FEAPM Policy Memo

Feasibility of Implementing Industrial Policies to Support Local Pharmaceutical Manufacturing in East Africa

A look at international trade law and existing best practices

Background

This analysis is based upon the FEAPM position paper *"Support for Local Pharmaceutical Manufacturing - Proposed Model for the Growth of the East African Pharmaceutical Manufacturing Sector"*. Knowledge of the content of this paper is necessary for the understanding of this feasibility study.

The *East African Model (EAM)* incorporates three policy tools: **Price preferences, Tax incentives and Import classification**. Figure 1 introduces the measures in detail.

This proposed set of policies builds upon an approach that proved highly successful in several countries before. The FEAPM position paper calls on policy-makers to adapt this model to the East African Community and put into place the proposed policy measures in order to implement the Regional Pharmaceutical Manufacturing Plan of Action (**EACRPMPoA**) with the aim of *increasing access to regionally-produced affordable quality essential medicine in the EAC*.

This paper aims to assess the **feasibility** of implementing the EAM: Firstly, checking its compatibility with international trade legislation. Secondly, comparing the proposal to existing practices in the EAC and, thirdly, to previous industrial policy implementation in other low-income countries.

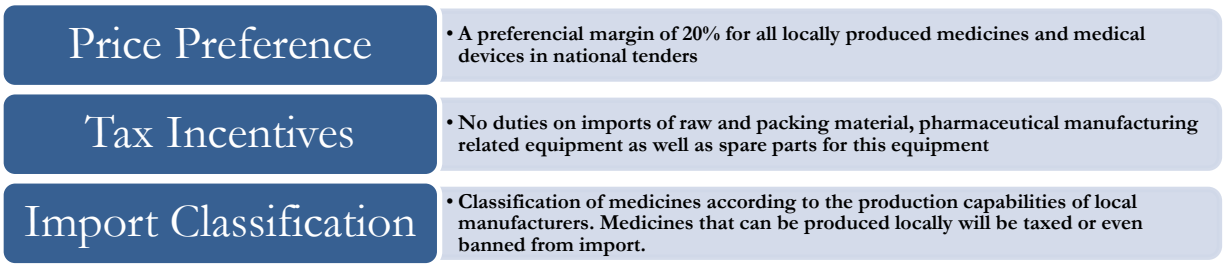

Figure 1: Key features of the EAM

Legal Assessment of Policy Interventions

The implementation process of the EAM needs to take the regional factor into account. This applies especially for the pooled public procurement: Preferential pricing needs to be applied on an EAC level and include manufacturers from all Partner States in order to promote a regional industrial development.

Price Preference:

- No EAC Partner States has signed the WTO Agreement on Government Procurement. Thus, they are not bound by WTO rules governing public procurement.
- The national treatment[1] clause of the General Agreement on Tariffs and Trade (GATT 1994: Art.3) does not apply to laws, regulations or requirements governing government procurement.

Policy Insight #1

- *Partner States **are not bound** by any WTO trade legislation and are free to support local pharmaceutical manufacturing through preferential pricing in national tenders.*

Tax Incentives:

- Freeing specific goods like pharmaceutical packaging or related equipment from all duties and taxes is in line with the most-favored nation principle[2] of Art.1.1 GATT 1947.
- Attention needs to be given to include all "like" products in the incentive scheme in order to stay within the WTO agreements. That means treating all products equally which share the same physical properties, serve the same end-uses, are perceived as substitutes by consumers and share the same international classification for tariff purposes[3].

Policy Insight #2

- *As long as like-products are not discriminated against, Partner States **are free** to give tax incentives for the import of goods required for pharmaceutical production.*

[1] The national treatment clause prohibits governments to treat imported products different from nationally produced goods (e.g. for domestic taxes or other national legislation)
[2] The most-favored nation principle prohibits governments to discriminate between its trading partners. A country would not be allowed to liberalize only imports from a single or a group of states.
[3] "Like Products", WTO rules and environmental policies: key GATT disciplines. Retrieved from: http://www.wto.org/english/tratop_e/envir_e/envt_rules_gatt_e.htm

Import Classification:

- Art. 11.1. GATT 1994 generally forbids import bans. Moreover, different custom duty rates depending on each pharmaceutical product are likely to violate the most-favored nation principle. Nevertheless, EAC Partner States can still use this policy tool, as subsequently explained.
- Under the **economic development exception** of Art.XVIII GATT 1994 developing countries are allowed to "*deviate temporarily from the provisions of the other Articles of this Agreement, as provided in Sections A, B, and C of this Article".* Protecting an infant industry like the pharmaceutical manufacturing sector from import competition falls under this exception.

Policy Insight #3

- *Partner States **are allowed to** use import classification to support their infant industry.*

Existing Practices of the East African Model in EAC Partner States

Figure 2 demonstrates that Partner States have already begun to implement measures of the Pharma-Policy Package and can serve as positive examples for the feasibility of this policy-mix.

	Preferential Pricing	Regional Preferential Pricing?	Tax and Custom Incentives	Import Classification
Tanzania	15% for all medicines produced in Tanzania. Factoring in clearance costs of imports, preference is really only **6.5%**	**No**	**All relevant inputs free of customs.** VAT can be reimbursed up to 8 months later	**None**
Kenya	15% for all medicines produced in Kenya 10% for all imported medicines traded by a company with at least 51% Kenyan ownership. Thus, real price preference for local producers **5%**	**No**	Imported **raw and packaging materials free of customs and taxes**. Yet, VAT levied on locally procured products.	**None**
Uganda	**15%** for all medicines produced in Uganda (implementation problems)	**No**	**Raw and packaging materials free of customs**. Machines and spare parts face 6% customs duty. VAT can be reimbursed later for all goods.	**None**
Burundi	**15%** for all medicines produced by companies with more than 50% Burundian ownership	**Yes, if reciprocity exist with Partner State**	**All relevant inputs free of customs and taxes.** Inputs that are produced in Burundi are excluded from the incentive scheme	**None**

Figure 2: EAM in Partner States

Cases of Pharmaceutical Industrial Policy from other developing countries

Figure 3 compares several examples of developing countries which have implemented similar Industrial Policy measures to successfully support local pharmaceutical manufacturing.

	Measures	Industry Growth	Quality of Medicines	Employment
Ghana	Similar to EAM	The share of local production increased from 10% to 30% with 39 local manufacturers in 2014 compared to just 9 in 1989	The quality improved significantly: For example, the share of sub-standard malaria medication in circulation fell from 39% to 3%.	Employment more than ten-folded: Currently about 6500 jobs in the industry
Bangladesh	Import classification and price ceilings	The share of local production increased from 35% to 97% with more than 170 approved & operating companies in 2013 compared to just 80 active in 1982.	The quality improved significantly. The industry began recently to export their products to countries in Asia, Latin America and Southern Europe and also to developed countries including USA, where the safety regulation is most stringent in the world.	Employment: currently about 100,000
India	Import duties and export subsidies	India's industry has been growing at an average annual growth rate of 10 %. In 2013 it was the third biggest exporter of medicines by volume	India is among top 20 pharmaceutical exporting countries. Indian drugs are exported to around 200 countries including high-regulated countries like the UK or the US	The industry currently employs about 4,50,000 people and has contributed significantly in creating a rich talent pool of researchers, scientists, doctors and project managers

Figure 3 Results from Pharmaceutical Industrial Policy implementation in other developing countries

Concluding Policy Insight

Implementing the "East African Model" in EAC Partner States can be done without violating any WTO agreements or other trade legislation. In fact, some measures are already in place in EAC countries. The remaining Partners are called on to follow their lead and implement *price preferences, tax incentives* and *import classification* in order to develop local pharmaceutical manufacturing as successfully as other low-income countries did in the past.