Episode 209. Will Trump's pharmaceutical tariffs lower prices and secure supply chains?

Episode webpage

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Transcript

(lightly edited)

Chad Bown: In early April, President Donald Trump announced new import tariffs of up to 100% affecting the pharmaceutical industry.

He also released some long-awaited details on the drug pricing deal his administration had been negotiating with the UK, titled the "United States-United Kingdom arrangement on Pharmaceutical Pricing."

When I was working on my book last year, I interviewed pharmaceutical executives, supply chain experts, and policy makers from around the world. Everyone agreed that something was wrong, and something needed to be done.

The common worry was about those medical and drug supply chains tied to China, and also to India. I am really excited to get back into the topic of pharmaceuticals today.

The book is titled *How to Win a Trade War.* I wrote it with my old *Trade Talks* co-host Soumaya Keynes from the *Financial Times*. The book will be out in May, but you can pre-order *How to Win a Trade War* today anywhere that you buy books.

And with that, let's get right into the show.

THE EPISODE

Chad Bown: You are listening to an episode of *Trade Talks*, a podcast about the economics of trade and policy. I'm your host, Chad Bown, the Reginald Jones Senior Fellow at the Peterson Institute for International Economics in Washington.

In this episode, we are going to talk about the problems facing the US pharmaceutical market, the Trump administration's tariffs and its deal with the United Kingdom, and what the impact of all this may be for American drug prices, as well as supply chain security.

To help us make sense of it all, I will be joined by a very special guest.

Tom Bollyky: I'm Tom Bollyky. I'm the Director of the Global Health Program at the Council on Foreign Relations.

Chad Bown: Tom Bollyky is at the Council on Foreign Relations and one of the world's great experts on trade and public health. Tom's work during the COVID-19 pandemic on the pharmaceutical industry, treatments, vaccines, and supply chains was massively important and influential.

Hi, Tom.

Tom Bollyky: Hi, Chad.

THE US PHARMACEUTICAL MARKET IS REALLY TWO SEPARATE MARKETS

Chad Bown: Tom, let's start off by trying to explain the problems for pharmaceutical products that the US government is using new policy to try to tackle. What's going on here?

Tom Bollyky: Let's start with just an acknowledgement that the US plays an outsized role in the world pharmaceutical market.

The US represents about 4% of the global population, roughly 340 million, out of the 8.1 billion people worldwide, but we represent 40% of the world's global pharmaceutical market [in terms of spending].

Now, within that, there really are two different US markets, and they have two different sets of challenges.

The first are generics – i.e., drugs that aren't protected by patents. These represent 9 out of 10 US prescriptions. So, they're filled with either generics or biosimilars, which are roughly the generic version of biologic drugs. And these represent the vast majority of what you or I might get from a pharmacy, or what might be given to you in a hospital.

But they are very cheap. They represent 90% by volume of the US pharmaceutical market, but just 13% of our spending.

And generic drugs in the US – for unbranded generic drugs, so not attached to a particular company or not with the brand name – those are just two-thirds of the price that they are in other OECD countries. So very cheap.

These drugs have issues because of the low margins, the high volume, you can't make a ton of money on them.

They've been prone to shortages in recent years, particularly some categories of drugs like sterile injectables, like things you would get through in an IV. Those drugs have been prone to record high shortages. A lot of the ingredients we receive are used for them, either the raw materials or, after it's refined into active pharmaceutical ingredients, much of it comes from foreign markets: Increasingly, for the raw materials and key starting materials from China, for the active pharmaceutical ingredient, often from India. And there's a lot of concern in the US for antibiotics or other drugs we get in the hospital setting that we're reliant on supplies from other countries.

But that's really about the generic market.

Chad Bown: Okay, so the first American pharmaceutical concern is in the market for low price generics. What's the second market?

Tom Bollyky: The second market is branded drugs and biologics. Brand name drugs, many on patent: Now these only represent roughly 10% by volume of what people take, but 87% of what we spend.

Now, these drugs are much higher priced than other markets. There was a RAND study in 2024 that did a comparison with other OECD markets, and they found for this category of drugs, branded drugs and biologics, US drugs are 278% of the OECD average.

Insulin drugs, for example, are nine times higher in price, than they are in these other 33 OECD countries. These drugs, we are not dependent on, for the most part, on materials produced in China or India.

Manufacturing costs aren't the big driver of those costs. It's around the innovation that drives [the cost of] those drugs. Finnish drugs are increasingly manufactured abroad, but mostly for tax reasons.

A lot of the anti-obesity drugs, the GLP-1 agonists you hear about, those are produced in Ireland or in Singapore, but really for tax reasons, and there's less concern in this space about our dependence, or our fragility of supply chains, and much more concern about just the extraordinarily high prices we pay.

So, it's helpful really to think about these as two different markets with two different sets of challenges.

Chad Bown: So two different sets of issues, one on generics and some concerns over the surety of supply, and then another for patented drugs and really prices. Let's start with the latter.

Why are prices in the United States so much higher for those patented drugs?

Tom Bollyky: The US does not have universal health coverage. We don't have a monopsony purchaser that negotiates with other companies.

So in the UK or in Australia, you'll have a health agency that will negotiate with pharmaceutical companies, and they may do that based on some assessment of the cost effectiveness of the drug, but they'll bargain. And because of that, they will get lower prices.

In the US system, much more fragmented, we give up a lot of that power, but also for the most part, through Medicare and Medicaid, we don't bulk negotiate for drugs.

You do see some purchasers in the US government, like for Tricare or the Veterans Administration or DOD, we'll have bulk purchasers, and they tend to get much better prices for that reason.

But for the broader market, we don't. And it's that lack of negotiation that really is the big divide between the US and other markets.

TRUMP TRADE POLICY

Chad Bown: So I think it's fair to say that these issues have been well known in the United States for a long time.

They were certainly raised in the Biden administration, and the Trump administration has put them on the priority list essentially since day one.

Let's get into some of what the Trump administration is doing about this specifically. How would you describe it?

Tom Bollyky: The big divide between the Trump administration and previous administrations is less of the concern about these two sets of challenges, which, as you rightly say, have existed for a long time. It's the fact that they're using trade policy to try to address them.

Now, historically, the role pharmaceuticals have played in US trade policy have been around ensuring consistent IP standards and regulatory standards in other markets, so that US exports are not disadvantaged or around market access in single payer systems. I.e., making sure there's clarity about how drugs are listed and you're not, again, disadvantaged in either US producers or foreign producers generally.

That's the provisions that we've historically had in US trade deals. And those provisions go back to really our first sets of bilateral free trade agreements all the way back to NAFTA, we started having those kinds of provisions.

What the Trump administration has done is that they have tried to tackle pricing, and to some extent, at least talked about trying to tackle foreign dependence in the US pharmaceutical market through trade arrangements. They've done that in a couple of ways.

One is that they had launched a Section 232 investigation about whether foreign exports threaten to substantially impair US national security.

They've also negotiated deals with other countries predicated on threats of high tariffs in part as a result of that 232 investigation.

They negotiated deals where other countries commit to raise the prices of their drugs as a way of guaranteeing a fixed tariff on their exports to the United States.

They have also reached deals with companies where companies commit to make investments in reshoring US manufacturing and giving the US the same prices that they charge in other markets.

So the big distinguishing factor is the use of trade arrangements.

US-UK DRUG DEAL

Chad Bown: And in early April, the Trump administration announced the result of this Section 232 investigation. They announced a set of tariffs that would be the result going forward for a bunch of different countries. And they also announced some of the details of the country-specific deal that they had reached with the United Kingdom.

They're talking with a lot of different countries about these pharmaceutical sorts of issues, but I think we've learned the most about how they're conducting these negotiations by looking at the text of the UK agreement in particular.

Let's start there. What are some of the basics of what was agreed between the United States and the United Kingdom in this particular deal announced this week?

Tom Bollyky: They had announced the agreement in principle in December and have provided more clarity on that.

The UK has one of those systems we talked about earlier, where the National Health Service, their monopsony purchaser, calculates whether drugs are cost-effective and then negotiates with companies on what the prices that will pay.

But they will only do that for drugs above a threshold of cost-effectiveness. What the UK agreed to do is that they would raise by 25% its cost-effectiveness threshold for listing medicines in the National Health Service, in exchange for the US providing a preferential tariff rate on US pharmaceutical imports for three years, exempting US-origin pharmaceuticals from 232 tariffs, and keeping tariff rates on UK medical technology exports at 10%.

Many of the deals they've announced with countries and companies are limited – the companies in particular to 2029.

It's not clear how effective this will be, either in terms of raising UK prices or affecting US prices, but that's the broad strokes of the UK arrangement.

Chad Bown: Let's suppose it is effective. And I agree, it's really unclear. We've never seen anything like this, to my knowledge, before play out. I think there is some question there. But let's suppose it actually works out as per the terms of the agreement.

As I read it, that actual agreement, it was really interesting.

The first four pages were really specific details of the United States government essentially negotiating on behalf of big pharmaceutical companies to get the UK government to commit to spending more money on drugs.

But to me, that sounds bad for the UK government. Why would the British actually agree to a deal like this? What's in it for them?

Tom Bollyky: For them, it's the certainty around exports. Obviously, Ireland already has been [successful], Singapore or other countries have had great success sending exports to the US in the pharmaceutical space. Maybe the certainty helps them attract more of that manufacturing there.

From the UK perspective, it's not clear how much of this is a departure from what might have happened anyways. According to the press releases, at least in December, the UK expected the bill to be around one billion pounds per year because of this shift by 2029. That's not a ton of money as the pharmaceutical market goes.

I think there was some sense that perhaps they needed to raise the cost-effectiveness threshold anyways because of what it might have done to delay drug launches in the UK if the spending was too parsimonious.

From a UK side, I think the sense is that maybe this isn't a big change from what they would have done anyways, and it gives them some advantages and maybe some certainty with the US market.

DO THESE DEALS LOWER US DRUG PRICES?

Chad Bown: Tom, let's turn back to the United States. What does the administration's deal with the UK do to help lower US prices?

Tom Bollyky: The argument has been the US is subsidizing the world's pharmaceutical market, and that if we cut our drug prices in the US, innovation would collapse because other countries are free riding off that.

Now, that's debatable, but that's the argument, that if other countries paid more, it would allow us in the US to pay less.

Most of what we know of how pharmaceuticals are priced is that they tend to be, particularly in the branded space, they're demand-side priced, not supply-side priced. What I mean by that is they're not priced by how much it costs to produce them or what went into them. They're priced by what payers are willing to pay for them.

So having the UK pay more for its drugs, it's not clear how that will enable the US to pay less unless the US becomes willing to negotiate a lower price. And that's where I guess the deals with the companies start to come in.

Chad Bown: Tell us about some of those deals that the US administration has been negotiating with the companies then.

Tom Bollyky: At the same time that the US has been negotiating deals with a set of countries – in exchange foregoing higher tariff rates on those countries' products – companies are making voluntary commitments to make investments in US manufacturing.

Right now, the companies that have had these deals are large pharmaceutical companies, and they've made as much as $480 billion in announcements of investments in US manufacturing.

It's not clear as of yet how much of that investment is occurring. My colleagues at the Council on Foreign Relations, led by Prashant Yadav, but others also, have done analysis, looking at the financial statements of the companies that are typically involved in making manufacturing equipment for pharmaceutical production. And when you look at those financial statements, at least by the end of the last year, we don't really see any indicia that companies are seeing larger purchases that might be indicative of more manufacturing coming to the US.

But the idea behind these deals is that this would guarantee the companies would give the same prices to the US that they provide in other countries, but also address some of the supply concerns by reshoring some capacity in the US for these large multinational companies.

The only issue I want to highlight here is that these companies, by and large, are all branded pharmaceutical companies – i.e., innovative companies. Those are not the companies where we

are most concerned about dependence on China or India or the fragility of supply. It's really the generic companies where that is and so far, those have been excluded from both sets of the deals we've talked about.

Chad Bown: We'll make sure to provide a link to Prashant's study that you mentioned in the show notes.

Would it also be right to say that merely having companies move production to the United States also is not necessarily going to help the pricing issue facing US consumers for these branded products if all they're doing is just shifting their source of supply from one place to another? It's still patented.

Unless the United States figures out how to negotiate with these companies better on prices, whether they're making a pill in Ireland or the UK or Michigan doesn't really matter.

That's still the underlying issue – i.e., it's how the United States chooses to negotiate with the companies over prices.

Tom Bollyky: Yes, it's not clear how these deals will advance either set of the US concerns.

Because we're largely excluding generics and their active pharmaceutical ingredients, or key starting materials, all the kinds of things that we really tend to get from other countries, we don't address the set of real concerns we have about US drug shortages, record high levels of US drug shortages, or the fact that we're concerned about potential adversaries weaponizing our dependence on other countries for our medicines. We don't really get at that in these deals to date.

We also, as you rightly said, don't really get at US pricing either. Reshoring capacity in the US doesn't make that capacity cheaper. In fact, given the investments, if anything, the US is a pretty high-cost place to manufacture. It's hard to see how that would lower prices.

It's also not clear by even guaranteeing most-favored-nation pricing levels – i.e., "reference pricing," how that has typically been called – will lower US prices either.

It might raise other countries' prices, but historically it's been really hard to enforce reference pricing commitments because it's unclear whether that's going to fully account for all the discounts, or other ways that companies give deals to monopsony purchasers.

So it might be, for instance, like buying a car from a car dealership where you pay the window price, the sticker price, and that's the basis for the reference price, or the most favored nation

price, as opposed to something that really captures the real price that those monopsony purchases are getting. So, it's hard to enforce from the US, and reshoring doesn't advance that cause either.

The most effective way for the US to lower its drug prices is to negotiate on its own behalf.

WHAT IS MISSING FROM US POLICY?

Chad Bown: So, if there's really nothing so far in this Section 232 action announcement of April that is really going to directly target some of the supply chain vulnerability issues that you mentioned back at the beginning when it comes to generics and the upstream ingredients of APIs and key starting materials. What should United States be doing then?

Tom Bollyky: Here too, we should separate out what they should be doing to address the supply chain concerns and what they should be doing to address the pricing concerns.

On the supply chain concerns, long-term federal purchase commitments through CMS, the Veterans Administration, DOD, to try to de-risk domestic investment in producing key starting materials and active pharmaceutical ingredients in the US. That's the way to move some of the capacity again for those across the supply chain for generics – i.e., starting to move some of that manufacturing back to the US.

We can't make everything, so that has to also include more coordination with allies, so that we have a facilitated mechanism to try to ensure production of key starting materials and API in friendly nations. There's a lot we can do to create the incentives there, to try to smooth the road from a regulatory perspective, so that we're not just dependent on countries like China, that we don't want to be dependent on for those products.

We also can invest in manufacturing technologies. It's a really conservative industry, the pharmaceutical industry, because it's so regulated, and of course, these are medicines.

Having the subsidies and tax credits to sustain the viability of new manufacturing technologies can really help them get over that hump, so you can start to see that widespread adoption of being able to do things more cheaply and cleaner so that we can move some of that capacity from abroad. So that's a set of things we could do on the generic supply chain issues.

On the innovative side, of course, we also need to rely on federal purchasing to drive that market and to lower those prices. There was a set of experiments really under the Biden

administration that people have talked about for a long time, which was around negotiation on a set of drugs to start to drive prices lower in the US. They started with just 10 drugs at a time – not the bold commitment we'd like to see, perhaps, in that space overall, but something that helps you get at pricing.

The other thing we need to do in the innovative space on branded drugs is, there is a concern, more of that research and development is going to eventually move abroad because of advantages of subsidies that you see in China and easier regulations and starting clinical trials.

The US really has to invest in science, invest in trying to make it easier to do first-in-human trials in the US, that really small and medium-sized biotechs rely on.

We need to have the best science happening here – that is really the best way to get that industry to stay here and back, and that's a way to have that investment so that we're producing the best science, and we don't create a dependency in a space where we don't really have it right now.

POTENTIAL TARIFF TARGETS IN PHAMACEUTICALS

Chad Bown: As my last question, last year we saw China restrict exports of a lot of products, including rare earth elements, permanent magnets, and semiconductors needed to make cars.

In this suddenly geopolitical world where American policymakers are now also concerned about the weaponization of medical supply chains, can you think of any areas of pharmaceutical products where it might make sense to impose tariffs?

Tom Bollyky: It would make sense to have targeted tariffs potentially addressing key starting materials and active pharmaceutical ingredients.

It is these materials that we really depend on China, and to some extent on India, and that's really where we have the level of dependence that raises national security concerns, but also adds fragility to the US pharmaceutical supply chain.

If you had tariffs that target those inputs, that might actually be a good incentive to move more of that capacity to the United States or to other markets that are not targeted by those tariffs.

If we had these deals exempting countries where we have pharmaceutical arrangements, that might be ways of shifting some of that manufacturing back to the US and to friendlier markets.

This latest deal that they just announced in April from the White House, the executive order does cover key starting materials, but only for branded pharmaceuticals.

What is strange there is these are raw materials that could be, in some cases used for both, and it's not clear how we could possibly enforce that for just branded pharmaceuticals but not to address generics.

It's very possible that companies will game those requirements as well. We need to have more targeted provisions for the real source of US dependence and particularly vis-à-vis China.

POLICY SUMMARY

Chad Bown: To sum up this episode, we all seem to agree that there are some serious pharmaceutical market problems that policy makers need to tackle.

One is the high price in the United States of branded patented drugs. The administration has announced deals with the UK and some companies to address high US prices, but only in a roundabout sort of way. We will have to watch to look for evidence of whether this indirect approach has any effect at all on lowering US prices.

The second problem is insecure supply of mostly generic drugs, as well as their inputs – i.e., active pharmaceutical ingredients and key starting materials – that are often imported from China and India. This is part of the market that faces frequent consumer product shortages and where there is a fear of weaponization.

My conversations with policy makers in Europe and elsewhere for the book made clear to me that this is an area ripe for American collaboration with like-minded countries.

But in terms of practical policy, the Trump administration's actions in April were mostly silent on this very important issue.

And certainly, when the administration is whacking these potentially allied countries with other tariffs, it does not look like they're prioritizing ways to share the burden and solve this problem together. But we will continue to watch this space, maybe there will be more to come from here.

Tom, thank you very much.

Tom Bollyky: My great pleasure, Chad. Always good to talk to you.

GOODBYE FOR NOW

Chad Bown: And that is all for *Trade Talks*. A huge thanks to Tom Bollyky at the Council on Foreign Relations.

Do follow Tom's work, including Think Global Health. This is a hugely valuable website dedicated to analysis of pressing issues in global public health, where Tom was the founding editor.

A big thanks as well to Isabel Robertson, our audio producer. Thanks to Melina Kolb, our supervising producer. And thanks to Sam Elbouez and Sarah Allen on Digital.

Please subscribe to *Trade Talks* on Apple Podcasts, on Spotify, or wherever you get your podcasts. Even if you are a long-time listener, please take two minutes to leave a review. That is how new listeners will find the show.

And if you have already ordered a copy of my new book titled *How to Win a Trade War*, thank you so very, very much. If you haven't yet, here's how to do so.

Bookshop.org has offered 15% off the book from now until the end of May, using the promo code HTWATW15. HTWATW is "How to Win a Trade War," 15 is "15%." I'll put all this information in the show notes.

See you next week, everybody.

READ MORE

- Bollyky, Thomas J., Close Searchinger, and Prashant Yadav, "America's Pill Problem. Tariffs won't fix the country's reliance on foreign medicines," *Foreign Affairs*, July 22, 2025.
- Yadav, Prashant and Chloe Searchinger, "Tracking Pharma's Progress on U.S. Onshoring Efforts to Avoid Tariffs," Council on Foreign Relations, Think Global Health, November 24, 2025