Most Favoured Nation
Impact and Mitigation Strategies for Global Pharma

How US drug pricing policy is reshaping ex-US launches, and what industry and governments can do about it

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Foreword

The Most Favoured Nation (MFN) policy developed by the United States is perhaps the biggest challenge facing the global pharmaceutical industry today. Here, we explore MFN background, impact, and possible mitigations, while also including insight from leading pharmaceutical executives.

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Disclaimer

This report includes and builds upon an initial blog series produced by Robert Kettell and James Lee, which was published on LinkedIn. Here we explore those themes in greater detail, including supplementing them with primary research.

Information is accurate as of the date of publication.

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Executive Summary

The United States' Most Favoured Nation (MFN) drug pricing policy links what Americans pay for medicines to the prices paid in a basket of other wealthy countries. Through this system of international reference pricing, a low net price agreed in a market such as the UK can now pull down US revenue for the same asset, linking US and ex-US prices for the first time. This paper sets out what MFN is, the impact it is already having, and the practical steps industry and governments can take in response.

The impact is significant although still emerging. MFN operates through the voluntary GENEROUS model feeding Medicaid pricing, and the mandatory GLOBE and GUARD models covering selected Medicare drugs. The UK is unusually exposed, sitting in both baskets and with net prices among the lowest in Europe, in part due to its cost-effectiveness methodology. Early evidence of launch hesitancy across MFN reference countries is becoming visible and is expected to accelerate as additional GENEROUS companies are announced, and the GLOBE and GUARD models are finalised.

The UK–US pharmaceutical deal is the key precedent of the type of national reform possible. In exchange for tariff protection, the UK raised the amount it would pay for medicines, capped rebates, and committed to doubling new medicines spend as a share of GDP. Whilst it proves system-level reform is possible, many in industry consider that it does not go far enough with further measures needed. Meanwhile, the US is employing this playbook across Europe, most clearly in Germany, and the pressure for countries to sign a deal similar to the UK's is increasing.

Supporting this perspective are interviews with six senior pharmaceutical leaders, whose consistent message was that MFN amplifies long-standing weaknesses in ex-US markets, that current reforms are a welcome start but not yet sufficient, and that in-country investment recognised through pricing is the mitigation with the most immediate promise.

We believe that an effective response is based on two complementary tracks. National-level policy reform can reshape the pricing environment itself, but can take time to realise and may not be achievable in every market. Bespoke asset-level commercial strategies may not have the same impact across all launch decisions, but companies have greater control over the terms and can act now. Both are needed to optimally mitigate MFN risks.

These asset-level strategies encompass non-standard commercial dealmaking between manufacturers and payers at the individual asset level. Much of this can be carried out within existing payer systems and processes, and there is extensive precedent for this type of commercial flexibility. They can include financial based constructs such as budget caps, outcomes deals including non-responder warranties, and value-add arrangements of which patient pathway support is an example. The applicability of each depends on factors including data availability and risk appetite.

MFN Background

The origin of MFN can be traced back to President Trump's first term

Most Favoured Nation (MFN) drug pricing is based on Trump's argument that Americans should not pay more for medicines than patients in other wealthy countries. In practice, the policy links US drug prices to those in a basket of reference nations, including the UK, through a form of international reference pricing (IRP). This creates a direct and potentially costly link between prices assessed as cost effective by ex-US HTA and payer organisations, including NICE, and revenues earned in the world's largest pharmaceutical market.

The policy has its roots in President Trump's first term. In September 2020, an executive order directed the Department of Health and Human Services to test an MFN payment model for Medicare. That attempt was blocked in the courts and subsequently abandoned by the Biden Administration. The second attempt, launched through executive orders in April and May 2025, is broader in scope and has a different legal basis. While this means that the same legal arguments used in the first term may not apply, it has not stopped this iteration of MFN being challenged on different bases in the courts. The April order laid out the principle of lowering drug prices, while the May order introduced MFN pricing directly. It stipulated that the US will access drug prices at parity with other economically developed nations and directed HHS to facilitate a direct-to-consumer mechanism

MFN follows a mandatory and voluntary track

Implementation is proceeding on two tracks; the first is voluntary with 26 of the world's leading pharmaceutical companies having signed individual MFN deals with the Administration, covering 89% of US branded sales. They have received three-year tariff exemptions and GLOBE & GUARD exemption in return for offering 'MFN prices' for: select assets covered by state Medicaid, potentially on all future drug launches, and on select assets through TrumpRx. The voluntary GENEROUS model sits alongside these deals acting as the implementation of MFN pricing in state Medicaid. To generate this price, it selects the second lowest GDP adjusted for PPP (purchasing power parity) manufacturer reported net price from an eight-country basket that includes the UK, France, Germany, Italy, Canada, Japan, Denmark, and Switzerland.

The second track is mandatory in the form of the GLOBE & GUARD models which require rebates for selected Medicare Part B and Part D drugs respectively. These models cover roughly 25% of Medicare beneficiaries in randomly selected test regions and use a broader 19 country reference basket. Two methods for calculating the benchmark price are available: Method 1 uses the lowest GDP adjusted for PPP publicly available list prices, while Method 2 draws on volume weighted GDP adjusted for PPP net prices derived from manufacturer reported sales revenues and volumes.

Response to MFN

The UK responded first to MFN related pressures

MFN is a tool to both reduce the cost of medicines in the US and increase prices paid for medicines outside the US. The first objective clearly concerns industry, though the second could be a partial antidote.

If industry can reshape ex-US markets, working with national governments and payers referenced by MFN to improve pricing and reimbursement conditions then revenue loss can be limited by reducing downward US price pressure and maximising ex-US prices. Those attempting to do this will find a natural ally and supporter in the US. The first mover, responding to the pincer movement of industry pressure and US geopolitical weight, has been the UK: and this provides an interesting blueprint for other nations.

The UK-US bilateral pharmaceutical arrangement is an example of what an MFN-powered system-level negotiation can look like, and what it costs. Under the agreement, the UK secured zero tariffs on British pharmaceutical exports to the US for at least three years, and exemption from Section 301 investigations, making it the only country with such favourable access to the American market. In return, the UK committed to a meaningful reform of its domestic pricing environment, amounting to significant additional medicines spend.

01 NICE's cost-effectiveness threshold, unchanged for over two decades, has been raised from £20,000–£30,000 per QALY to £25,000–£35,000 per QALY. This increase in the effective price ceiling means a higher net price can be referenced by the US, mitigating MFN impact. The cost is estimated by the Institute for Fiscal Studies at £1.5bn over three years. Together with changes to the NICE valuation methodology, prices for new launches could increase by up to 25%.

02 NHS rebates on branded medicines have also been capped at a maximum of 15%, down from 22.9% in 2025, and locked in until the end of the current rebate scheme in 2028. This ensures that the UK Government cannot give with one hand and take with the other: spend-linked clawbacks cannot erode the price uplifts anticipated from the changes to NICE methods. Industry will continue to pay an additional 1% on top, to support the UK's Innovation Fund which provides additional capacity for clinical trials infrastructure, medicines manufacturing, and horizon scanning.

03 Perhaps most significantly, the UK committed to doubling its spending on new medicines as a proportion of GDP from 0.3% in 2026 to 0.6% by 2036, with intermediate milestones along the way. This has been broadly welcomed by industry but leaves open many critical unanswered questions. Early analysis suggests the NICE methods changes and the elimination of spend-linked clawbacks may get around half the way to the 0.6% GDP target: a further debate is brewing as to how the remainder is achieved through major improvements in the adoption and uptake of new medicines, or whether further action on prices is needed.

Europe's response to MFN is split three ways

The application of the UK playbook is most clearly visible in Germany, where the same combination of public industry withdrawal threats, direct US diplomatic pressure and confidential government-level negotiation is now in play.

AstraZeneca's Pascal Soriot floated removing eight markets, including Germany, from forecasts, and previously warned AstraZeneca may launch no new medicines in Germany in 2027. Novartis's Vas Narasimhan has also warned that over 40% of US-launched drugs could fail to reach Europe without faster action. Insmed has gone beyond rhetoric, pausing all European and UK launch activity for Brinsupri. On diplomacy, a US embassy official has been seconded to London to study how the UK deal was reached, and USTR Jamieson Greer has publicly urged Germany to "follow suit" with a

deal. Greer opened a Section 301 investigation into German drug pricing on 18 June 2026, framing the administration's objective as "appropriate burden sharing", and has said talks with Berlin are continuing but "challenging". This is the same instrument the UK was ultimately exempted from.

Germany's response so far has been resistance, tightening spend (increasing and fixing the manufacturer rebate from 7% to 15.5%, with exemptions for new active substances that run significant trial activity in Germany) while trying to encourage domestic trials and launches.

Italy has opened structured dialogue with Washington while pursuing its own reforms, including a Consolidated Law on Pharmaceuticals with faster access, holistic HTA, real-world evidence and a greater role for managed entry agreements. Health Minister Schillaci argues that this will let companies "maintain an adequate net price without incurring MFN penalties."

Spain has fast-tracked legislation to keep net prices confidential in procurement, reversing its earlier transparency push, aiming to prevent pharmaceutical companies from disclosing under MFN and thereby effectively removing Spain from the reference basket. However, faced with competing legal obligations from the US and Spain, it is likely companies will defer to the US. This approach also comes with the risk that the firms auditing MFN prices may refuse to sign off on an omitted Spanish price due to liability concerns.

France has seen few major changes to its drug pricing system, and signs of resistance have emerged. A proposed amendment to make drug net prices public was voted down, Macron publicly rejected Trump's claim that France agreed to raise medicine prices, and Paris has co-launched a Franco-German collaboration on EU pharma competitiveness and availability.

For now, there is no coordinated European position, which leaves the US free to pursue a country-by-country approach. Reporting points to a widening list of targets with France and Australia being named as likely next candidates for Section 301 investigations, with several other countries including Italy and Spain reported to be in scope.

So, the European response splits three ways:

Close cooperation with the US in exchange for preferential treatment

UK

Engagement plus a distinct national agenda

Italy

Resistance with domestic fixes

Germany, Spain, and France

However, early moves are being made toward a more aligned European positions This includes Spain's proposal of a European Coordinated Market Access Toolbox, "Europeanised" pricing and collaborative procurement in the prospective Critical Medicines Act and mandatory launch requirements in the EU Pharma Package. So far, this is tracking with the German and Spanish approach of resisting US pressure.

MFN impact is significant but variable between assets and companies

MFN exposure is not uniform across markets or assets. At the country level, the two main factors which determine this are inclusion within MFN reference baskets (GENEROUS, GLOBE/GUARD) and how far local net prices sit below US levels. Mechanisms that hold net prices down, such as HTA cost-effectiveness thresholds and confidential rebate schemes like the UK's VPAG, widen that gap and with it the exposure.

At the asset level, five key factors help determine MFN exposure: 1) to what extent an asset falls under GENEROUS, GLOBE, or GUARD, 2) specifics of net price calculation methods used, 3) launch sequencing, 4) US vs ex-US revenue split, and 5) variance between US and ex-US net prices. For some assets,

exposure may be low, while for others the calculus could lead manufacturers to delay ex-US launches or set prices that fall outside what countries would normally accept.

The landscape remains uncertain, with legal challenges to GLOBE & GUARD likely and the US pushing for UK-like deals across Europe. What is certain is that US price referencing is here, and here to stay in one form or another. More than ever, global teams need to consider how potential ex-US launches impact price and revenue across the Atlantic, informing any launch sequencing discussions.

The international impact of MFN is hard to quantify, but evidence of launch delays is building

There is growing evidence that MFN is contributing to launch hesitancy in Europe, though the picture is not yet clear cut. A March 2026 GlobalData analysis found a 35% decline in pharmaceutical launches across Europe in the ten months following the MFN executive order compared to the preceding ten months, rising to 43% in markets referenced under the GLOBE and GUARD models. Withdrawal rates for branded medicines increased also by 43% over the same period, with Amgen's withdrawal of Repatha from Denmark cited as an early concrete example of companies prioritising US pricing integrity over European market presence.

This data should nonetheless be interpreted with caution. The ten-month comparison window used by GlobalData is methodologically limited given launches observed in the period immediately after the MFN announcement will largely have been planned – and in many cases submitted for regulatory and HTA review – well before MFN was a policy reality, given that the time from submission to launch routinely exceeds ten months. The observed decline may therefore reflect pre-existing trends, macroeconomic pressures, or the cumulative effect of European cost-containment policies and the new EU pharmaceutical legislation, rather than just MFN specifically. A more instructive metric would be the number of new HTA submissions received before and after MFN compared to the equivalent prior-year period, and whether US launch rates have similarly declined. What the data does confirm is a structural disincentive to launch early in lower-priced European markets, and real-world examples of companies delaying or withdrawing are already emerging.

Separately, EFPIA has highlighted that the share of FDA-approved medicines also receiving EU marketing authorisation fell from around 80% for the 2021 cohort to approximately 40% for the 2025 cohort, with the decline accelerating sharply from October 2025 onwards. While this data has a stronger link to MFN related pressures, it does not prove causality.

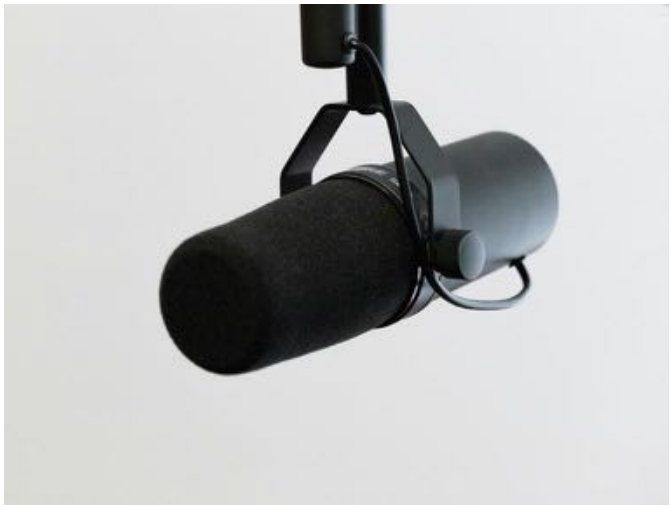
At a national level, a March 2026 survey by the industry association Lif in Sweden found that, if MFN is implemented without any policy response from the Swedish government, 86% of respondents considered delayed launches likely or very likely in the next 0-3 years, rising to 97% over 4–6 years. A majority also expected to reduce clinical trial activity, and around a third could withdraw products already on the market. In France, a similar survey found that 47% of industry respondents believed there would be a sharp decrease in new launches due to MFN, with a further 17% saying the decrease would be moderate.

In contrast to this, the recently leaked European Commission MFN report, which surveyed all member states bar Hungary, Poland, Slovakia and Slovenia, showed that 75% of responding states saw no launch delays. Half of the remainder saw delays no longer than pre-MFN norms and only 2 of 23 responding nations were aware of withdrawal threats. Half of responders did see requests for higher prices, though in many cases MFN was just one of many reasons for this. The Commission's conclusion is that it is impossible to isolate MFN effects at this stage and that any delays may reflect anticipation as opposed to MFN policy beginning to bite.

Taken together, a picture of launch hesitancy in MFN-referenced countries is developing, but definite conclusions are not yet visible.

Interviews with Pharmaceutical Leaders

While top line data and anecdote show launch hesitancy resulting from MFN, the decision-making underlying this is unclear. To uncover the core drivers of launch delays, and therefore better target remedies, Newmarket has undertaken a set of expert interviews with six senior pharma executives.



2x **Heads of Market Access**

2x **General Managers**

1x **Biotech CEO**

1x **EUCAN President**

Consequences and outlook

The dominant message was of the UK remaining highly exposed, and of MFN amplifying an existing problem rather than creating a new one: the relatively low valuation of innovative medicines at launch. As one leader put it, "MFN is just a mirror to a wider issue." The pressure has risen, but the underlying concerns with the UK ecosystem were already there.

The leaders saw several reasons the UK stands out among affected markets, primarily the perception that launch prices are among the lowest in Europe. That sits alongside their assessment of the UK having the rigid pricing methodology of low thresholds, difficult comparators, and a health-economic approach that can depress the assessed value of a large share of medicines. One leader argued MFN could be “a fatal blow to inflexible QALY-based methodology” if it is not reformed. A sharper relational point also came through: frustration that the UK has "had a free pass" on drug pricing for decades, did not listen to industry concerns, and now wants the industry's help to soften MFN. According to our interviewees, the erosion of goodwill leaves little appetite to do the UK any favours on launches or investment. As a counterweight, it should be noted that since the UK-US trade deal was announced, the UK has received major investment from companies such as AZ, BMS, and GSK.

The uncertainty is already changing launch decisions, as much as any realised impact. With the policy picture unclear, "a lot of the marginals are immediately noes and most of the yeses become marginal or unknown." Some companies are sorting pipelines into tiers, 1) assets written off entirely and removed from the forecast, 2) "pathfinder" assets kept alive on minimal regulatory and access spend in case a window opens, and 3) assets that remain straightforwardly viable because their US price is low or they are MFN-exempt. The cost shows up in attention as well as decisions – "we're spending so much of our time asking questions that we didn't have to ask before."

The counter to this overall view came from one respondent who was markedly more relaxed across the board, arguing much of the UK's difficulty predates MFN and traces to Brexit. We include that as a genuine rebuttal, though the majority felt it understates how quickly marginal launches are already being lost.

UK policy response

Reflecting on the impact of the UK-US deal, leaders were positive regarding its direction but did not regard it as sufficient. Movement on thresholds was recognised but seen as a starting point. Views on government intent were divided: some with good visibility of Whitehall saw the recent sprints moving "at pace and with intent," while others saw little beyond delay. Several also detected a possible shift from treating all innovation equally towards the government selectively approving only the innovation that fits within its healthcare and economic priorities – which would make the UK a narrower, more curated destination than it has been.

The expectation that UK net prices will end up feeding US calculations, with the added fear that mandatory disclosure could escalate beyond existing GENEROUS constructs creates significant pressure to raise UK prices. Leaders felt the current reforms were unlikely to offer a viable launch corridor in all cases, making further reform necessary. Further reforms highlighted by leaders as important for consideration included rebate elimination, a ring-fenced MFN fund for desirable medicines with access challenges, and formal recognition of investment such as by reflecting UK trial activity in more flexible NICE thresholds.

Despite the short-term impact of the UK-US deal being perceived as modest, leaders considered its true value lies in demonstrating to other ex-US markets that system-level reform is an achievable objective with the right combination of geopolitical pressure, industry action, and alignment of economic objectives with a broader set of Government stakeholders beyond healthcare.

Immediate mitigation options

Of possible mitigations available to them now, leaders saw the greatest potential in policies to enable the value of in-country investment (e.g. clinical trials, infrastructure, patient pathway transformation) to be recognised through the medicine pricing system. This is more than just a theory, with companies already actively exploring such deals, and in some cases starting to put them into practice.

A serious caution around execution ran through these conversations. One leader recounted a real example where a low UK price for an asset was offered in exchange for uptake support, only for delivery issues in a decentralised NHS to result in very low patient numbers. Their broader diagnosis was that the complex and devolved nature of NHS authority means a strong understanding of the UK system and delivery experience will be key in executing any investment-linked scheme.

Country Level Mitigations

Making significant step changes in the pricing environment requires national level policy changes, as indicated in our interviews. If industry can reshape ex-US markets, working with national governments and payers referenced by MFN to improve pricing and reimbursement conditions, then downward US price pressure coming from IRP can be limited. Those attempting to do this will find a natural ally and supporter in the US, for whom this is a stated policy objective. Only the UK has secured such a deal so far, and how it was won sets out what advocacy in other markets could require.

Further national level reform may require external pressure

The UK example demonstrates that national system reform is possible, but it required US involvement in domestic politics combined with noisy and politically-damaging industry withdrawals from the UK market.

The balance of power swung towards companies with a strong US identity and European influence, along with the major UK based players AstraZeneca and GlaxoSmithKline, and away from UK industry groups without White House links. This new power dynamic enabled the much more assertive stance seen from the key industry players. UK divestment decisions – by AstraZeneca, Merck, and Lilly – were publicised to achieve maximum political damage to a Government emphasising the need for economic growth and job creation. The subsequent public consideration given by AstraZeneca to delist from the London Stock Exchange further emphasised the economic threat posed by the gravitational pull of the US. This aligned pressure from the US administration and industry resulted in a powerful case for system change.

Expanding the UK deal model across Europe

The UK deal is an early example of the type of change possible, and the industry now has an opportunity to use this template in executing similar policy shifts across the markets referenced by MFN.

Using national pricing reviews, budget settlements and working groups can provide the moment to act. In Japan this could be the Honebuto (annual financial policy roadmap) which pointed toward greater recognition of innovative medicine value or their Growth Strategy which states that the market for patent-protected drugs should grow in line with global growth (9.6% per year). In Denmark the recently established MFN task force could be leveraged, and in Sweden this opportunity could come from the expanded mandate of the national payer to assess if the willingness to pay threshold should change. In the UK, the existing deal can be taken further, with the space to advocate for this coming from the predicted shortfall between current new medicines spend predictions and the new 0.6% of GDP target. The natural vehicle to advocate for these additional changes will be the 2027 Spending Review and the negotiations on a new voluntary scheme scheduled to start in June 2027.

When pushing for policy change, the two measures which may have the greatest alignment with government objectives across Europe are:

Explicit recognition of the wider economic benefit of medicines in net pricing decisions: Governments across Europe face the same economic and fiscal imperatives of cutting social security payments and raising workforce productivity as populations age and health-related inactivity rises. Medicines that keep people in work deliver against that, but the benefit sits outside the health budget and rarely influences the net price paid. Reflecting this benefit within the price of a medicine aligns the incentives of a company with those of governments. The UK has taken the first step, with labour market productivity planned to be reflected in the NICE appraisal process by the end of 2027, giving a precedent to press for elsewhere in Europe.

Recognition of company inward investment in pricing and clawback rates: Formalising reward for R&D and manufacturing investment in the prices and clawback rates a company faces could act as a strong MFN mitigation as well as supporting growth and jobs objectives. Germany is a leading example here, where strict pricing guardrails are waived if at least 5% of clinical trial participants are enrolled in Germany. This principle could be extended to further markets and applied in greater depth. The UK shows both the appetite and the difficulty of this type of policy, with the Government proposal of linking clawback rates to increased clinical trial activity ultimately failing.

Both measures could strengthen the existing UK deal and shape future deals across European markets, though each will require sustained advocacy to realise.

Asset Level Commercial Strategies

While the UK deal offers an encouraging precedent from an industry perspective replication has not yet been seen in other countries. Even if it was, policy and system change may be insufficient on its own to generate enough confidence for ex-US launch decisions. There are three reasons for this:

First, the UK deal required significant leverage from both industry and the US government: such an empowered and aligned coalition will not exist in every reference market. The countries in MFN reference baskets all operate under different political constraints, different fiscal pressures, and different relationships with the US. Achieving system change elsewhere may be harder, slower, and in some cases not possible.

Second, any system change may take time to flow through into a price effect. Short term fiscal challenges mean that any pricing reforms may be a longer-term commitment. But with MFN already in motion, companies must grapple immediately with ex-US launch decisions.

Third, system reform improves the overall medicines pricing environment, but it does not guarantee success for each asset. Different assets will be exposed to different levels of risk dependent on their funding channel within the US market, as well as the specific price points that can be achieved in MFN comparator countries.

For these reasons, innovative commercial strategies to achieve an optimal net price have never been more critical – and achieving them will demand a higher appetite for risk from all parties.

Key commercial strategies

Innovative commercial models can offer the opportunity to secure a higher net purchase price for a particular asset than would otherwise be possible through a simple discount on invoice. Unlike policy changes, they can be leveraged now. The UK has a track record of implementing such agreements where there is a strong value proposition for the health system and patients, offering an analogue that can be considered across ex-US launch markets. As company MFN responses have developed, and details around implementation have become clearer, three innovative commercial options stand out:

Drug, service, and pathway investment: companies are increasingly working in partnership with the NHS to provide financial support for pathway transformation: supporting new models of patient identification which enable rapid adoption of newly-approved medicines. This additional value has the potential to be recognised by health systems as part of the net price of the associated medicine. Any investment would need to be product-agnostic and clinically appropriate, but system investment offers the potential for companies to offer value to health systems beyond simply the price of the asset. This is an immediate option, unlike the previously mentioned systemic linking of rebate rates and QALY thresholds to inward investment, which would need time to be implemented.

Differential pricing: schemes such as volume tiering and outcome-based agreements can offer the potential for higher net prices immediately after launch, albeit which may subsequently decline over time. Volume tiering acts primarily as a delay, with higher initial prices eventually eroded over a 5-10 year time horizon following adoption at scale: such a model would take any future price reductions beyond the window of the current MFN agreements. Outcome-based agreements, based on rebates if clinical performance does not meet initial company expectations, would allow companies to accrue for a net price based on their forecast clinical performance and rebates only due in later years if those outcomes are not achieved. Both models have precedent in the UK to resolve affordability concerns or clinical uncertainty: both therefore offer an opportunity to secure net pricing improvements.

Multi-drug packages: a further strategy – again, with precedent in the UK – can be the use of multi-asset commercial approaches such as therapy area subscription models and multi-asset budget caps. Such models may support a more flexible attribution of value between assets within the group, enabling some company discretion to be applied to the apportionment of portfolio-level rebates. These models bring significant complexities for healthcare systems, particularly around the potential for market distortion across competitor products but could be considered by both companies and health systems in high-priority clinical areas.

Case Study: Izervay in Japan

This is the clearest and perhaps first example of MFN being used as positive pricing leverage at an asset level, rather than a reason to delay or withdraw. Astellas explicitly argued in its submission to Japanese pricing authorities that the domestic reimbursement price of Izervay could influence US pricing under MFN. CEO Naoki Okamura confirmed the company had "leveraged this most favored nation dialogue" and that the outcome was more generous than typical Japanese outcomes. Astellas secured a Japanese reimbursement price of ~$891 per vial against a US wholesale acquisition cost of $2,100. Okamura acknowledged he could not confirm that Japanese authorities explicitly considered the MFN argument behind closed doors, however subsequent developments, in particular the Japan Growth Strategy, point towards a more active management of MFN by Tokyo.

MFN Strategy

None of these options are straightforward and, by necessity, they represent the art of the possible, not business as usual. Inertia in the face of MFN uncertainty may be the overriding instinct for many, but positive decisions remain possible. The two levels outlined reinforce each other; asset-level strategies deliver incremental improvement now, within a company's control, while national advocacy pursues the step-change that asset-level tactics alone cannot reach. Neither is sufficient by itself, and both are needed.

Each asset should be assessed for MFN exposure in the knowledge that impact will vary enormously, asset by asset, and health system commercial flexibilities used judiciously. Each requires early planning and a willingness to engage payers in conversations that go well beyond standard price negotiations. However, companies with transformative assets are likely to find there is a greater risk appetite from health systems to develop creative solutions. The prize for companies who begin that work now is the possibility to get ahead of MFN headwinds, avoid launch delays, reach patients faster and protect both US and ex-US revenues.

The strategic implications, however, are not uniform. Large companies with broad portfolios and genuine negotiating leverage face a different calculus to mid-size biotechs. Smaller firms often lack the market power to extract higher prices from foreign governments yet cannot afford those lower international prices being imported back into the US. Companies in this position face a difficult choice: seek much higher international prices, which payers abroad will almost certainly refuse; risk importing lower prices to the US; or withdraw from those ex-US markets entirely, potentially ceding space to competitors. A strategic response which matches the scale and complexity of this challenge is required.

MFN is not a temporary disruption to be managed and forgotten. Whatever form it ends up taking, it reflects a durable shift in how the world's largest drug market thinks about pricing, and increasingly how it expects trading partners to think about it too. The response has to match that, with incremental gains secured now at the asset level, and a coordinated industry push for the national reform that will move the environment permanently.

Appendix: MFN Response by Country

With the UK as the first mover, the remaining 18 GENEROUS, GLOBE and GUARD countries have begun responding with:

1 implementing substantial mitigations

3 enacting partial mitigations

7 launching reviews of MFN impact

Country	Status	Detail
Spain	**Substantial**	Fast-tracked a ban on disclosing net prices in public procurement, driven by MFN concerns that transparency weakens its position; officials calling for EU-level coordination; a Permanent Strategic Dialogue signed with China naming pharma as a key sector.
Denmark	**Partial**	Cross-ministry MFN task force on supply, access, trials and responses; payer has settled a compensation claim against Amgen over the Repatha withdrawal (breach of supply obligations to at least July 2027; ~4,000 patients switched to Praluent; penalties estimated €10.8–18.3mn).
South Korea	**Partial**	Nov 2025 pricing improvement plan: faster reimbursement, expanded dual pricing to protect confidential net prices, higher ICER thresholds for severe/rare disease. MFN not named, but identified as the rationale in external legal analysis.
Sweden	**Partial**	TLV commissioned to monitor MFN; withdrew proposed systematic price cuts citing MFN uncertainty; a wider pricing/reimbursement overhaul under review, with the minister citing MFN; TLV's mandate expanded to assess whether the willingness-to-pay threshold should change.
Switzerland	**Active review**	Life Sciences Location working group (FOPH, Jan 2026) reporting by end-2026; favoured option is a dedicated fund for new launches financed by cantonal taxes, allowing higher prices for future launches while leaving existing prices unchanged.

Country	Status	Detail
Japan	**Active review**	This year's Honebuto points toward greater recognition of innovative-medicine value; task force on US trade talks; Japan Growth Strategy states that market for patent-protected drugs should grow in line with global growth.
Canada	**Active review**	Pharmaceutical and Life Sciences Sector Task Force (Mar 2026) on domestic manufacturing and faster reimbursement; industry has linked this explicitly to MFN.
France	**Active review**	Macron publicly rejected Trump's claim that France agreed to raise prices; co-launched a Franco-German collaboration on EU pharma competitiveness and availability.
Germany	**Active review**	Major cost-containment changes not framed as MFN, but a Jan 2026 Pharma and MedTech Dialogue has discussed surging interest in confidential pricing; Franco-German collaboration co-launched; Merz resisting US price pressure while acknowledging private talks.
Norway	**Active review**	Rapid threshold review (Feb 2026) recommended no interim change; Health Minister acknowledged (Apr 2026) MFN's potential effect on access, production and R&D; cross-ministry group established.
Italy	**Active review**	Ministry in direct dialogue with USTR; panel assessing MFN implications; Consolidated Law on Pharmaceuticals under discussion (holistic HTA, expanded RWE, wider managed entry agreements).
Australia	**No response**	Minister repeatedly stating PBS fundamentals are not up for negotiation; acknowledges Australian prices may feature in future MFN calculations; concern about a chilling effect on launches.
Austria, Belgium, Czech Republic, Ireland, Israel, Netherlands	**No response**	No MFN-specific government response identified.
EU (bloc-level)	**Partial**	Critical Medicines Act (supply chain, manufacturing, collaborative procurement); US–EU framework capping pharma tariffs at 15%; 11 health ministers convened. Early proposals to "Europeanise" pricing surfacing, though pooled purchasing has historically lowered prices, not raised them.

Launched in 2021, Newmarket Strategy is a first in class consultancy for the health and life sciences industry. Our unique application of policy, commercial and technical experience ensures our clients earn better commercial returns and patients get earlier access to innovative treatments.

Meanwhile, our exposure across pharmaceuticals, diagnostics, med tech, service provision and health data means we understand the opportunities and complexities in healthcare more deeply. We are proud to work with the world's largest and most innovative life sciences companies, many of whom we have supported for several years with our various capabilities.

At the interface of healthcare systems and industry partners, our insights help unlock "win:win" agreements which benefit patients and shareholders. We have supported more than 150 clients – creating successful commercial strategies, influencing system policies and securing reimbursement for more than 600 individual assets.

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