict access to medicines—aside from the obvious effect of price inflation? More importantly, at what point do tariffs become a public health hazard?

Governments could increase access to medicines by lowering tariff rates.

There is plenty of evidence to show that reducing tariffs on medicine and other health-related products yields abundant rewards. An earlier study of the effects of tariffs, domestic taxes, and other regulatory restrictions on access to essential drugs, vaccines, and devices concluded that governments could increase access to medicines by lowering tariff rates, as any decrease in tariffs for a particular class of medical products is directly associated with increased access to that class of products.[2]

Other scholarly studies have also shown that countries with high tariff rates are often those with the lowest rates of access to available medicines. A study comparing the prices and availability of fifteen different essential medicines in Ethiopia, Kenya, Uganda, and Tanzania reinforced this assessment. In Ethiopia and Tanzania, where tariff rates are very high, there was little to no availability of the studied essential medicines.[3]

How extensive is the practice of imposing tariffs on medicines? In a 2005 study, two WHO economists, after reviewing available data on tariff rates and revenue generated by over 150 countries on different categories of pharmaceutical products, found that 59 percent of countries levy tariffs on active pharmaceutical ingredients, 61 percent levy tariffs on finished pharmaceutical products, and 35 percent levy import duties on vaccines. Furthermore, the authors argued that while tariffs may not fully explain why medicines are inaccessible in developing countries, there is still no legitimate reason to retain them. Ultimately, "tariffs on medicines target the sick, which cannot be good public policy."[4]

Many anecdotal examples of the problems associated with tariffs have surfaced recently. Mikkel Frandsen, chief executive officer of Vestergaard Frandsen, a company that produces and exports bed nets to prevent insect-borne diseases such as malaria, spoke at length about his experience at a recent meeting of the United Kingdom's All Party Parliamentary Group for Malaria. He affirmed that "tariffs do create problems, for example [in] Nigeria, where they change quickly and create delays."[5]

Local tariffs and taxes on medicines are precisely what limit the provision of essential medicines in many developing countries. Furthermore, they contribute to corruption, smuggling, and counterfeiting, and they reduce the supply of drugs available to those in need.

Corruption, Smuggling, and Counterfeiting

For anyone who has tried to clear an item through customs in Africa, the seemingly endless paperwork and bureaucratic heavy-handedness is all too familiar. A *Customs Modernization Handbook* published by the World Bank lists eleven different steps necessary to clear customs. Throw into this burdensome mix poorly paid and occasionally unscrupulous customs agents, as well as a highly variegated tariff system in which no one seems to know the exact rates or bothers to look them up, and corruption is almost inevitable.

Our new research studies the link between tariffs and corruption.[6] It assembles over a hundred firsthand accounts from global health and pharmaceutical agencies and organizations working to provide essential medicines to developing countries (see table 1). We found that tariffs provide opportunities for irregular payments and delay product shipment. Also, frequently altered tariff rates create an opportunity for public officials to extract bribes. Local officials often have asymmetric knowledge about the correct fees, and are endowed with the authority to change them locally, giving the officials improper leverage. In some cases, they waive official fees in exchange for bribes.

Capricious intervention by customs officials makes criminals of importers by leaving them with little choice but to pay bribes to avoid delays, especially where goods with short shelf lives (for example, antibiotics that need refrigeration) are concerned. In about a third of the cases we surveyed, bribes were demanded

TABLE 1
TARIFFS AND CORRUPTION: SUMMARY

Country	Number of cases/ tariffs paid	Unnecessary delay		Nonofficial payment		
		Time[1]	Legal cost[2]	Admin. charge	Other charge	Bribe[3]
Uganda	14/12	14	4	6	11	3
Ethiopia	11/9	11	2	4	11	3
Nigeria	21/18	17	4	13	18	7
Kenya	18/16	16	3	9	14	6
Vietnam	12/8	4	5	3	12	10
China	14/12	12	0	1	12	3
India	15/14	15	3	4	15	4
Total	**105/89**	**89**	**21**	**40**	**93**	**36**

NOTES: 1. Excess of at least twenty-four hours over what is considered good practice in these locations by exporters/importers. 2. Exporter/importer incurred significant excess legal cost. 3. A bribe was demanded. There is no consistent data on whether bribes were paid.
SOURCE: Roger Bate, Richard Tren, Lorraine Mooney, and Kathryn Boateng, "Tariffs, Corruption and Other Impediments to Medicinal Access in Developing Countries: Field Evidence," (working paper 130, AEI, Washington, DC, 2006), available at www.aei.org/publication24749/.

from drug exporters at ports; in particular, Vietnamese officials routinely demand bribes. Such corruption contributes to the instability of access to medicines. Unsurprisingly, most respondents stated that tariffs are a "serious threat" to medicinal access.

But this is not all. Just as high customs charges foster bribery, they also encourage the smuggling of drugs and the counterfeiting of medicines. Several respondents stated that they occasionally resorted to smuggling drugs hidden under vacation clothes in otherwise ordinary suitcases. By not declaring the goods, they avoid the often outrageously high tariff rates and demanded bribes.

Likewise, counterfeiting is encouraged by the existence of high tariffs. In Nigeria, counterfeit medicines, most of which originate from India, constitute between 40 and 50 percent of total supply. Both Nigeria and India have extremely high tariff rates, and while the link between counterfeit medicines and tariffs may not be immediately obvious to the casual observer, a closer look shows that developing countries "stimulate demand for cheaper fakes by artificially driving up the price of legitimate drugs through taxes and tariffs which further inflate the retail price of the drugs."[7] We believe that this link is not entirely coincidental.

Declining Interest in Drug Donation

Our study also revealed that the pernicious effects of tariffs on medical goods are damaging future prospects for drug supply from international suppliers to poorer countries. Drug exporters to Ethiopia, where less than 20 percent of the population have access to medical care, complain repeatedly that customs fees are too high for drugs with a limited market in the country, forcing companies to consider the volume of potential sales before they incur such costs. To make matters worse, strict documentation requirements and the payment of "small" fees—supposedly for customs "support" services—are bound to make exporters increasingly wary. Consequently, imported drugs can sometimes languish for months in customs warehouses, awaiting required laboratory tests, even though local labs are rarely ever stocked with the reagents and other chemicals necessary to carry out the procedures.

A leading U.S.-based global health-care provider, the Catholic Medical Mission Board (CMMB), donates approximately $175 million of pharmaceuticals each year to over fifty countries in approximately 500 different shipments. CMMB crosses many borders and is familiar with customs operations around the world. Since all CMMB pharmaceutical shipments are humanitarian donations, one would think they would be exempt from all duties and customs clearance fees. But each time CMMB brings goods into a country, it is asked by customs officials to pay questionable "administrative handling fees" for documentation filings in proportion to the statistical value of each shipment. In Vietnam, some form of payment is regularly demanded of CMMB upon the entry of its donated medicines.

CMMB is not alone in its experience. Janssen-Cilag, a United Kingdom–based research and pharmaceutical

company, also reports a similar experience in Burma, where it frequently pays a "premium in addition to the import duties and VATs imposed by the country,"[8] increasing the price of the drugs by an additional 15 to 20 percent.

Gilead Sciences, a biopharmaceutical company, had its global-outreach commitment tested in 2004 and 2005 when drugs shipped to Kenya, Uganda, and South Africa were held up at ports. In one case, a drug shipment meant for Médecins Sans Frontières (MSF, known in English as Doctors Without Borders) treatment programs in South Africa was repeatedly delayed. To make matters worse, MSF—which is only in the business of providing medical care—was ill-equipped to tackle the bureaucratic requirements of obtaining permits and securing prepayments for the release of the drugs, leading to even greater delays. After three years the situation was resolved, but only after the services of local distributors had been secured. To sum up their frustrations, some Gilead officials remarked that such hurdles are a significant deterrent to their ongoing commitment to the region.[9]

Certainly not all drug supply efforts have met with this frustrating opposition. Larger donors, such as the President's Emergency Plan for AIDS Relief and the U.S. Agency for International Development, have successfully demanded that tariffs and all forms of nonofficial payments be suspended for their donations. Other nongovernmental groups, however, have not been as successful. Unlike aid from European Union (EU) member countries, a significant amount of American foreign aid is disbursed by private organizations,[10] which means that they are not exempt from tariffs.

With bureaucratic hurdles and mounting costs, it would not be surprising if global health groups abandoned their efforts altogether. In the face of impending disaster, why do some governments keep their tariffs in place?

Just as high customs charges foster bribery, they also encourage the smuggling of drugs and the counterfeiting of medicines. Several importers resort to smuggling drugs hidden under vacation clothes in otherwise ordinary suitcases.

Stark Realities

Today, many developing countries struggle with the most appropriate way to ensure that sufficient resources are available for the provision of basic amenities and services: law and order, national defense, clean drinking water, health care, and education. Historically, nations have been allowed to raise government revenue from a variety of sources, including tariffs on goods (subject to world trade rules). So it may seem paradoxical—perhaps even hypocritical—for rich countries to advocate loosening or removing tariff restrictions which would theoretically deprive poor countries of needed revenue. However, studies have shown that most countries receive very little revenue from medical tariffs. According to one survey, revenue from tariffs on medicines accounts for less than 1 percent of total government revenue in most countries, and in all but a handful of these countries, it is even less than 1 percent of the national health-care budget.

Many countries also shy away from eliminating tariffs because they protect domestic drug industries. This argument makes little economic sense. Granted, there are a few countries—Brazil, Kenya, and India—with thriving local drug industries. Most developing countries, however, lack the requisite pharmaceutical manufacturing capacity and are dependent on drug imports or the benevolence of philanthropic organizations for their supplies. Even so, protecting local industries from international competition does not necessarily guarantee that sustainable companies will emerge to meet consumer demand internationally and generate long-run income. For emerging economies, protecting local industry is usually perverse, especially if the overall effect is an unhealthy and dying population.

Governments in many developing countries believe that rich nations are devious and conniving when it comes to global trade. The Doha trade talks have repeatedly stalled, mostly because wealthy countries (particularly the United States and EU countries) refuse to end indefensible agriculture subsidies. In return, developing countries will not budge on anything else until the agriculture-subsidy issue is resolved, despite the attendant harm to their populations. While the West deserves criticism, leaders of poor nations must realize that they can hold no other entity but themselves accountable for their nations' tariffs on medicine. Tackling other trade inequities must not prevent them from addressing this responsibility.

The United States, Switzerland, and Singapore have proposed removing import tariffs on medicines. G8 leaders

also advocated this course at their 2006 summit in St. Petersburg: "We encourage governments around the world to consider eliminating import tariffs and non-tariff barriers on medicines and medical devices, where appropriate, as a measure to reduce further the cost of health care for the poor and expand their access to effective treatments."[11] Developing countries must respond to this urgent call before it is too late.

Examples to Emulate

The first action taken by developing countries that could be considered promising occurred in 2000, when several African countries promised to reduce taxes on bed nets. In January 2005, India markedly lowered both its import tariff and VAT rates, although rates are still high. Last summer, Kenya dropped its 10 percent import tariff on essential medicines and medical devices; regrettably, other port charges remain. More needs to be done if millions more are to have access to vaccines and HIV drugs.

Tariffs fund corrupt bureaucracies, keeping valuable medicines out of the hands of desperate patients. Furthermore, charitable pharmaceutical organizations may decline to assist stubborn countries that maintain barricaded fortifications against the importation of drugs. A global health policy in which pharmaceutical companies pick and choose the nations they help based on trade rules would be unfortunate, but it may be the direction of international health if the governments of poor nations continue to slap tariffs and taxes on medicines that can prevent death and disease among their citizens.

AEI editorial assistant Evan Sparks worked with Mr. Bate and Ms. Boateng to edit and produce this Health Policy Outlook.

Notes

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5. Mikkel Frandsen, discussion of tariffs on medicines (transcript, All Party Parliamentary Group for Malaria, London, July 2005).

6. Roger Bate, Richard Tren, Lorraine Mooney, and Kathryn Boateng, "Tariffs, Corruption and Other Impediments to Medicinal Access in Developing Countries: Field Evidence," (working paper 130, AEI, Washington, DC, 2006), available at www.aei.org/publication24749/.

7. *Civil Society Report on Intellectual Property, Innovation and Health* (London, International Policy Network, 2006).

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9. Ibid.

10. See Karina Rollins, ed., *The Index of Global Philanthropy* (Washington, DC: Hudson Institute, 2006).

11. Group of Eight, Summit 2006, *Fight Against Infectious Diseases* (St. Petersburg, Russia, July 16, 2006), available at http://en.g8russia.ru/docs/10.html (accessed December 6, 2006).