

GLOBAL ACCESS, FOUR STRATEGIC LOGICS

Different Markets. Different Mechanisms. Different Playbooks.



EXECUTIVE SUMMARY: There is no single “global access model.” The U.S. offers the most commercial flexibility at launch but is the most fragmented and least transparent on net price. Japan is centrally administered and broad in coverage but governed by national price controls and repricing. Europe consists of different archetypes—cost-effectiveness (UK), clinical-comparison (Germany/France), and budget-impact (Italy/Spain). China is now faster on regulation and more institutionalized on reimbursement, but success depends on sequencing approval, reimbursement, and dual-channel execution.

	U.S.	Japan	EU4+UK (Three Archetypes)	China			
MARKET ACCESS MODEL	<p>Most commercially flexible, most fragmented</p> <p>Decentralized, multi-payer system with PBMs, insurers, Medicare, Medicaid, and multiple channels.</p>	<p>Centrally administered, broad in coverage</p> <p>MHLW-led system with national pricing and broad reimbursement once listed.</p>	<p>Not one market—three logics</p> <p>UK (cost-effectiveness), Germany & France (clinical-comparison), Italy & Spain (budget-impact).</p>	<p>Regulation fast. Reimbursement institutionalized. Execution decisive.</p> <p>NMPA approval, NHTA negotiation, procurement, and dual-channel execution.</p>			
CONVERSION MECHANISM: FROM APPROVAL TO PATIENT ACCESS	<p>Approval → Rapid commercialization → Access filtered by PBMs, insurers, utilization management, Medicare rules, and Medicaid rebates.</p>	<p>Approval (PMDA) → NHI listing & price → Broad reimbursement fast for most approved products.</p>	<table border="1"> <tr> <td> <p>UK (NICE)</p> <p>Cost-effectiveness assessment → Value for money at NHS net price threshold.</p> </td> <td> <p>DE/FR</p> <p>Clinical benefit or added clinical value → Price negotiation.</p> </td> <td> <p>IT/ES</p> <p>Budget impact & affordability drive access conditions.</p> </td> </tr> </table>	<p>UK (NICE)</p> <p>Cost-effectiveness assessment → Value for money at NHS net price threshold.</p>	<p>DE/FR</p> <p>Clinical benefit or added clinical value → Price negotiation.</p>	<p>IT/ES</p> <p>Budget impact & affordability drive access conditions.</p>	<p>Approval (NMPA) → NHTA reimbursement negotiation → Annual national catalog → Procurement/implementation → Dual-channel & hospital access.</p>
<p>UK (NICE)</p> <p>Cost-effectiveness assessment → Value for money at NHS net price threshold.</p>	<p>DE/FR</p> <p>Clinical benefit or added clinical value → Price negotiation.</p>	<p>IT/ES</p> <p>Budget impact & affordability drive access conditions.</p>					
PRICING & ACCESS DRIVERS	<ul style="list-style-type: none"> List price freedom at launch Rebates & confidential discounts Utilization management (PA, step therapy) Medicare Part D redesign & negotiation risk Medicaid rebates & 340B implications 	<ul style="list-style-type: none"> National price listing Regular repricing (market-size driven) Cost-effectiveness less formalized Strong price governance 	<ul style="list-style-type: none"> Confidential discounts essential (UK) Comparator-based benefit assessment (DE) ASMR & CEESP clinical value (FR) Budget impact & affordability caps (IT/ES) 	<ul style="list-style-type: none"> Value-based negotiation (NHTA) Annual reimbursement cycles Centralized & alliance procurement Price compression & volume-based deals Dual-channel (hospital + retail/OTC) 			
SPEED TO BROAD ACCESS (TYPICAL)	<p>Fast to launch, variable to broad access & optimal net price</p>	<p>Relatively fast to broad reimbursement once listed</p>	<p>Market-dependent: Medium to fast in UK/DE, slower in FR/IT/ES</p>	<p>Much faster on regulation; speed to access depends on reimbursement cycle</p>			
KEY RISKS / CHALLENGES	<ul style="list-style-type: none"> PBM leverage and rebate erosion Utilization management friction Medicare negotiation & redesign Low transparency on net price Patient affordability & adherence 	<ul style="list-style-type: none"> National price governance Frequent repricing pressure Limited premium pricing upside Evidence expectations rising 	<ul style="list-style-type: none"> Heterogeneous HTA & pricing timelines Opaque discounts & complex agreements Budget constraints & clawbacks (IT/ES) Evidence bar rising across markets 	<ul style="list-style-type: none"> Price compression & procurement risk Annual listing uncertainty Dual-channel execution complexity Margin pressure & price corridor 			

LAUNCH PLAYBOOK: ARCHITECTURE-FIRST, NOT LABEL-FIRST

<p>Evidence Architecture First</p> <p>Design studies to answer the right value questions for each market's assessment logic.</p>	<p>Prioritize Early Wins</p> <p>Exploit UK & Germany early with strong comparative evidence or clear clinical differentiation.</p>	<p>Sequence Intelligently</p> <p>Move into France with ASMR & CEESP strategy; then Italy, Spain and China.</p>	<p>Align Access & Pricing With Realities</p> <p>Match pricing expectations and access mechanisms in each market.</p>	<p>Build Execution Muscle</p> <p>Invest in HEOR, market access, pricing, policy, and channel capabilities.</p>
---	---	---	---	---

THE STRATEGIC QUESTION IN EACH MARKET

<p> U.S.</p> <p>Can our overall dossier survive PBM leverage, utilization management, Medicare redesign, and future Medicare negotiation exposure?</p>	<p> Japan</p> <p>How do we prepare for national price governance and repricing while maximizing early broad access?</p>	<p> EU4+UK</p> <p>How do we meet different value expectations (cost-effectiveness vs. clinical benefit vs. budget impact) across countries?</p>	<p> China</p> <p>Can we win reimbursement and access supply, hospital, and dual-channel access without losing the price corridor?</p>	<p> Common to All</p> <p>How do we deliver real patient access, affordability, and adherence in each unique system?</p>
---	--	--	--	--



KEY TAKEAWAY: The world's access systems are converging on value—but through different mechanisms. Success comes from matching your evidence, pricing, policy, and execution architecture to each market's logic, not from assuming a single global blueprint.



GLOBAL MARKET ACCESS: COMPARATIVE FRAMEWORK

Different Reimbursement Logics. Different Evidence Rules. Different Launch Playbooks.



COMPARATIVE FRAMEWORK: REIMBURSEMENT LOGIC ARCHETYPES

Markets convert regulatory approval into patient access through different primary logics. These archetypes predict which evidence, contracting approach, and launch timing are most likely to succeed.



COST-EFFECTIVENESS DRIVEN

Formal economic value thresholds are central to routine recommendation and net-price resolution.



CLINICAL-COMPARISON DRIVEN

The decisive question is whether the drug offers incremental patient-relevant benefit vs. an accepted comparator; price negotiated downstream.



BUDGET-IMPACT DRIVEN

Affordability, expenditure ceilings, procurement, and financial sustainability are explicit primary determinants of access.

EU4 AND UK ARCHETYPES

MARKET	PRIMARY ARCHETYPE	SECONDARY ARCHETYPE	WHY IT FITS
France	Clinical-comparison driven	Budget-impact driven	HAS CT centers on SMR/ASMR; CEESP economics become important for higher claimed value and higher-spend products; CEPS then sets price.
Germany	Clinical-comparison driven	—	G-BA/IQWiG added-benefit assessment versus the appropriate comparator is the core reimbursement determinant; routine QALY thresholding is not the central gate.
Italy	Budget-impact driven	Clinical-evidence hybrid	AIFA negotiates price under expenditure governance and payback logic, with monitoring registries and MEAs used to manage uncertainty and spend.
Spain	Budget-impact driven	Clinical/economic positioning hybrid	Law 1/2015 criteria explicitly include cost-effectiveness, budget impact, lower-cost alternatives, and innovation; IPT plus national funding decisions then meet regional execution realities.
UK	Cost-effectiveness driven	Budget-impact constrained	NICE's cost-per-QALY framework is central, while PAS/CAA and the budget impact test shape transactability and timing.



The comparison below is an analytical synthesis of official frameworks across markets. It is not an official scorecard. It helps launch teams anticipate where pricing freedom, net-price opacity, evidence risk, and patient-affordability pressure are likely to be highest. The synthesis is grounded in U.S. PBM and public-program rules, Japan's national listing logic and PMDA evidence guidance, EU4+UK HTA and negotiation frameworks, and China's NHSA/NMPA rules.



High / Strong



Low / Weak



Not applicable / Not primary



Medium / Moderate

CROSS-MARKET STRATEGIC COMPARISON

MARKET	GROSS-TO-NET SPREAD Typical magnitude of rebates/discounts	NET-PRICE TRANSPARENCY Visibility into realized net prices	PUBLIC NEGOTIATION POWER Strength of central payer or public negotiation	SPEED OF BROAD PATIENT ACCESS Time from approval to broad reimbursement and availability	PATIENT AFFORDABILITY AT POINT OF USE Out-of-pocket burden and financial protection	EVIDENCE BURDEN FOR REIMBURSEMENT Overall rigor and scope of evidence requirements
U.S.	Very high	Low	Rising but still fragmented	Fast at launch, uneven in coverage	Weakest of the comparison set	High, but split across payer, channel, and value-assessment needs
Japan	Low to medium	High to medium	Very high	Fast once nationally listed	Strong	Moderate to high, with increasing RWD readiness
France	Medium	Medium	High	Moderate; faster for early access	Strong	High, comparative clinical burden; economics for selected cases
Germany	Low to medium historically; rising opacity for eligible products from 2025	Historically high, now mixed	High	Fast initial launch; net price disciplined quickly	Strong	Very high comparator and patient-relevant outcome burden
Italy	Medium to high	Low to medium	High	Moderate to slow	Strong to moderate	High, with operational RWE/registry demands
Spain	Medium	Medium	High	Moderate to slow	Strong to moderate	High, especially on budget and positioning rationale
UK	Medium	Low on net price	Very high	Fast when NICE timing and deal align	Strong	Very high on cost-effectiveness and transactability
China	Medium to high after reimbursement/procurement	Mixed	Very high	Fast on regulation; reimbursement depends on cycle and execution	Moderate and locally variable	High, increasingly including RWE/RWD and pharmacoeconomics



KEY TAKEAWAY:

Access success depends on matching your asset, evidence, contracting, and launch sequence to each market's reimbursement logic, not on assuming one global blueprint.



Different markets. Different mechanisms. Different playbooks. One goal: patient access.

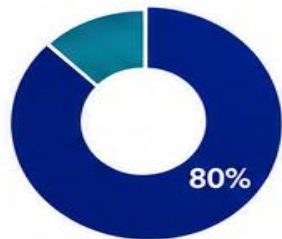


Fast to Launch. Complex to Access. Opaque on Net Price. Exposed to Policy Change.



The U.S. offers the **fastest nominal launch** among major markets but **real patient access is mediated** by PBMs, insurers, Medicare rules, and Medicaid rebates. Pricing is a **layered architecture**: commercial rebating, statutory obligations, ASP reporting, and now direct Medicare negotiation for selected high-spend drugs. Success requires navigating **conflicting incentives** across payer segments and anticipating future policy and negotiation risk.

1. THE U.S. MARKET STRUCTURE: DECENTRALIZED & CONCENTRATED



Top 3 PBMs processed
~80%
of ~6.6B prescriptions
dispensed by U.S.
pharmacies in 2023

■ Top 6 PBMs processed >90%



PBMs sit at the center of formulary access, rebate extraction, and channel economics for commercial and Part D markets.

2. PRICING AS A LAYERED ARCHITECTURE



Commercial & Medicare Part D
Formulary placement, rebates, fees, and utilization management



Medicaid (MDRP)
Statutory rebates: greater of 23.1% of AMP or AMP – Best Price plus inflation rebate



Medicare Part B (ASP)
Payment anchored to Average Sales Price (ASP) reporting & payment files



Medicare Negotiation (IRA)
Direct negotiation for selected high-expenditure, single-source drugs (2027 prices published; 2028 includes first Part B drugs)



Realized Net Price

Varies by payer, channel, benefit design, and statutory requirements

3. ACCESS REALITY: FAST LAUNCH, VARIABLE REAL-WORLD ACCESS



Fast to launch
Often the earliest among major markets



Coverage is mediated
Plan formularies, prior authorization, step therapy, and other UM rules



Access rules under scrutiny
CMS increasing oversight of prior authorization and timely access in Medicare Advantage & Part D



“Covered,” affordable, and easy to prescribe”
may lag approval by months and vary widely by payer segment

4. KEY POLICY & REGULATORY DRIVERS



FTC FINDINGS

High PBM concentration drives leverage in rebates, formularies, and network design



MEDICAID REBATES

MDRP creates significant price exposure via AMP, Best Price, and inflation rebates



ASP REPORTING (PART B)

ASP affects payment levels and can influence commercial net price



IRA MEDICARE NEGOTIATION

Direct negotiation expands annually; new cycle adds Part B products



ACCESS OVERSIGHT

CMS rulemaking targets prior authorization timelines and transparency

5. STRATEGIC CONSEQUENCES FOR MARKET ACCESS



U.S. success is not a single-HTA hurdle—it's managing conflicting incentives across PBMs, insurers, Medicare, Medicaid, providers, and patients.



High WAC can be rational—but only if the full downstream logic holds: rebates, Medicaid exposure, ASP impact, affordability, and future Medicare negotiation.



Demands the most channel-specific HEOR strategy vs. Europe and Japan.



Still more permissive at launch than China, but more opaque on realized net price and more vulnerable to access friction from benefit design.



KEY TAKEAWAY:

The U.S. offers commercial flexibility and early launch, but real patient access depends on navigating a complex, layered system of rebates, rules, and reforms—today and in the future.



Most commercial flexibility at launch



Most fragmented & complex to access



Least transparent on net price



Most exposed to policy and channel conflict



Fast to List. Broadly Reimbursed. Public Price Governance.



Japan's system is **highly centralized**. Once approved, drugs are listed in the National Health Insurance (NHI) Drug Price Standard—which is both the national reimbursement price table and the list of drugs usable in insurance-covered care.

This delivers **broad and coherent patient access**, **strong affordability protection**, and **predictable pricing** governed by public policy.

1. HOW REIMBURSEMENT WORKS



PMDA Approval
Regulatory approval for marketing in Japan



NHI Drug Price Standard Listing
Added to the national price table and reimbursement list



Broad Reimbursement
Usable in insurance-covered care nationwide

**One system.
One list.
One national reimbursement price.**

Driving speed, coherence, and predictability.

2. PATIENT ACCESS & AFFORDABILITY



Standard Co-payment
Typically 10–30% depending on age and income.



High-Cost Medical Expense Benefit
Caps out-of-pocket burden above income-based thresholds.



Result: Strong affordability protection and limited financial toxicity for patients.

3. PRICING LOGIC: NOT REBATES, BUT PUBLIC PRICE GOVERNANCE



- Prices are centrally set for reimbursement under the NHI Drug Price Standard.
- Regular price revisions (typically every 2 years) and interim revisions.
- Manufacturer freedom is bounded by national price setting and fiscal sustainability of the NHI system.



Not a confidential rebate market.
A centrally governed reimbursement-price system with predictable repricing risk.

4. EVIDENCE & REGULATORY EVOLUTION



RWD/RWE Workstreams
PMDA has established formal workstreams for real-world data.



Guidance on RWE Use
PMDA has issued guidance on the use of registry data and real-world evidence for development, review, and certain post-approval changes.



Global Development Support
PMDA supports global clinical development including Japan, with appropriate ethnic-factor considerations.

Japan is increasingly aligned with global evidence standards—but still requires deliberate local planning.

5. STRATEGIC ATTRACTIVENESS



Strongly Attractive For:

- ✓ Products needing fast, nationally coherent reimbursed access
- ✓ Companies that can operate within public price governance and accept future repricing
- ✓ Therapies addressing high unmet need with broad clinical value



Less Attractive For:

- ✗ Strategies relying on sustained premium pricing
- ✗ Unbounded price-maximization goals

6. IMPLICATIONS FOR HEOR & MARKET ACCESS



Plan for Japan early in global development and evidence strategy.



Design studies with Japan's needs and PMDA guidance in mind.



Model Japan as a central-price market with predictable repricing and strong access once listed.



Right Posture:
Treat Japan as a central-price market with growing receptivity to better evidence packages—not a “mini-Europe” and not a U.S.-style rebate market.



KEY TAKEAWAY

Japan offers one of the world's most coherent and predictable access systems. Success comes from aligning global evidence with Japan's needs, navigating public price governance, and planning for future repricing.



Fast once listed



Broadly reimbursed



Strong affordability protection



Predictable pricing under public control



A Hybrid System: Clinical Evaluation Leads. Economics Informs. Price Follows.



France blends **clinical assessment**, **economic evaluation**, and **price negotiation**. **HAS** assesses clinical benefit and added value (SMR/ASMR). **CEESP** provides economic opinions for higher-value and higher-budget products. **CEPS** sets reimbursable prices, preferably through conventions. **Early access can be fast for truly innovative products**—routine reimbursement and pricing remain sequential and deliberate.

1. THE FRENCH ACCESS & PRICING PATHWAY



HAS

Transparency Committee

Scientific & medical assessment

- Clinical benefit (SMR)
- Clinical added value (ASMR)
- Reimbursement rate linked to level of benefit

Clinical assessment comes first



CEESP

Economic Evaluation

Provides economic opinions to support price negotiation

- Economics matter more for high ASMR
- Major spending implications

Activated when value and budget are high



CEPS

Price Setting

Interministerial body that sets reimbursable prices

- Preferably via conventions with companies

Price follows value and negotiation



Reimbursement rates are tied to the assessed level of benefit, with a differentiated structure for high-need vs. lower-value products.

2. EARLY ACCESS: FASTER FOR INNOVATION



2021 reform strengthened early access
HAS now makes early-access authorization decisions under short, regulated timelines.

~60 DAYS

Average decision time after implementation

Faster timelines for COVID-19 products.



Very rapid patient access possible for products with genuine innovation and unmet need.



Early access ≠ automatic pricing

Early access can be granted quickly, but routine reimbursement and price setting remain sequential and more deliberate.

3. WHAT FRANCE REWARDS (AND WHAT IT DOESN'T)



France rewards:

- ✓ Strong clinical-comparison narratives vs. appropriate comparator
- ✓ Demonstrated patient-relevant benefit and added clinical value (ASMR)
- ✓ Credible budget & economic story for high-value, high-budget products
- ✓ Post-launch evidence plans when uncertainty remains



France does not reward:

- ✗ A pure pharmacoeconomic story without strong clinical basis
- ✗ Products built mainly on immature or surrogate evidence
- ✗ Attempts to bypass clinical assessment with economics alone



Bottom line:

Maximize the plausibility of a favorable ASMR first. Then ensure the economic and budget case is credible enough for CEESP and CEPS.

4. EVIDENCE EXPECTATIONS



Clinical evidence is the foundation

HAS assessment is based on available clinical evidence at the time of evaluation.



Real-life studies are important

HAS acknowledges the role of real-world data to confirm effectiveness in actual practice.



Post-registration studies may be requested

HAS can require studies to reduce uncertainty and confirm long-term outcomes.

Focus for launch teams:

- ✓ Head-to-head comparisons
- ✓ Patient-relevant outcomes
- ✓ Unmet need and severity
- ✓ Post-launch evidence planning

5. STRATEGIC IMPLICATIONS



France is not a cost-effectiveness-first market like the UK. It is clinical-benefit-first, then economic.



High ASMR + high budget impact = economics and negotiation become decisive.



Early access is a real accelerator for innovation and unmet need.



France is attractive for innovative products, but requires a sequential, value-first strategy.

6. KEY TAKEAWAY



France offers a balanced path: strong clinical assessment, faster early access for innovation, and negotiated pricing aligned with value and spending impact.

Clinical first. Economics when it matters. Price through negotiation.



France can be one of the fastest routes to patient access in Europe for truly innovative products.



Success comes from a strong clinical story, a credible budget & economic case, and a proactive post-launch evidence plan.



Understand the order of operations:
HAS (clinical) → **CEESP** (economics) → **CEPS** (price).



Design your launch around ASMR, not just ICER—then prove it's worth the price.



AMNOG System: Added Benefit → Negotiated Price → National Reimbursement



Germany's AMNOG system is built on one core question: **Does the new medicine show added benefit vs. the appropriate comparator?**

The G-BA's finding on **added benefit** is the basis for negotiating the **national reimbursement** amount with GKV-Spitzenverband.

Launch can happen before price is set. The final price applies from **month 7** after launch nationwide.

1. THE AMNOG PROCESS: STEP-BY-STEP



Key principle: Benefit assessment is comparative and patient-relevant, not a cost-per-QALY exercise. The comparator choice is decisive.

2. REFERENCE PRICING (FESTBETRAGSSYSTEM)

Germany groups therapeutically similar medicines and sets a reference price.

- Reference groups defined by the G-BA
- Updated regularly
- Drives pricing and reimbursement within the group



3. MAJOR POLICY SHIFT: CONFIDENTIAL REIMBURSEMENT ROUTE

Following the 2024 Medical Research Act, products first entering AMNOG negotiations from 2025 may under certain conditions:



- ✓ Avoid publication of the reimbursement amount in public price and product directories
- ✓ Available to manufacturers with qualifying R&D presence in Germany
- ✓ Creates a confidential net-price pathway for eligible products



Strategic impact: Germany is no longer always a transparent international reference price anchor for every innovative medicine. Confidentiality can protect true net price.

4. WHAT MAKES GERMANY UNIQUE?

- Launch before price**
Early patient access while benefit assessment and price negotiation are ongoing.
- Comparator is everything**
Wrong comparator can damage both reimbursement credibility and price.
- Patient-relevant added benefit**
Focus on outcomes that matter to patients and clinical practice.
- One price, many payers**
The national reimbursement amount applies to SHI, private insurance, and self-pay patients.

5. IMPLICATIONS FOR LAUNCH TEAMS

- ✓ One of the best first-wave EU markets for clinically differentiated products.
- ✓ Strong evidence vs. the right comparator is non-negotiable.
- ✓ Patient-relevant endpoints and robust methodology are critical for added benefit.
- ✓ Prepare early for dossier quality, comparator rationale, and negotiation readiness.

6. KEY TAKEAWAY



Germany rewards clinical differentiation, not just innovation.

Prove added benefit vs. the right comparator, and the system will deliver access—and a negotiated price.



BOTTOM LINE

Germany's AMNOG system is comparator-driven, time-structured, and increasingly nuanced on price transparency. Evidence wins access. Comparator strategy wins price.



6+6 Months Process



Comparative & Patient-Relevant



Negotiated National Price



Confidential Option for Eligible Products



One Price for All Payer Segments



Budget-Impact Driven Market with Strong Use of Managed Entry Agreements



Italy's system is built on **budget sustainability** and operational control. AIFA negotiates prices, manages the National Pharmaceutical Formulary, and uses **monitoring registers** and **Managed Entry Agreements (MEAs)** to link access to real-world use, outcomes, and financial performance. National approval is necessary—but **regional execution** and spending limits determine real-world access.

1. HOW IT WORKS: BUDGET CONTROL + CONDITIONAL TOOLS



MEAs are embedded in negotiation practice, not peripheral. They are a core tool for managing uncertainty and spend.

2. BUDGET IMPACT & GOVERNANCE REALITY

Expenditure Ceilings
When spending ceilings are exceeded, payback procedures are triggered.

Regional Responsibility
Regions manage healthcare delivery and spending. Local uptake can vary.

National AIFA decision is necessary, but not always sufficient for uniform local uptake.

Budget sustainability and fiscal governance are structural drivers of access conditions.

3. PROCESS EVOLUTION: SIMPLIFY & ACCELERATE WHERE POSSIBLE

AIFA has introduced:

- ✓ Updated pricing & reimbursement guidance
- ✓ New dossier processes
- ✓ Simplified & fast-track procedures for selected cases

Applies especially to:



Generics



Biosimilars



Shortage-related medicines



Administratively straightforward cases



Innovation still faces full negotiation and budget scrutiny. Delay is reduced in some cases, not eliminated.

4. STRATEGIC IMPLICATIONS FOR LAUNCH TEAMS

- Italy rewards flexible contracting.
- If uncertainty is clinically or financially resolvable, registries & MEAs create an access bridge.
- If uncertainty is fundamental, the same tools can become a burden with limited upside.

Design the right plan:

- Which patients?
- How monitored?
- What financial exposure?
- What adjustment mechanism if use or outcomes differ from expectations?

5. WHAT IT TAKES TO SUCCEED IN ITALY

- Credible value claim:** Clear clinical benefit and patient-relevant outcomes.
- Pragmatic governance plan:** Registries, controls, and monitoring are expected—not exceptional.
- Financial alignment:** Accept payback risk and performance-linked arrangements where needed.
- Regional readiness:** Understand local dynamics and engage early.
- Real-world execution:** Deliver on data reporting and adherence to agreement terms.

6. KEY TAKEAWAY



Italy ties access to affordability and performance.

Flexible tools enable access when risk is manageable.

The best dossiers combine strong value with a credible and operational plan.



BOTTOM LINE

Italy offers access when value is real and risk is manageable. Success comes from aligning clinical value, financial sustainability, and operational control.



AIFA negotiates price and conditions. MEAs & registries operationalize control.



Expenditure ceilings drive payback and financial discipline.



Regional execution determines real-world access and speed.



Plan for patients, monitoring, financial exposure, and adjustment mechanisms.



Spain combines **strong national price authority** with a legal framework that explicitly integrates **clinical value, cost-effectiveness, and budget impact**. The Ministry of Health sets financing criteria, and the Interministerial Pricing Commission sets the maximum industrial price for funded medicines. National decisions are central, but **regional and hospital execution** shapes real-world speed and uptake.

1. HOW THE SYSTEM WORKS



Publicly funded financing is a state competence. Legal criteria ensure decisions consider value, sustainability, and alternatives.

2. LEGAL CRITERIA FOR FINANCING (Ministry of Health)

- Disease severity
- Specific population needs
- Therapeutic and social value
- Incremental clinical benefit with cost-effectiveness
- Public-spending rationalization and budget impact
- Existence of lower-cost alternatives
- Degree of innovation

Value, cost-effectiveness, budget impact, and innovation are all explicit legal criteria—not optional.

3. TRANSPARENCY & EVIDENCE-BASED TOOLS

Transparency Since 2018

- Publication of prices
- Financing criteria
- Decision rationales
- Public-search tools

Clinical & Economic Process Tools

Therapeutic Positioning Reports (IPT)
AEMPS & REvalMed create a single evidence-based positioning report for the National Health System.

VALTERMED
Real-world therapeutic-value infrastructure for selected high-impact products to track outcomes in practice.

National transparency and real-world evidence tools strengthen decision quality and post-market learning.

4. SYSTEM REALITY: NATIONAL DECISION, DECENTRALIZED EXECUTION



- National financing decision is central but not always sufficient.
- Decentralized execution in hospitals and autonomous communities can moderate speed and uptake.
- Spain often behaves like a budget-impact market in practice, even though value criteria are legally embedded.

Expect variability in access timing and conditions across regions and hospitals.

5. IMPLICATIONS FOR LAUNCH TEAMS

- Succeed in the IPT: demonstrate clear clinical legitimacy and comparative positioning.
- Prove economic proportionate: show cost-effectiveness and manageable budget impact nationally.
- Ensure operational absorbability: align with regional budgets, hospital logistics, and real-world implementation capacity.
- Engage early with Ministry, AEMPS, REvalMed, and key regional stakeholders.
- Design for real-world evidence: plan VALTERMED or other outcome tracking where relevant.

6. KEY TAKEAWAY



Spain rewards products that can tell three stories at once:

- ✓ Clinically legitimate in the IPT
- ✓ Economically proportionate at the national level
- ✓ Operationally absorbable at the regional and hospital level

Three stories. One access plan.



BOTTOM LINE

Spain integrates value, cost-effectiveness, and budget impact into law—then executes nationally with regional reality. Align all three lenses to win and sustain access.



National authority sets rules and prices.



Legal criteria include value, cost-effectiveness, budget impact, and innovation.



Transparency and tools (IPT, VALTERMED) improve evidence and accountability.



Regional & hospital execution determine real-world speed and uptake.



Structured by NICE. Enabled by Commercial Solutions. Delivered by the NHS.



The UK is the archetypal **cost-effectiveness-driven** market. NICE applies a **£25,000–£35,000 per QALY** threshold (standard range). A positive NICE Technology Appraisal triggers a **legal NHS funding obligation within 90 days**. When appraisal, commercial solution, and budget impact align—the UK can be both **highly structured** and relatively **fast**.

1. THE NICE PATHWAY: FROM APPRAISAL TO ACCESS



Expedited routes are available for some medicines, delivering decisions in as little as **~30 days**.

2. THE COMMERCIAL SIDE: CONFIDENTIAL & FLEXIBLE



Patient Access Scheme (PAS)
The preferred approach. Confidential fixed or percentage discount when list price alone is not cost effective.



Commercial Access Agreement (CAA)
Confidential agreements on price, volume, or other terms agreed at NHS England's discretion.



NHS Commercial Framework for New Medicines
Enables earlier and more purposeful engagement on value, affordability, and transactability.



Budget Impact Test

A **£40 million** annual threshold in any of the first three years triggers additional budget-management discussion.

3. VALUE EVIDENCE: WHAT NICE CONSIDERS



- ✓ Standard threshold: **£25,000–£35,000 per QALY** gained (a range, not a fixed number).
- ✓ Committees consider all relevant evidence, including **real-world evidence (RWE)**.
- ✓ Managed access agreements link registry and post-launch data to access decisions.
- ✓ Uncertainty can be addressed through managed access with data collection.



Real-world data and registries are integral to demonstrating value and reducing decision uncertainty.

4. WHAT MAKES THE UK DISTINCTIVE



Cost-effectiveness is the central gate.



Confidential commercial solutions are the norm, not the exception.



Budget impact adds an explicit affordability layer.



Clear timelines and legal funding obligation drive speed when aligned.



Not just HTA; it's a **cost-effectiveness-plus-commercial-design** system.

5. IMPLICATIONS FOR MANUFACTURERS



Most favorable when you are ready early: Coherent economic model, comparator strategy, budget-impact submission, and simple commercial solution.



Decide the access strategy early: Simple confidential discount vs. managed access with data collection.



Plan for real-world evidence: Registries and post-launch data can unlock or sustain access.



Least favorable to "finish the clinical story first" and improvise the net-price story later.

6. KEY TAKEAWAY



In the UK, unlike the U.S., the **net-price story is often the access story**.

- ✓ Value at the right price
- ✓ Affordable within budget
- ✓ Delivered through the NHS



Win the appraisal, design the commercial solution, manage the budget impact, deliver patient access.

BOTTOM LINE

The UK rewards early strategy, economic rigor, affordable solutions, and real-world evidence. **Align all four, and access follows—fast.**



Cost-effectiveness is the central driver (NICE £25k–£35k/QALY).



Confidential commercial solutions (PAS/CAA) are essential.



Budget impact matters (£40M annual threshold in first 3 years).



Legal NHS funding obligation within 90 days (standard cases).



Real-world evidence and managed access reduce uncertainty.



From High-Growth Market to Rule-Bound, Value-Based Access System.



China combines accelerated regulation, annual national reimbursement negotiation, dual-channel execution, and expanding procurement pressure.

Coverage is broad, reform is nationwide, and the system increasingly demands both regulatory-quality evidence and payer-quality evidence.



1.326 BILLION
People covered by basic medical insurance (95% of population)



DRG/DIP Reform
Covers all pooling areas nationwide



>500
Drug varieties in national or provincial centralized procurement by end of 2024

1. BROAD COVERAGE & SYSTEM REFORM (NHSA 2024)



Basic medical insurance enrollment reached **1.326 billion** people at the end of 2024, with coverage at **95%**.



DRG/DIP-style payment reform now covers **all pooling areas**.



The number of nationally organized or provincial centralized-procurement drug varieties **exceeded 500** by year-end 2024.

What this means:

- ✓ Huge patient base with stable coverage
- ✓ Systematic payment reform nationwide
- ✓ Procurement scale creates continued price pressure

2. ACCELERATED REGULATORY APPROVAL (NMPA)



Four accelerated pathways to speed innovative drugs to patients.



Priority review: 200 working days → **130 days** or **70 days** for urgently needed drugs approved overseas.



Breakthrough therapy, conditional approval, and priority review formalized in 2020.

Implication:



China is now fast, predictable, and increasingly aligned with global R&D timelines.

3. ANNUAL NRDL NEGOTIATION CYCLE (NHSA)



Jun 28, 2024
Work plan published



Jul 1-14, 2024
Filings opened



Nov 28, 2024
Updated NRDL announced



Jan 1, 2025
New list took effect



91 drugs added in the 2024 update, **89** through negotiation or competitive bidding.



Total drugs on NRDL: **3,159**.



Negotiated drugs receive national payment standards; some (marked with *) may not be disclosed publicly.



Not a transparent list-price market—reimbursement-effective economics may be only partially public.

4. DUAL-CHANNEL ACCESS (NHSA 2021)



Designated Medical Institutions

Parallel access for negotiated drugs



Designated Retail Pharmacies



- ✓ Unified reimbursement policies across both channels
- ✓ Solves hospital-entry bottlenecks
- ✓ Improves access to high-value, urgently needed products



Channel execution is part of reimbursement strategy: hospital stocking, retail designation, e-prescription routing, and field support.

5. EVIDENCE EXPECTATIONS ARE EXPANDING



Regulatory Evidence
High-quality clinical evidence for safety, efficacy, and quality.



Payer Evidence
Drug value assessment and pharmacoeconomic evaluation to balance clinical value with fund sustainability.



Real-World Evidence (RWE/RWD)
NMPA guidance (2020, 2021) supports the use of RWE/RWD in drug development and review.



The successful China dossier is a joined-up regulatory, pharmacoeconomic, and operational access dossier.

China now expects both:



- ✓ Regulatory-quality evidence
- ✓ Payer-quality evidence

6. KEY TAKEAWAYS FOR LAUNCH TEAMS



Sequence matters:
NMPA approval → NRDL negotiation → dual-channel execution.



Win the value case:
Strong clinical value + pharmacoeconomics + RWE strengthen negotiation outcomes.



Prepare for procurement:
Expect price pressure from national and provincial centralized procurement.



Execute both channels:
Hospital access and retail channel setup determine real-world uptake.



China is now:

- ✓ Large & essential
- ✓ Faster & more predictable at approval
- ✓ Rule-bound at reimbursement
- ✓ Execution-driven in the real world



BOTTOM LINE

China has matured into a rule-based access system with scale, speed, and sophistication. Success requires alignment across regulation, value, negotiation, and execution.



Accelerated regulation gets you to the door.



Annual NRDL negotiation gets you in.



Dual-channel execution delivers patients.



Evidence quality sustains the value.



Think integrated. Execute end-to-end. Win access. Win patients.

GLOBAL ACCESS STRATEGY: INSIGHTS, SEQUENCING & EXECUTION

Align Evidence, Economics, and Execution with Each Market's Reimbursement Logic

STRATEGIC IMPLICATIONS FOR PHARMA

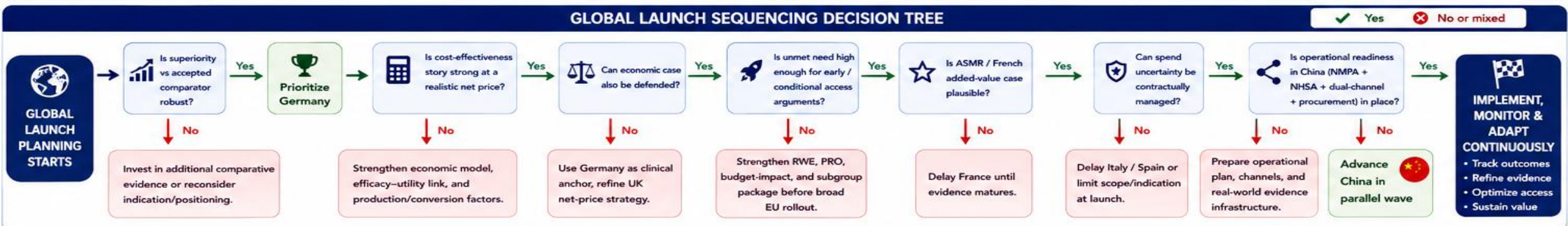
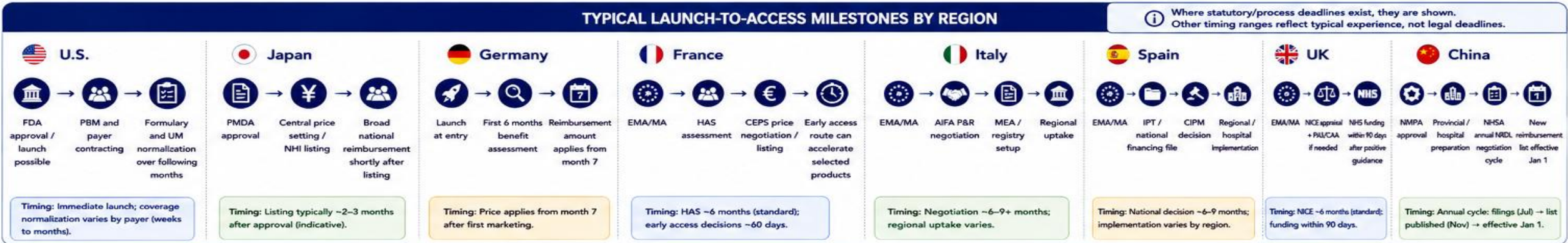


- 1. LAUNCH SEQUENCE FOLLOWS REIMBURSEMENT LOGIC**
- Start with the market that best matches your product's evidence identity.
 - Germany first for strong superiority data (powerful external signal).
 - UK first if economic case and net-price solution are feasible.
 - France only with a plausible ASMR or early-access rationale.
 - Italy/Spain later, when story and contracting posture are mature.
 - China when NMPA, NHSA, dual-channel, and procurement strategy can be coordinated.

- 2. EVIDENCE GENERATION BY ARCHETYPE**
- Germany/France: high bar on comparator discipline and patient-relevant outcomes.
 - UK: credible cost-utility and budget-impact cases.
 - Italy/Spain: evidence must withstand affordability and implementation scrutiny; include real-world monitoring.
 - Japan/China: increasing acceptance of RWD/RWE, but not data-light; plan evidence generation post-launch.
 - Surrogates can open doors with unmet need, but durability comes from pre-planned confirmatory and real-world evidence bridges.

- 3. CONTRACTING STRATEGY IS CUSTOMIZED**
- U.S.: model net-price architecture end to end (PBMs, MDRP, CMS changes).
 - UK: aim for the simplest commercial arrangement that clears NICE and the budget impact test.
 - Italy: use MEAs when they genuinely resolve uncertainty or smooth affordability.
 - Spain: pair national funding file with a credible VALTERMED-ready outcomes plan.
 - China: access contract = price + distribution + pharmacy + implementation contract.

- 4. IRA & BIOSIMILAR RISK IN LIFECYCLE PLAN**
- CMS negotiation cycles are underway (2027 prices published; 2028 includes first Part B drugs).
 - U.S. strategy must integrate future Medicare leverage from the start.
 - Design lifecycle, indication order, evidence maturation, and contracting with future negotiation in mind.
 - Biosimilar/post-exclusivity risk varies:
 - Germany: comparator & reference pricing
 - China: centralized procurement
 - U.S.: pharmacy benefit vs. Part B economics



THE THROUGH-LINE

Successful global access is not a one-size-fits-all rollout. Align your evidence identity, economic value, and execution model with each market's reimbursement logic. Plan early, build modular evidence, contract smartly, and execute relentlessly.

- Right Market, Right Time, Right Story
- Evidence Drives Access, Access Drives Value
- Contracts Align Affordability with Innovation
- Execution Converts Access into Patient Outcomes



ACRONYMS USED IN THIS PAPER

Complete Glossary of Acronyms by Category

REGULATORY & GOVERNMENT BODIES

AEMPS	Agencia Española de Medicamentos y Productos Sanitarios (Spain)
AIFA	Agenzia Italiana del Farmaco (Italy)
CEESP	Comité Économique des Produits de Santé (France)
CEPS	Comité Économique des Produits de Santé (France)
CIPM	Interministerial Pricing Commission (Spain)
CMS	Centers for Medicare & Medicaid Services (U.S.)
EMA	European Medicines Agency
FDA	U.S. Food and Drug Administration
G-BA	Gemeinsamer Bundesausschuss (Germany)
HAS	Haute Autorité de Santé (France)
IQWiG	Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (Germany)
NHSA	National Healthcare Security Administration (China)
NHS	National Health Service (UK)
NICE	National Institute for Health and Care Excellence (UK)
NMPA	National Medical Products Administration (China)
PMDA	Pharmaceuticals and Medical Devices Agency (Japan)

HEALTH TECHNOLOGY ASSESSMENT (HTA) & EVALUATION

ASMR	Amélioration du Service Médical Rendu (France)
CAA	Commercial Access Agreement (UK)
HEOR	Health Economics and Outcomes Research
HTA	Health Technology Assessment
IPT	Informe de Posicionamiento Terapéutico (Spain)
PAS	Patient Access Scheme (UK)
PRO	Patient-Reported Outcome
RWE	Real-World Evidence
RWD	Real-World Data
TA	Technology Appraisal (NICE process)
VALTERMED	Sistema Español de Verificación de los Resultados en Salud (Spain)

PRICING, REIMBURSEMENT & PAYMENT SYSTEMS

ASP	Average Sales Price (U.S.)
DIP	Diagnosis-Intervention Package (China)
DRG	Diagnosis-Related Group (China)
MEAs	Managed Entry Agreements
MDRP	Medicaid Drug Rebate Program (U.S.)
NHI	National Health Insurance (Japan)
NRDL	National Reimbursement Drug List (China)
PBM	Pharmacy Benefit Manager (U.S.)
P&R	Pricing & Reimbursement
SHI	Statutory Health Insurance (Germany)
UM	Utilization Management
WAC	Wholesale Acquisition Cost (U.S.)

MARKETS, PAYER CHANNELS & ACCESS PATHWAYS

Dual-Channel	Dual-Channel Procurement Mechanism (China)
MA	Marketing Authorization (EMA/European approval)
NHS England	The commissioning arm of the NHS responsible for national services (UK)
Part B	Medicare Part B (physician-administered drugs, U.S.)
Part D	Medicare Part D (prescription drug benefit, U.S.)
SSN	Servizio Sanitario Nazionale (Italy)
UMD	Uniform Medicare Distributors (U.S., Part B)
VBP	Value-Based Procurement (general term)

CLINICAL & EVIDENCE TERMS

Comparators	Standard of care or comparator therapies in comparative evaluation
QALY	Quality-Adjusted Life Year
Surrogate Endpoint	A biomarker or intermediate outcome used to predict clinical benefit
Unmet Need	A condition with insufficient or no satisfactory therapy

POLICY, LEGISLATION & REFORMS

AMNOG	Arzneimittelmarkt-Neuordnungsgesetz (Germany)
IRA	Inflation Reduction Act (U.S.)
MFN	Most-Favored-Nation (U.S. IRA provision)
Orphan Drug Policy	Policies that provide incentives for development of rare disease therapies

PROCUREMENT & MARKET ACCESS INFRASTRUCTURE

Centralized Procurement	Government-led bulk purchasing to negotiate lower prices
E-Prescription	Electronic prescription systems
National Code Assignment	Official product code assignment for reimbursement and pricing (e.g., Spain)
Reference Pricing	Pricing based on a reference group of similar medicines

OTHER COMMON ABBREVIATIONS

EU	European Union
GDP	Gross Domestic Product
MoH / MOH	Ministry of Health
RCT	Randomized Controlled Trial
SOC	Standard of Care
YoY	Year over Year

NOTES:

- Acronyms may vary slightly by country or organization.
- This list includes all acronyms used in the paper across U.S., Japan, France, Germany, Italy, Spain, UK, and China sections.
- Where applicable, country/region is indicated in parentheses.

WHY ACRONYMS MATTER

Understanding these terms is essential for navigating global market access, policy discussions, and cross-country comparisons.