evohealth

September 2025

WHEN NATIONS COMPETE

WHY ‘MOST FAVOURED NATION’ MATTERS FOR MEDICINE ACCESS IN AUSTRALIA

Evohealth acknowledges that we work on the traditional lands of many Aboriginal clans, tribes, and nations.

We commit to working in collaboration with Aboriginal and Torres Strait Islander communities and peoples to improve health, emotional and social well-being outcomes in the spirit of partnership.

About **Evohealth**

The delivery of healthcare is complex.
Our focus is not.

Better health for all.

WHEN NATIONS COMPETE

WHY 'MOST FAVOURED NATION' MATTERS FOR MEDICINE ACCESS IN AUSTRALIA

CONTENTS.

ABOUT **THIS REPORT**

Background

When nations compete: Why 'Most Favoured Nation' matters for medicine access in Australia examines how Most Favoured Nation (MFN) medicine pricing policies could reshape global pharmaceutical markets and threaten Australia's model of affordable, equitable medicine access. It unpacks the mechanics of MFN pricing, contrasts the United States (US) and Australian healthcare systems, and explores the risks to the core tools of the Pharmaceutical Benefits Scheme (PBS), including confidential negotiations, value-based assessments, and managed entry agreements. Developed independently by Evohealth, a specialist life sciences advisory firm, this original report draws on global policy analysis. It provides objective analysis and commentary on the potential implications of MFN pricing for Australia's health system and advocates for preserving the principles that underpin Australia's universal access to medicine framework.

Approach

This report has been informed by:

- a comprehensive review of published academic and grey literature on pharmaceutical pricing policy, international reference pricing, and MFN mechanisms; and
- analysis of case studies from Australia, the US and other comparator markets.

WHEN TRADE POLICY **UNDERMINES HEALTH POLICY**

Most Favoured Nation (MFN) pricing, a longstanding principle of international trade, has entered the pharmaceutical policy arena with renewed force. In 2025, the United States (US) revived and expanded its MFN policy to link medicine prices across key government programs to the lowest list price available in comparable countries.[1] The stated aim is to bring down domestic medicines costs. The likely result is something very different.

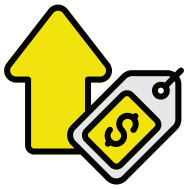
MFN pricing does not address the structural drivers of high prices in the US market. Instead, it shifts pricing pressure outward, targeting countries with embedded value and access evaluation frameworks. Systems like Australia's Pharmaceutical Benefits Scheme (PBS) are directly in the crossfire. By anchoring US prices to the lowest global benchmark, MFN policies threaten to undermine the confidential negotiations, value-based assessments, and managed entry agreements that make the PBS effective.

[1] The U.S. Department of Health and Human Services (HHS) also advised that it will calculate the MFN price as the lowest price in a country that is part of the Organisation for Economic Co-operation and Development (OECD) and that has a per capita gross domestic product (GDP) of at least 60 per cent of the U.S. per capita GDP. [1]

The impacts for Australia would be significant, not merely theoretical:

Delayed or withdrawn product launches

Pharmaceutical companies may hold back new medicines from Australia to avoid setting a low global benchmark.

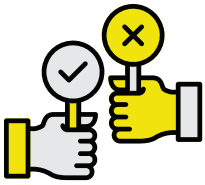


Loss of confidential pricing

The separation between public list prices and negotiated net prices could collapse, eroding the PBS's ability to manage affordability.

Global upward price pressure

Countries that achieve low prices become a liability, creating incentives to remove discounts and lift prices globally.



Weakened health technology assessment

Decisions risk being driven by global price exposure rather than domestic evidence of value.

These pressures would force Australia to choose between higher medicine prices or slower access, eroding both the equity and sustainability of the PBS. Over time, the result will be a two-speed global system with early access for some countries, affordability for others, but rarely both.

Australia must act now. Protecting the PBS negotiation framework, advocating internationally for recognition of diverse health system designs, and strengthening domestic resilience are essential. Without these safeguards, MFN could compromise affordable access, undermine policy flexibility, and increase public spending in Australia.

TWO SYSTEMS, **ONE COLLISION COURSE**

In 2020, the US proposed a sweeping new pricing mechanism through an Executive Order issued by then-President Donald Trump. The order aimed to benchmark Medicare payments to the lowest price paid in any Organisation for Economic Co-operation and Development (OECD) country for the same medicine. [2] The order was ultimately frozen by the incoming Biden administration and formally withdrawn in 2021. [3]

Following the introduction of the 2020 Executive Order, the pharmaceutical industry responded swiftly and defensively, filing legal challenges against the rule. [4-6] Companies warned of delayed or withdrawn medicine launches in countries with lower prices. But globally, the response was more muted. In Australia, for example, the order went largely unrecognised, with no formal response from government or media, likely overshadowed by the COVID-19 pandemic.[2] Still, it marked the moment MFN logic, once confined to goods like steel or wheat, entered the healthcare domain, signalling a shift that would resurface with greater force in years to come.

Fast forward to May 2025, and the policy has re-emerged with vigour. While the original 2020 order signalled intent, its implementation was short-lived, blocked in court and largely unnoticed outside of the US. This time, a more aggressive and far-reaching iteration drew global attention. The White House formally revived MFN pricing with the announcement of a new directive aimed at anchoring US medicine payments to the lowest prices in comparable international markets.[3] [7] Unlike its predecessor, the 2025 version expanded beyond Medicare, invoked trade enforcement mechanisms, and marked a shift in both tone and ambition, a change explored in more detail later in this report. [7]

While framed as a tool to make medicines more affordable for the US, the global implications are significant. Countries like Australia, which rely on confidential, value-based pricing for some medicine listings, now face renewed pressure to either raise prices or accept delayed and restricted access to future launches.

In this report, we argue that MFN clauses do not reduce global prices. Instead, they redistribute the pricing burden outward. In doing so, they risk undermining established pricing models like the PBS and triggering broader disruptions across international pharmaceutical markets.

[2] No formal response from the Australian Government or media was identified through official statements, press coverage, or PBS updates at the time. This suggests the order had limited direct resonance in Australia, likely due to COVID-19 dominating the policy agenda in 2020.

[3] The HHS also advised that it will calculate the MFN price as the lowest price in a country that is part of the OECD and that has a per capita GDP of at least 60 per cent of the U.S. per capita GDP. [1]

UNDERSTANDING **THE TWO SYSTEMS**

To understand why MFN pricing causes concern, we need to firstly understand how medicine price is set in both Australia and the US. Australia's system is designed around government-led value assessments and negotiated pricing. [8] In contrast, the US system relies more on market-based processes and private negotiations. [9]

These differences reflect each country's healthcare structure and policy goals. But when international price comparisons are introduced, as in the case of MFN pricing, these differences become more than technical. They start to shape how medicines are launched, priced, and accessed globally.

Australia's system: Value, equity and sustainability

Australia's approach to medicine access is built around the PBS, a national program that subsidises a wide range of prescription medicines to ensure equity, sustainability and affordability for all Australians. The PBS operates within the framework of Australia's National Medicines Policy (NMP), which provides the north star for the system with its guiding principles of timely access, affordability, sustainability and quality use of medicines. [10] The PBS is grounded in a simple but powerful principle: public money should only be spent on medicines that deliver good value for patients and the health system. [8]

At the heart of the PBS is the Pharmaceutical Benefits Advisory Committee (PBAC), an independent body that evaluates new medicines and vaccines through a structured and rigorous health technology assessment (HTA) process. The PBAC evaluates clinical safety, as well as comparative and cost-effectiveness. Only medicines that demonstrate value for money are recommended for subsidy. This is referred to as listing on the PBS. [11]

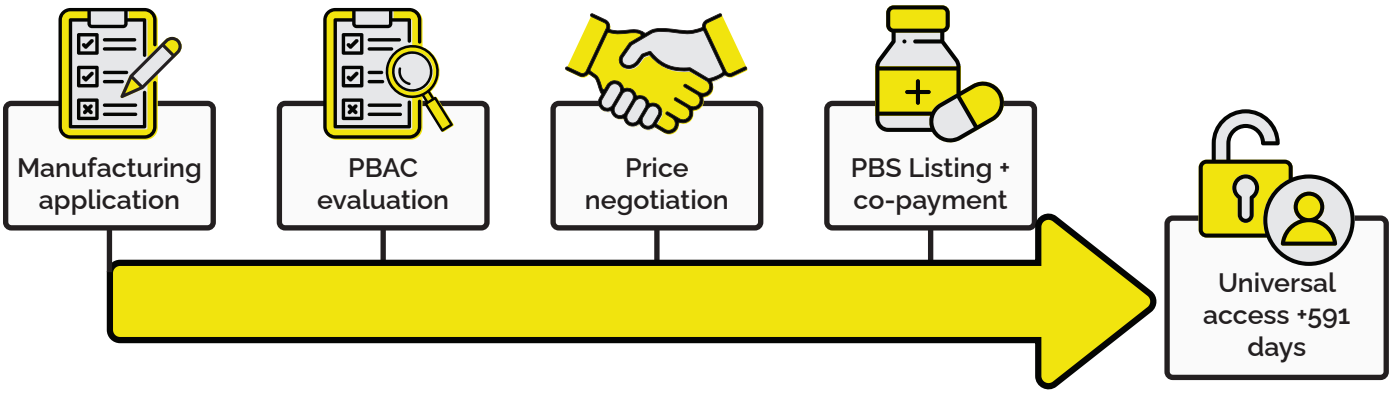
Australia's PBS system also recognises that some medicines are not interchangeable. Two treatments may target the same disease but can differ significantly in formulation, dosing, patient experience, or side-effect profile. [11] In line with the NMP, these differences are explicitly considered to ensure that patients receive access not only to affordable medicines, but to the most appropriate therapies for their needs. [10] Pricing is not just about minimising cost; it is about maximising patient outcomes while keeping funding sustainable.

Once recommended by the PBAC, a medicine moves into confidential price negotiations between the sponsor[4] and the government. These negotiations can result in confidential risk-sharing agreements, managed entry schemes, or special pricing arrangements that account for real-world uncertainties. These arrangements reflect both the PBS's statutory framework and the NMP's commitment to balancing affordability with sustainability. These confidential processes are an important step in allowing Australia to provide universal access within the parameters of PBS restrictions (e.g., indication-specific eligibility criteria). [12]

[4] In the PBS context, a "sponsor" refers to the pharmaceutical company or organisation that applies for a medicine or vaccine to be subsidised under the PBS. The sponsor is responsible for submitting clinical and economic evidence to the PBAC and entering into price negotiations with the Australian Government if the medicine is recommended for listing.

While the PBS model achieves universal access, it is also slower than most international systems. As shown in Figure 1, a 2024 report by Amgen found that, between January 2021 and April 2024, the average time from Therapeutic Goods Association (TGA) registration to PBS listing for new medicines was 591 days. This delay was even longer, reaching 638 days on average, for medicines that required cost effectiveness analysis. These figures suggest that patient access to clinically superior treatments continues to be delayed by protracted HTA, multiple PBAC submissions, and extended price negotiations. [13]

Figure 1: Australian Patient Access Timeline

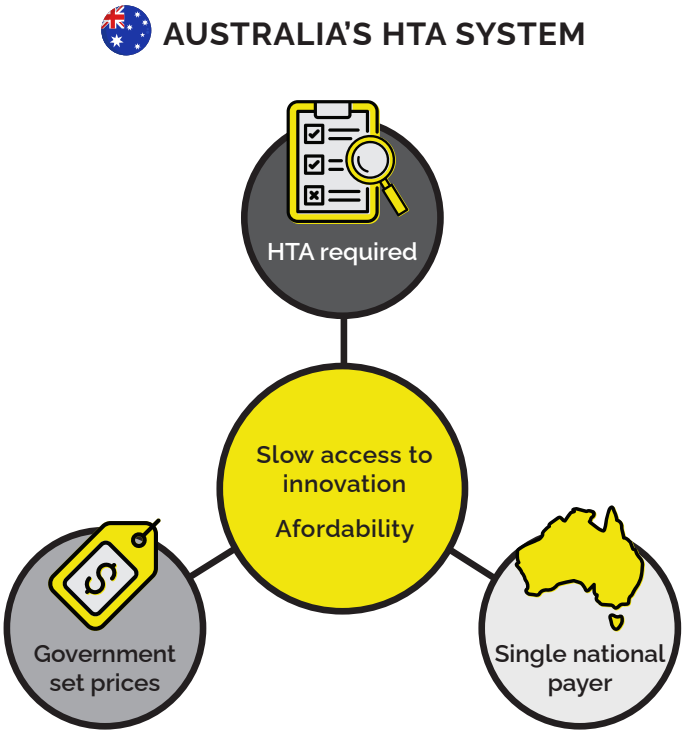


Source: [13]

These delays affect both patients and the healthcare system. For patients with unmet needs, slower access can lead to worse health outcomes. For the system, it may result in higher interim treatment costs while waiting for newer, potentially more effective therapies to become available.

Once listed on the PBS, a medicine becomes available to eligible Australians at a capped patient co-payment, with the government covering the remaining cost. PBS pricing policies also include price disclosure and other policies, that collectively support long-term system sustainability and affordability. [8]

This layered approach delivers strong cost containment and promotes equity. However, because many pricing arrangements are confidential, some of Australia's prices are not visible. [12] This lack of transparency sits in tension with the NMP's emphasis on equity of access and becomes problematic when MFN policies seek to compare and align prices across borders. The tension arises because the NMP promotes fair and transparent access domestically, while confidential rebates, although supporting affordability within Australia, limit the visibility of some prices internationally and create challenges when external systems use them for cross country comparisons.



The U.S. system: Early access, expensive outcomes

The US operates a fragmented and commercially driven pharmaceutical system. There is no single national insurer that covers prescription medicines for the entire population. Instead, medicine coverage is provided through a mix of private health insurers, employer-sponsored plans, Medicare for older adults and people with disability, and Medicaid for low-income individuals. [14]

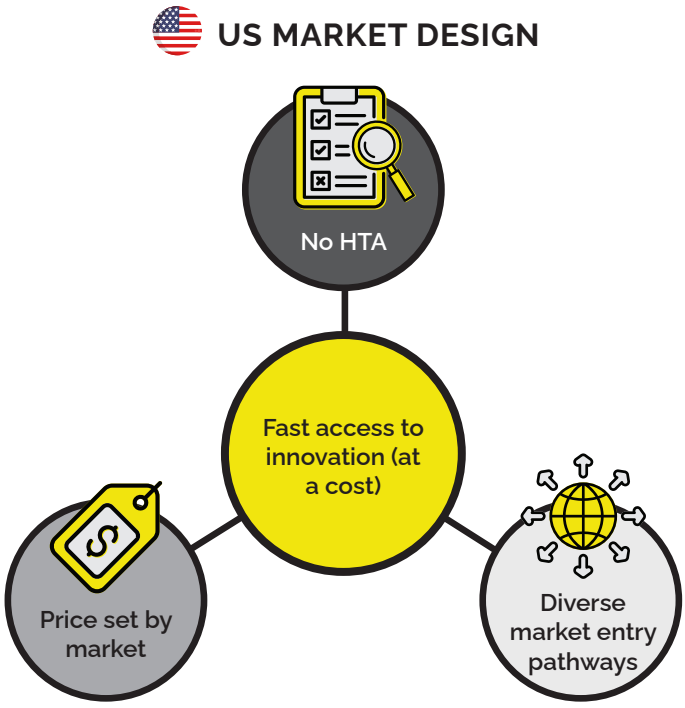
Unlike Australia, there is no national process for assessing the value of new medicines before they reach the market. The US Food and Drug Administration (FDA) evaluates safety and efficacy, but not cost-effectiveness. [15] Pharmaceutical companies are free to set list prices, and access depends on whether insurers or pharmacy benefit managers (PBMs) choose to include the medicine on their formularies.[5,6] These decisions are often opaque, inconsistent across insurers, and influenced by confidential rebate arrangements. [16]

This system allows for rapid market entry, with medicines able to be launched immediately following FDA approval. There are no centralised reimbursement negotiations or delays due to cost-effectiveness reviews. For patients with urgent or unmet needs, this speed can offer earlier access to promising treatments. [16]

But fast access comes at a cost. The US pays the highest medicine prices in the world. Many patients face significant out-of-pocket costs, especially for high-cost specialty medicines. Coverage is variable and often tied to an individual's employment, leaving millions either underinsured or entirely without access to essential medicines. [16]

Despite these issues, the US remains the world's innovation powerhouse. In 2024, the FDA approved 50 novel medicines and nine cell and gene therapies, a total of 59 new treatments. Nearly half of the novel medicines approved were first-in-class, offering new mechanisms of action not previously available. Over the past decade, the FDA has approved an average of 47 new medicines per year, the highest rate globally. [17]

This innovation is supported by massive investment. In 2023, US pharmaceutical companies spent over USD 96 billion on research and development, accounting for more than half of all global biopharmaceutical spending. US based companies reinvest around 21 per cent of their revenue into research and development, sustaining a pipeline of high-risk, high-reward therapies. [18]

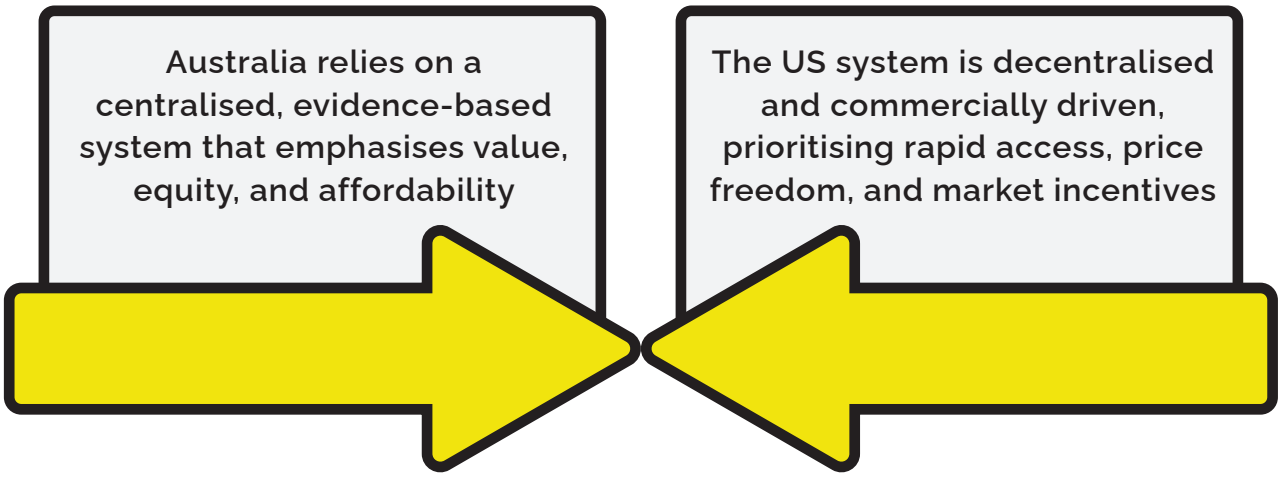


[5] PBMs are third-party administrators of prescription medicine programs. They negotiate rebates with pharmaceutical companies, determine pharmacy networks, and manage which medicines are covered for insurers or employers.

[6] Formularies are the official lists of medicines covered by an insurance plan, typically organised in tiers that affect cost-sharing and prescribing decisions.

Where systems collide

The structural differences between Australia's PBS and the US pharmaceutical system create a fundamental conflict when international price comparisons are introduced. Australia relies on a centralised, evidence-based system that emphasises value, equity, and affordability over speed to market. [8] In contrast, the US system is decentralised and commercially driven, prioritising rapid access, price freedom, and market incentives. [16]



MFN policies attempt to harmonise medicine prices by referencing the lowest price paid internationally. However, applying MFN logic across systems with such different healthcare system foundations does not smooth out disparities. It creates pressure points. What may seem like price alignment in theory can result in commercial disruption in practice.

If the US were to mandate MFN pricing based on prices in lower-cost countries like Australia, pharmaceutical companies would face a strong incentive to raise prices in smaller markets. [19] This is not a theoretical risk. It reflects basic market logic. The US is the largest and most profitable pharmaceutical market in the world. Companies are unlikely to accept reduced revenue in the US simply because lower prices have been negotiated elsewhere. Instead, they will seek to increase prices in countries like Australia to protect global margins.

This is not just a clash of pricing methods. It is a collision of policy values, commercial incentives, and health system responsibilities. The US system, despite its high costs, underwrites much of the world's pharmaceutical innovation. [17, 18] Its market size and tolerance for high launch prices generate the returns needed to sustain research and development across the globe. In 2021, US pharmaceutical companies invested over USD 96 billion in research and development, accounting for more than half of global spending. [18]

Countries like Australia benefit from this dynamic. We access high-cost, high-impact therapies, including first-in-class medicines and gene and cell treatments, at significantly lower prices. [12] This is achieved using public assessment processes, confidential rebates, and delayed entry to manage affordability. [13]

MFN policies threaten this balance. By anchoring US prices to international comparators, MFN could weaken the commercial foundations of global research and development while simultaneously forcing countries like Australia to rethink their pricing policies and tools.

The result is a cascading effect that directly impacts patient access. Australia could lose access to confidential rebates, face pressure to publish negotiated prices, and risk undermining the PBAC's role in determining cost-effectiveness. Pricing leverage would erode. The Australian Government may have to choose between accepting higher prices or delaying access even further. The PBS, long regarded as a benchmark for sustainable and equitable access, would face increased financial strain and reduced policy flexibility. In this scenario, only pharmaceutical companies are likely to benefit, if they lift global prices in response to US policy changes.

MFN policies overlook the legitimate variation in population needs, market structures, and health policy tools. Rather than respecting these differences, MFN imposes a single pricing logic across borders. In doing so, it risks damaging the very systems that enable affordable and equitable access in smaller markets. What is framed as a move toward fairness could, in reality, unravel international cooperation and compromise access to medicines worldwide. [20]

MFN PRICING: **CONCEPT AND CONSEQUENCES**

As global pricing pressure intensifies, MFN has emerged not just as a technical mechanism but as a symbol of shifting power dynamics in global pharmaceutical markets. What was once a niche pricing strategy is now being positioned as a central policy lever by the world's largest pharmaceutical market. To understand why this matters, and why countries like Australia should be concerned, we need to consider how it differs from other international approaches, and why its logic, though appealing on paper, may prove dangerous in practice.

What is MFN and why do governments use it?

The concept of MFN originated in international trade law. Under the World Trade Organization (WTO) rules, if a country gives a favourable term to one trading partner, such as lower tariffs or better access, it must offer the same terms to all others. The goal is to ensure fairness and prevent discrimination between countries. [21]

In health policy, MFN has been adapted to mean something very different. Instead of extending equal treatment, MFN pricing demands that a country pay no more than the lowest price available in a group of comparator countries. [7] When applied to medicines, this means a government ties its medicine prices to the single lowest list price found anywhere in its reference group, often drawn from comparable high-income nations. [7]

Governments are drawn to MFN pricing because it offers political and financial appeal. It creates the appearance of fairness and fiscal responsibility. If other countries are paying less for the same medicine, then taxpayers in higher-cost markets want to know why. In countries like the US, MFN is framed as a way to stop subsidising access elsewhere and to get a better deal at home. [7]

This logic is easy to communicate but deeply flawed. Medicine prices vary for many reasons. Countries negotiate confidential discounts based on budget impact, disease burden, and the value a treatment provides. Comparing prices without context ignores the complexity of these systems. MFN simplifies pricing to a single number, often the list price, and treats it as a universal benchmark.

MFN in medicine: From trade to treatment

By 2025, the Trump administration revived MFN pricing with a broader scope, building on earlier but short-lived attempts. The updated directive extended beyond Medicare and applied to a wider range of government reimbursement programs. It linked medicine prices to the lowest available list price across an expanded set of countries. It also stated that confidential rebate structures used by other countries would be treated as barriers to transparency and fairness. The policy was tied to trade enforcement and gave US negotiators new tools to pressure foreign governments and companies into higher list prices. [7]

For countries like Australia, this shift is significant. MFN directly challenges confidential negotiations and risk-sharing mechanisms that underpin pricing. It places pressure on countries to raise their list prices or delay access to avoid setting a low benchmark for larger markets like the US.

How MFN differs from International Reference Pricing (IRP)

MFN pricing is often mistaken for international reference pricing, but the two approaches are very different.

International reference pricing, or IRP, is used in many countries to inform pricing decisions. Governments look at what other countries are paying and calculate an average or median price to guide negotiations. [22] IRP is usually one part of a broader pricing framework that includes HTA, budget impact analysis, and clinical need. It allows flexibility and recognises that pricing must reflect local context. [22]

MFN pricing removes that flexibility. It demands that a country pay no more than the lowest list price in its reference group, regardless of how that price was set or what it includes. [21] This creates several problems:

- **Single-country distortion**. A very low price in one small country can set the benchmark for all others, even if that price is based on limited use or restricted access.
- **Confidential rebates become a liability**. Countries like Australia that depend on rebates to keep PBS prices affordable could be penalised. MFN only looks at list prices; however, if pharmaceutical companies perceive a risk that the US may push for transparent pricing, they may be reluctant to offer rebates.
- **Access delays increase**. Pharmaceutical companies may avoid launching in lower-priced countries altogether to protect their ability to charge higher prices in larger markets.

MFN is not just IRP with stricter rules. It is a fundamentally different policy tool. It takes a trade concept and applies it to healthcare in a way that ignores system design, equity, and clinical value. For countries that prioritise affordable access through public negotiation, MFN threatens to unravel carefully balanced systems.

EXPECTED IMPACT: **PRESSURE WITHOUT PROTECTION**

MFN pricing has the appearance of economic rationality. In theory, tying reimbursement to the lowest international price should create downward pressure on medicine costs and improve affordability for US patients. But in practice, that logic breaks down. MFN pricing does not address the underlying drivers of high prices in the US market. Instead, it pushes those costs outward. [19, 20]

Rather than lowering global prices, MFN redistributes the burden. It punishes countries that have successfully negotiated affordable pricing, distorts how and where new medicines are launched, and undermines national frameworks designed to ensure equity and sustainability. For countries like Australia, the impact is not theoretical. It is structural. MFN threatens access, affordability, and the long-term integrity of the PBS. [20]

Delayed or withdrawn access in lower-price markets

One of the earliest and most visible impacts of MFN pricing is the way it could influence pharmaceutical launch behaviour. When prices in one country are tied to the lowest prices elsewhere, pharmaceutical companies become cautious of listing in those low-price regions. A low price in Australia does not just affect local revenue. It becomes a global reference point that could lower prices in the much larger US market. The commercial logic is simple: delay or withhold medicines in the lower-price country to protect margins in the higher-price regions. [23]

This is not theoretical. The European Union (EU) experience with international reference pricing already shows how pricing spillovers can drive launch delays. Pharmaceutical companies prioritise high-income, high-price markets first, then move down the chain slowly, if at all. [24] MFN raises the stakes. Unlike IRP, where averages can buffer outliers, MFN locks in the lowest price as the benchmark. A single discounted price in a small country can reset expectations globally.

In Australia, this could mean longer waits for new cancer therapies, rare disease treatments, or next-generation biologics. Even when a medicine is deemed clinically valuable and cost-effective by the PBAC. Pharmaceutical companies may delay submitting for PBS listing or demand access under restrictive conditions. [23, 24]

Over time, the result is a two-speed system. High-income, large markets like the US and parts of Western Europe secure earlier access, while smaller or lower-price markets such as Australia risk being pushed to the back of the queue in exchange for affordability. MFN pricing makes it increasingly difficult to achieve both.

Loss of confidential pricing and system flexibility

Australia's PBS is built on negotiation. The system depends on health technology assessment to determine whether a medicine provides value, and on confidential pricing negotiations that reflect both clinical benefit and budget constraints. These arrangements allow the government to fund a wide range of treatments without inflating global benchmarks. [12]

MFN pricing disrupts this model. If a confidential discount offered in Australia leads to a lower reference price in the US, pharmaceutical companies may withdraw from the negotiation or increase the list price to avoid commercial exposure. [20] The ability to separate the public price from the negotiated cost is lost. In turn, the tools that make the PBS efficient and adaptable begin to break down.

Pharmaceutical companies may start refusing to offer meaningful discounts or may shift toward flat pricing strategies that ignore Australia's ability to assess value. This increases the overall cost of listed medicines and makes it harder to manage clinical uncertainty or respond to population needs. Managed entry agreements, price-volume deals, and conditional listings all become less feasible.

Although the PBS does not operate under a fixed annual budget, rising medicine costs driven by global pricing pressure make it more difficult to preserve the principle of universal access. Without confidential pricing arrangements, the government must spend more for the same outcomes. Every dollar spent on inflated prices reduces capacity for other listings, program expansions, or public health investments.

Global upward price pressure, not downward

MFN pricing claims to bring prices down, but the effect is the opposite. Instead of correcting high prices in large markets, it encourages companies to remove low prices from smaller ones. The goal becomes protecting revenue in the largest and most profitable jurisdictions. With the US estimated to account for between 64 to 78 per cent of global pharmaceutical profits in 2018, MFN rules are more likely to push the global price floor upward than to reduce costs. [25]

This is the central paradox. The more aggressively MFN is applied, the stronger the incentive for companies to eliminate low-price medicine listings. Rather than rewarding countries that negotiate effectively, it turns them into a liability. Pharmaceutical companies will act to preserve high benchmarks, not lower them.

For Australia, this means being penalised for doing what the PBS was designed to do: secure fair access at a sustainable price. Instead of being a model of value-based pricing, Australia becomes a market risk that must be managed. The reward for successful negotiation is restricted access, commercial caution, or higher list prices.

Globally, this creates a cascade of negative impact. Countries that have negotiated lower prices through public mechanisms are pressured to align with the new global benchmark. Smaller markets lose leverage. List prices inflate. And the overall result is higher public spending without better outcomes.

Undermining HTA and value-based pricing

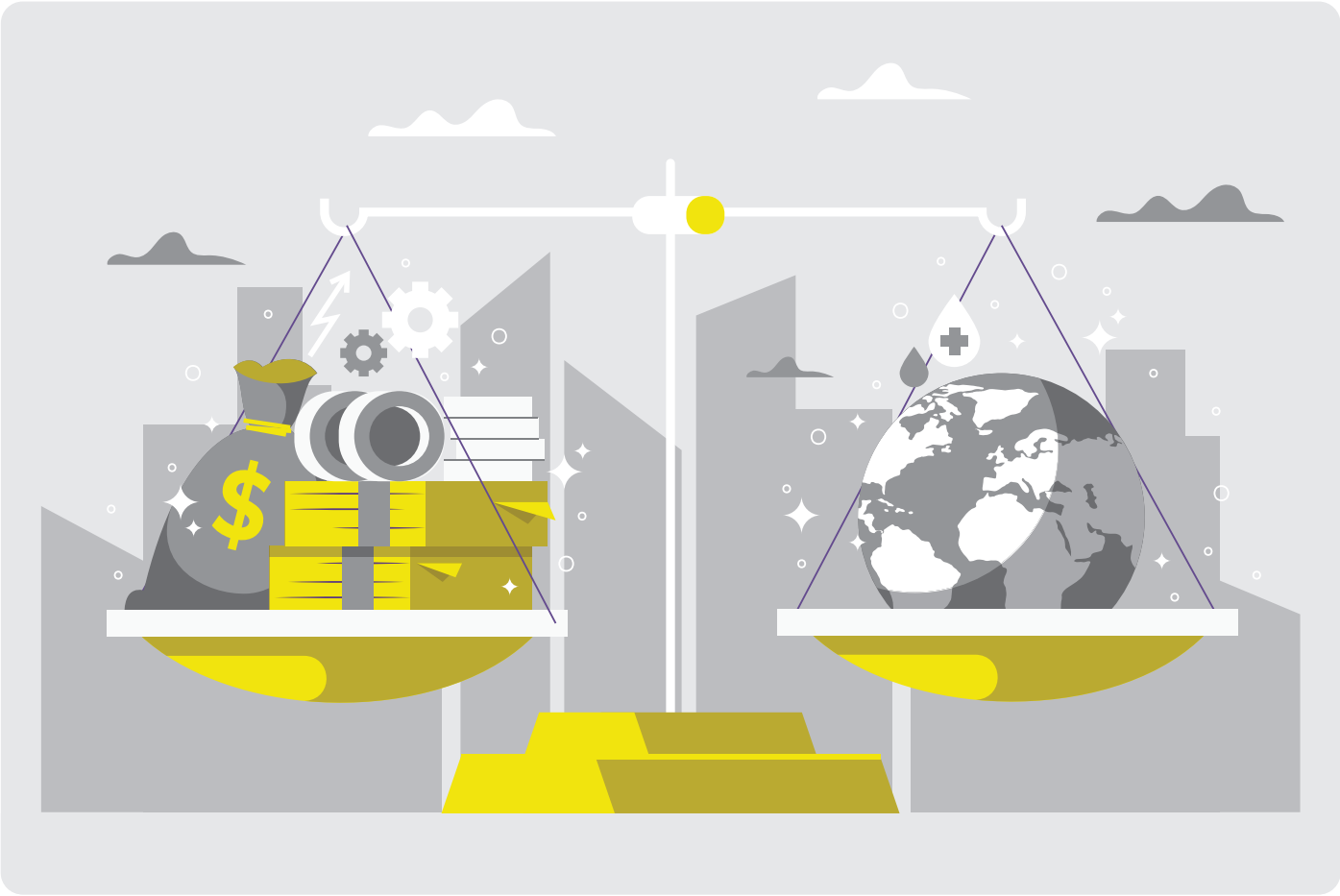
At the core of the PBS is a commitment to evidence. MFN pricing ignores that principle entirely. It assumes that the lowest price available in any country is inherently the best deal. It takes a pricing shortcut and ignores the context, evidence, and population needs that HTA is designed to consider.

The more countries are forced to respond to MFN-linked pricing pressure, the less influence HTA processes have on final decisions. Pharmaceutical companies may deprioritise the submission of evidence or resist local assessments altogether. The Australian Government may be pressured to approve medicines quickly to maintain access parity, even when local clinical data is limited.

Over time, HTA risks becoming symbolic. If prices are anchored externally and decisions are driven by market exposure rather than domestic evaluation, the core role of the PBAC and related bodies is weakened. The system becomes less about what works for Australians and more about what protects global pricing strategies.

This is especially damaging for emerging therapies. Medicines that come with high uncertainty or small patient populations require careful assessment and flexible pricing. MFN removes that space for nuance. It forces governments to choose between paying global prices or accepting delayed access, even when treatments could be life changing.

In the long run, MFN pricing undermines the very systems that make equitable access possible. It reduces pricing to a single figure, strips away context, and removes the tools that countries like Australia have used to manage public funds while maintaining clinical rigour. It is not a policy that rewards efficiency. It is a policy that penalises it.



A **CALL** TO **ACTION**

Australia cannot afford to treat MFN as a distant policy experiment. If the US pursues aggressive MFN implementation, the ripple effects will be felt in our medicine supply, budgets, and patient outcomes. Policymakers, industry, and patient advocates must move now to:

1 Protect the PBS negotiation framework

Australia's PBS is underpinned by a negotiation framework that balances access, affordability, and sustainability through different funding arrangements. The framework must be protected and shielded from external pressures. We need to reinforce the importance of confidential rebates, managed entry agreements, and value-based assessments in all trade and pharmaceutical policy discussions.

2 Ensure Australia rewards value and innovation

Australia must accelerate reforms that recognise the value of innovation, as well as increase investment in health. Value should not only be attributed to direct clinical outcomes, but also to indirect benefits such as productivity, quality of life, social impact and outcomes that matter most to patients. Positioning Australia as an innovation partner of choice, will safeguard patient access to medicines into the future.

3 Engage proactively in international forums

Australia plays a critical role in shaping global dialogue on cross-border pharmaceutical pricing. Proactive engagement in international forums, alongside strengthened partnerships in the Asia–Pacific, will be essential to resist attempts that impose rigid MFN clauses. We need to advocate for recognition of legitimate differences in population needs, healthcare system structures, and policy tools when MFN or other cross-border pricing mechanisms are debated.

4 Strengthen domestic resilience

Global pressures on pricing could constrain Australia's ability to list innovative medicines in a timely manner. To protect us from the uncertainty of future pricing environments, we can aim to strengthen our domestic resilience through multiple approaches. Potential measures include increasing our efforts on horizon scanning mechanisms to prepare innovative funding strategies or using targeted incentives for domestic manufacturing.

5 Build an evidence base

Evidence will be critical to ensure Australia's position on MFN and pharmaceutical pricing is credible and well-informed. The government should seek to commission and publish analyses on the potential impact of MFN on launch timelines, pricing, and availability in Australia to inform both domestic and global policy debates. These findings can be made publicly available to support a transparent and informed debate.

By taking these steps, Australia can position itself to defend the principles that underpin equitable and sustainable access to medicines while contributing constructively to global pricing discussions.

MFN pricing is politically attractive and easy to explain. It promises fairness by aligning prices across borders. Yet with medicines, fairness is not achieved by flattening prices to the lowest common denominator. It is achieved by ensuring that each health system can secure the medicines its people need, at prices that reflect value, affordability, and population health priorities.

For Australia, MFN is not just an abstract trade concept. It is a direct challenge to the PBS, a model that has delivered decades of equitable access through careful, evidence-based negotiation. If implemented without safeguards, MFN could raise our prices, slow our access to new therapies, and weaken the very processes that protect our health budget from unsustainable growth.

The global conversation on pharmaceutical pricing must recognise that different systems achieve fairness in different ways. The risk of MFN is that, in pursuit of price parity for one country, it sacrifices the equity, sustainability, and innovation incentives that others have worked hard to balance. Australia's challenge is to ensure that in the rush toward global price alignment, we do not lose sight of the core tenants of our NMP: timely access to medicines that Australians need, affordable costs for patients and the community, and long-term sustainability of the system.

ABBREVIATIONS

Abbreviations	Description
EU	European Union
FDA	US Food and Drug Administration
GDP	Gross Domestic Product
HHS	US Health and Human Services
HTA	Health Technology Assessment
IRP	International Reference Price
MFN	Most Favoured Nation
NMP	National Medicine Policy
OECD	Organisation for Economic Co-operation and Development
PBAC	Pharmaceutical Benefits Advisory Committee
PBM	Pharmacy Benefit Manager
PBS	Pharmaceutical Benefits Scheme
TGA	Therapeutic Goods Administration
US	United States
WTO	World Trade Organization

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Date of preparation: September 2025

Authors: Renae Beardmore, James Taylor

Report design: Adam Sorgini

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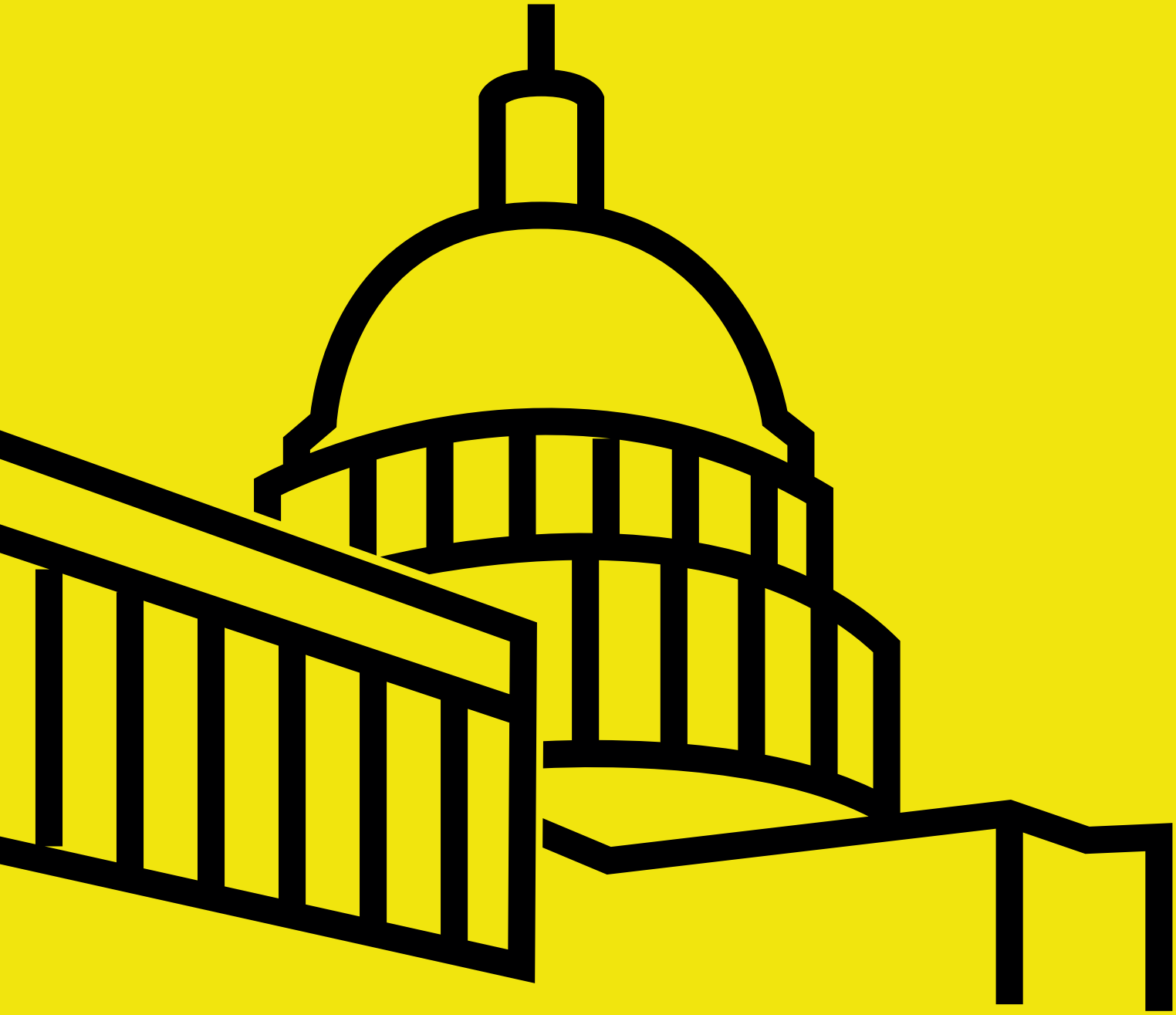
Page 14 photo by Andrew Teoh (Unsplash)

Suggested citation: Evohealth. 2025. *When nations compete: Why 'Most Favoured Nation' matters for medicine access in Australia*, Evohealth, Canberra



September 2025

+612 6198 3440

www.evohealth.com.au

Level 1, 18 National Circuit,
Barton ACT, Australia 2600

evohealth