EGMONT PAPER 142

– OCTOBER 2026 –

Does Europe Pay Too Little For Its Medicines?

Three questions any rational European (or American) should answer, and a call for action.

F. Vandenbroucke & G. Ghéquière

EGMONT Royal Institute for International Relations

ABOUT THE EGMONT PAPERS

The Egmont Papers are published by Egmont – The Royal Institute for International Relations. Founded in 1947 by eminent Belgian political leaders, Egmont is an independent think-tank based in Brussels. Its interdisciplinary research is conducted in a spirit of total academic freedom. A platform of quality information, a forum for debate and analysis, a melting pot of ideas in the field of international politics, Egmont's ambition – through its publications, seminars and recommendations – is to make a useful contribution to the decision-making process. The opinions expressed in this paper are those of the author alone, and they do not necessarily reflect the views of the Egmont Institute.

ABOUT THE AUTHORS

Frank Vandenbroucke is Vice-Prime Minister and Minister of Social Affairs and Public Health of Belgium, in charge of the Fight against Poverty. An economist by training, he studied at KU Leuven and the University of Cambridge (MPhil in Economics) and obtained his DPhil at the University of Oxford with a thesis on social justice (Springer, 2001). He entered politics in 1984, led his party and served as federal Minister of Social Affairs, Health Insurance and Pensions, then of Employment, and later as Flemish Minister of Education and Work. He subsequently returned to academia as Professor at KU Leuven, holder of the Herman Deleeck Chair at the University of Antwerp's Centre for Social Policy, and University Professor at the University of Amsterdam, where he held the Joop den Uyl Chair. He chaired the Belgian Commission on Pension Reform 2020–2040. In 2020 he returned to government as Minister of Social Affairs and Public Health in the Vivaldi coalition and was reappointed in 2025.

Gloria Ghéquière is Deputy Head of Cabinet to Frank Vandenbroucke. She is responsible for pharmaceutical policy. She holds degrees in philosophy (Ghent University) and European studies (KU Leuven). Before joining the cabinet, she was an adviser on international trade in the European Parliament, where she worked on pharmaceutical value chains during the COVID-19 pandemic and helped set up the Parliament's special committee on COVID-19 (COVI), tasked with drawing lessons for Europe's handling of health crises. In the cabinet she worked on the Belgian Presidency of the Council of the EU in 2024 and was a driving force behind the Critical Medicines Act, the EU initiative to strengthen Europe's security of supply of medicines. In 2023 POLITICO named her to its Power 40, Brussels Class of 2023.

ACKNOWLEDGEMENTS

We thank Prof. Jan De Loecker, Joeri Boterman and Tine Carmeliet for helpful comments and discussions.

Declaration of generative AI use. During the preparation of this paper, the authors used Claude (Opus 5.5 and Fable 5.1, Anthropic) and ChatGPT (GPT-6.1 Sol and GPT-6 Astra, OpenAI) to search for and summarise literature, to discuss and critique draft versions of the argument, and to edit the text for clarity and structure. The authors checked references against the original source. The arguments, interpretations and conclusions are the authors' own, and the authors take full responsibility for the content of this article.

Table of Contents

Summary **4**

1. Introduction **5**

2. The Price Gap **6**

3. The Complaint: Do Americans Pay More Because Europeans Pay Less? **6**

3.1 The Standard Textbook Analysis: Pricing in Separate Markets 6

3.2 How Market Institutions Shape Prices 7

3.3 Beyond the Textbook Analysis: How Prices Can Become Linked 9

3.3.1. Pharmaceutical Research as a Global Public Good: the Military Alliance Analogy 9

3.3.2. International Reference Pricing 10

4. The Charge: Does Europe Contribute Less Than Its Fair Share? **12**

4.1 Fair Choices in Health Care 12

4.2 Caring for Future Patients 14

5. The Remedy: Will MFN Lower US Prices and Provide for a More Just Global Distribution on Innovation Costs? **16**

6. Implications for European Policy **17**

6.1 Defending the European Health Care Model 17

6.2 Closing the Gap in Capital and Scale 18

6.3 A European Framework for Price Incentives? 19

7. Conclusion **20**

References **21**

Endnotes **25**

Summary

In 2025 the American president signed an executive order on 'Most Favoured Nation' prices (MFN), asserting that Americans 'should not be forced to subsidize low-cost prescription drugs and biologics in other developed countries'. The argument for MFN combines a complaint, a charge and a remedy. The complaint is that Americans pay more for their medicines because Europeans pay less. The charge is that Europe benefits from pharmaceutical innovation while leaving Americans to bear more than their fair share of its cost. The remedy is most-favoured-nation pricing, which ties American prices to those paid in other wealthy countries. This paper examines each part of the argument.

Can the complaint be supported by economic evidence and sound analysis? Americans do pay substantially more for brand-name medicines. In the standard analysis of separate markets, however, a manufacturer sets the profit-maximising price in each market, independently of the price it obtains in the other. A lower European price therefore does not by itself raise the American one. American prices reflect the organisation of the American market: manufacturers set their own launch prices, purchasing is fragmented and there is no collective negotiator who values the medicine before the price is set. Nuances that might be formulated with regard to the standard analysis do not change the conclusion: a causal link between the two prices arises most likely when a deliberate policy ties them together, typically through international reference pricing. Imposing such a link would raise prices substantially in smaller markets while reducing American prices only modestly.

The charge raises a different, second question: what would a fair contribution be? American prices are no self-evident benchmark for that judgement. Drawing on Ronald Dworkin, we argue that a decision on what society is willing to pay for a treatment is fair when it is taken collectively, with the best available knowledge and against the background of a fair distribution of resources. Universal compulsory insurance and collective assessment of therapeutic value meet these conditions in Europe. A fair choice also takes future patients into account, and Europe provides for them: its prices lie well above the cost of production, and it supports research through public funding (albeit less than the US), tax support and protection from competition. American payments are the product of a domestic choice, which brings world class innovative medicine quickly to those who are well insured, at the cost of inequalities in access that European systems simply do not accept. For sure, there is no denying that pharmaceutical R&D generates an international public good which is potentially beneficial to any country in the world. However lower spending than in the United States does not, by itself, establish that Europe is unfairly benefitting from a public good that is created predominantly in the United States, i.e. it does not establish that Europe can be accused of free riding.

The third question is about the remedy: would it serve the purported objective? All available evidence indicates that it risks imposing substantial – even disruptive – costs on European health systems for comparatively modest American gains. Once the American price is tied to the European one, a manufacturer has a strong reason to refuse lower prices abroad, and the European purchaser's ability to walk away loses much of its force. One model, by Dubois, Gandhi and Vasserman (2022), shows that prices in the reference country would roughly triple while American prices fall by 7.5 to 15 per cent, and the smaller the country, the heavier the adjustment. Neither the difference in prices nor the responsibility to support innovation establishes an obligation to bear those costs.

Three implications follow. Given the risk of disruption for European health care policies at large, Europe should defend its model of universal access and evidence-based, negotiated prices through the Union's instrument against economic coercion, rather than member state by member state. And it should act where it actually loses innovation, between discovery and development, by closing the gap in capital and scale. Finally, where prices and levies are used as incentives, they should be targeted at research and production in Europe, within a European framework rather than through national preferences.

1. INTRODUCTION

In May 2025 the American president signed an executive order on 'Most Favoured Nation' prices, asserting that Americans 'should not be forced to subsidize low-cost prescription drugs and biologics in other developed countries'. The order sought to bring American medicine prices into line with those paid abroad and instructed the administration to act against foreign practices said to suppress pharmaceutical prices below fair market value (Executive Office of the President, 2025: 20749–20750). The administration has pursued this policy through payment measures in Medicare and agreements with manufacturers that include price commitments for Medicaid, two major public health insurance programmes.[1] Alongside these domestic measures, it has put trade pressure on foreign governments.

In June 2026 the United States Trade Representative also opened an investigation into Germany's pharmaceutical pricing practices under section 301 of the Trade Act (USTR, 2026a). The investigation concerns what USTR calls Germany's 'persistent underpayment' for innovative medicines. It focuses on the discount Germany requires from manufacturers that want their price kept confidential, and on new legislation that adds a mandatory rebate from 2027 (SGB V, §130a). The American objection is that the resulting lower prices reduce manufacturers' revenue and investment in research and so shift Germany's share of research costs onto American patients (USTR, 2026a: 38073). Under section 301, the administration can challenge a foreign practice as unfair and burdensome to American commerce even if it violates no international trade obligation. The implications extend beyond Germany: on this reasoning, a public purchaser's efforts to secure lower medicine prices can themselves become grounds for trade pressure (USTR, 2026a: 38073).

The administration has also signed MFN agreements with twenty-six manufacturers, covering, according to the White House, 89 per cent of the branded drug market (White House, 2026). Two agreements, with Eli Lilly and Pfizer, have been released in redacted form. They contain clauses that link prices in parts of the American market to prices paid to a basket of reference countries.[2] A lower European price can therefore also reduce a company's American revenue, giving it an additional reason to demand more in Europe (HHS and Eli Lilly, 2026; HHS and Pfizer, 2026). The agreements specifically provide that prices of reference countries in which the product has been withdrawn, no longer count for the American price. Moreover, the agreements require the company to share with the American government a portion of the additional revenue it earns from higher prices outside the United States. The size of that share has not been disclosed. Higher foreign payments thus become a source of revenue for the American government itself (HHS and Pfizer, 2026).

The US government justifies these measures with a moral accusation of freeriding. Other countries, it is said, pay too little for their medicines. Innovation costs money, Americans pay for it through their high prices, and the rest of the world enjoys the results without paying their fair share. That is free riding, and free riding is unfair.

The American argument combines a complaint, a charge and a remedy. The complaint is that Americans pay more for their medicines because Europeans pay less. Section 2 documents the price gap. Section 3 examines whether European prices cause higher American ones: notwithstanding possible nuances, the standard model of firm behaviour in separate markets shows that they do not causally explain higher prices. Only a policy that ties the two prices together through the application of international reference pricing creates a causal link. But then, it is a link that raises prices substantially in smaller markets while reducing American prices only modestly. The charge is that Europe benefits from pharmaceutical innovation while leaving Americans to bear more than their fair share of its cost. Section 4 asks what a fair contribution would be, drawing on Ronald Dworkin's account of fair choices in health care, and examines what Europe contributes through medicine prices, public research, tax support and protection from competition. The remedy is most-favoured-nation pricing. Section 5 asks whether it would lower American prices and lead to a fairer distribution of the costs of

innovation, and what it would ask of European health systems. Section 6 draws the implications for European policy: defending the European model against economic coercion, closing the gap in capital and scale where Europe actually loses innovation, and targeting price incentives at research and production in Europe. Section 7 concludes.

2. THE PRICE GAP

The fact that a price gap exists between the US and the rest of the world is uncontested. According to the most recent RAND study on this issue, manufacturer prices in the United States across all medicines were 278 per cent of those in 33 other OECD countries in 2022. For brand-name originator medicines they were 422 per cent, and 308 per cent after adjusting for estimated rebates (Mulcahy, Schwam and Lovejoy, 2024).[3] Only for unbranded generics, where competition rather than negotiation sets prices, are American prices lower, at 67 per cent of the comparison countries.

The difference is not confined to medicines. In 2024 the United States spent 14,885 dollars per person on health (at purchasing power parity), 17.2 per cent of its GDP, more than any other OECD country; Belgium spent 7,750 dollars, 11.0 per cent. Life expectancy at birth in 2023 was 78.4 years in the United States and 82.5 in Belgium (OECD, 2025a: 17, 24–25). Americans pay more for their medicines, and more for health care in general, while having lower life expectancy.

3. THE COMPLAINT: DO AMERICANS PAY MORE BECAUSE EUROPEANS PAY LESS?

The American complaint assumes a picture of innovation as a fixed bill. Research costs a certain amount; Europe pays too little towards it; Americans must therefore make up the difference. The picture is intuitive, but it does not follow from the standard textbook analysis of a firm selling the same product in separate national markets. On that analysis, perhaps surprisingly, the claim is mistaken.

3.1 The Standard Textbook Analysis: Pricing in Separate Markets

Imagine two national markets, market 1 and market 2. The analysis distinguishes two decisions: whether to select and fund a research project that may yield a medicine for sale in both markets, and, once that medicine has been developed, what price p_1 to seek in market 1 and what price p_2 to seek in market 2.

The first decision concerns the selection of projects from a research portfolio. The firm considers the research cost, the probability that the project will deliver a marketable medicine and the operating profits it expects to earn if it succeeds. Those profits depend on the costs of supplying the medicine, the prices obtainable in both markets and the quantities sold. The total expected returns from the two markets together therefore influence the research decision. The second decision concerns pricing once the research has delivered a marketable medicine. At that point, the research cost has been incurred, for all markets together, and it no longer directly influences the price.

In the textbook analysis, the firm seeks the price that maximises its profit in each market, given the marginal cost of production and the conditions of demand there, particularly the elasticity of demand. Unless a link exists between the markets, price setting in market 1 is independent of price setting in market 2. There is therefore no causal link between p_1, say the American price, and p_2, say the price in a European country. If a higher p_1 would yield more profit in market 1, the firm would already have chosen it, whatever it earned in market 2.

This independence of prices between markets rests on three assumptions: medicines bought in one market cannot be resold in the other; the marginal cost of supplying one market does not change with the quantity sold in the other; and no rule ties the price in one market to the price in the other. These conditions are made explicit in the structural model of Dubois, Gandhi and Vasserman (2022: 13, 59–61), which we discuss below when examining international reference pricing. Independence does not require firms to set prices unilaterally in both markets: it can also exist when a public purchaser negotiates the price in one of them. As Danzon, Wang and Wang (2003: 23) explain, if markets were perfectly separable, a firm would have no reason to withhold a medicine from a low-price country as long as the price covered the costs of supplying it.

As mentioned above, a government that negotiates a lower p_2 may affect the firm's research decisions. A reduction in expected operating profits can make some projects less attractive and leave them unfunded. Evidence that pharmaceutical innovation responds to expected market size supports this observation (Acemoglu and Linn, 2004; Dubois et al., 2015). But the effect is on the incentive to undertake research: a lower p_2 does not, by itself, raise p_1.

Obviously, if p_1 is higher than p_2, an identical volume of sales generates a larger contribution towards the initial research cost in market 1 than in market 2, assuming the same costs of supply. The same is true when market 1 buys a larger volume at the same price. Americans may therefore account for a larger share of the revenues available to cover research, other costs and profits. That accounting observation does not establish that the European price caused the American one. The difference must be sought in other mechanisms that directly influence prices. Nor does it establish that Europe's contribution is unfairly small.

3.2 How Market Institutions Shape Prices

To understand why American prices are higher, we must examine the conditions under which prices are set and negotiated in each market. The starting point is how people are insured.

European governments tend to organise their health care system around compulsory (near) universal coverage. Their institutional arrangements to obtain this objective differ: collective coverage can operate through a national health service or through compulsory insurance with several sickness funds. For medicines, public authorities establish reimbursement conditions for the collectively covered population. In Belgium, for example, 99.1 per cent of the population is covered by the national health insurance scheme, and people exercise their rights through a sickness fund (KCE, 2024). Contributions to the national health insurance are related to income and the reimbursement framework is generally the same for all citizens, regardless of wealth or health status.

In the United States, coverage is divided among employer-sponsored insurance, individual insurance and public programmes such as Medicare and Medicaid, while part of the population remains uninsured: 26.7 million people had no cover at all in 2025 (Bunch and Ketema, 2026). These arrangements cover different groups under different conditions. A decision by one insurer to reimburse a medicine does not establish access for everyone, and a price negotiated for one programme does not generally determine what other purchasers pay. Some purchasers are very large, but none acts on behalf of the population as a whole.

In both Europe and the United States, a medicines regulator assesses whether a medicine meets the required standards of quality, safety and efficacy before it can be marketed.[4] This authorisation establishes that its benefits outweigh its risks for the approved use. It does not necessarily establish that the medicine is better than the treatments patients

already receive, or that its benefits justify the price the manufacturer asks. It also does not establish at what price the manufacturer can come to the market.

European health insurance systems, which fall exclusively under the competence of the national member states, therefore organise a further assessment to inform reimbursement and pricing. These so-called 'Health Technology Assessments' (HTA) examine how a medicine compares with existing treatment to determine its cost-effectiveness. Does it extend life, improve quality of life or reduce side effects, and if so, by how much? A small improvement may justify only a small price increase compared to what is already available on the market; a major improvement may justify substantially more. Where no additional benefit has been demonstrated, the purchaser has little reason to pay a premium over the existing treatment and therefore to accept a higher price than similar alternatives that are already on the market.

Health Technology Assessments provide a basis for judging whether the medicine is worth its proposed price, and inform the public officials who are conducting price negotiations with the firms. If the manufacturer's terms remain unacceptable, the public purchaser can refuse reimbursement. The manufacturer must therefore weigh its price demand against the risk of losing access to the national market. The manufacturer can also refuse to supply if it thinks the insurer's willingness to pay is too low. The price emerges from a negotiation in which both parties have alternatives to agreement.

The situation is different for the US, where membership of a sickness insurance scheme is not compulsory, and where there is no single purchaser who can negotiate on behalf of the population as a whole. Contrary to Europe, manufacturers set their own launch prices on the US market. Only then do private insurers and public programmes make their coverage decisions, notably through Pharmacy Benefit Managers (PBMs). These are intermediaries that draw up formularies that determine whether a medicine is covered and in which line of treatment. They usually negotiate discounts with manufacturers in return for a more favourable position on those lists. Their scale can give them substantial bargaining power (Federal Trade Commission, 2024a). But their incentives do not necessarily favour lower list prices: part of their income comes from rebates and fees calculated as a percentage of the list price. In 2024 the Federal Trade Commission accused the three largest PBMs of favouring highly rebated insulins with high list prices over cheaper alternatives. One of them, Express Scripts, has since settled without admitting wrongdoing and agreed, among other things, to delink manufacturers' payments to it from list prices in its standard offering (Federal Trade Commission, 2024b; 2026).

Some American rules also limit purchasers' ability to refuse a medicine. State Medicaid programmes must cover nearly every medicine of a manufacturer participating in the rebate programme, and Medicare drug plans must cover almost all medicines in six protected classes (Social Security Act, §§1927(d) and 1860D-4(b)(3)(G)). These requirements protect access, but they also restrict an important source of bargaining power. A manufacturer faces a different negotiation when the purchaser has limited scope to exclude its product. The gap with other countries is largest for precisely such medicines: if Medicare Part D paid prices based on those abroad, its net spending on medicines in the protected classes would decrease by 74 per cent, against 67 per cent for other medicines (Hwang et al., 2026: 1342). Rebates and other spending controls still apply of course, but the point is that the purchaser's alternatives are shaped by the fact that, contrary to their European counterparts, they cannot easily refuse a medicine because its costs outweigh its benefits. These arrangements reflect policy choices about how insurance is organised, which medicines must be covered, how their value is assessed and who can negotiate on whose behalf. They shape the conditions under which manufacturers can obtain high prices in the United States.

The two systems embody different choices. Europe has opted for universal coverage and for collective price negotiations based on HTAs, so that access does not depend on a person's known health risk or their financial firepower, and price

is not set by the manufacturer alone. The United States has opted for a market in which manufacturers set their prices immediately upon marketing approval and insurers compete. That market responds quickly and brings new technology to patients fast. The Draghi report reports a median approval time of 334 days in the United States for a medicine to come to the market, as opposed to 430 days in the European Union (Draghi, 2024: 193). Even afterwards, patients often have to wait on lengthy reimbursement decisions. EU Member States try to bridge this gap by creating special programmes for early and fast access to new therapies, such as in Belgium (Vandenbroucke, 2026) and France (Haute Autorité de Santé, 2026). On the other hand, the US system tolerates inequalities in access that European systems simply do not accept. In the US, access to new therapies depends on a person's insurance coverage and their ability to meet out-of-pocket costs, whereas in the EU coverage is near universal. Each choice therefore has its drawback, its price to pay.

These differences help explain why manufacturers obtain higher prices in the United States. Within the textbook analysis of separate markets, higher European payments would leave the conditions determining American prices unchanged. However, before we conclude that the American price is not influenced by prices in other countries, we must investigate whether there are other ways in which prices could be linked.

3.3 Beyond the Textbook Analysis: How Prices Can Become Linked

The textbook analysis does not establish that national markets are always independent. It shows that a causal link between p_1 and p_2 requires an additional mechanism. Research costs alone do not provide that mechanism. We must therefore examine how decisions in one market might affect the price obtained in another.

A possible nuance that would bear upon the textbook analysis as we presented it, might arise from global-level economies of scale in the production or the selling of a pharmaceutical product. Such economies of scale would create a link between operational decisions in different national markets. However, that would not change the thrust of this paper's analysis and claims. In contrast, one can think of policy-related mechanisms – mechanisms not triggered by market forces but by public policies – that would change the argument significantly. The impact of policies has been examined in the literature starting from the observation that pharmaceutical R&D is an international public good. We first revisit this argument. Next, we focus on a specific type of policy intervention, international reference pricing, and the impact it might have if applied by the US government.

3.3.1. Pharmaceutical Research as a Global Public Good: The Military Alliance Analogy

Notwithstanding the commercial nature of the pharmaceutical industry's R&D and its protection by IP rights, this R&D ultimately generates knowledge constituting a public good with an international character. National governments' willingness to support innovation, given the international public good generated by R&D, might provide a mechanism linking prices in different countries. Olson and Zeckhauser (1966) explain how countries in a military alliance contribute to a public good whose benefits they share, in casu collective security. They show that a larger country can have a stronger incentive to contribute more to the alliance because more people benefit from that effort.[5] Smaller countries do not have the same incentive because their contributions buy comparatively less. They may therefore choose to benefit from what the large country's contributions make possible, and put in comparably less effort.

Under these conditions, larger countries may respond to lower contributions elsewhere by raising their own contributions, and bear a disproportionate share of the total. It is important to note that Olson and Zeckhauser see this as deliberate choice by the countries in the alliance, i.e. they reveal a causal mechanism. Large countries *decide*, as a matter of public

policy, that the extra effort is worth it to protect their own citizens. Small countries *decide* to do disproportionately less. It is noteworthy that Olson and Zeckhauser did not frame such rational behaviour by governments as a moral problem.

Frech et al. use this theory to explain 'why the US pays so much more for patented pharmaceuticals than do other rich countries' (2026: 1167). However, such an application of Olson and Zeckhauser presumes that there is a conscious decision taken by the US government to pay a certain price for innovation. The reality is that its complex and fragmented institutional set-up produces vastly different prices. In 2017, Medicaid paid on average $118 per prescription for the top-selling brand-name drugs, while Medicare Part D paid $343, with the Veterans Affairs and Defence departments in between (CBO, 2021). It is far more likely that these internal price differences are produced by different institutions, rather than a conscious decision by a government. Admittedly, one might counterargue that successive American governments deliberately *allowed* this complex and fragmented institutional to exist in order to support innovation by the resulting high prices. For sure, supporting innovation has been a declared goal of American policies and legislation. However, claiming that the actual patchwork of institutions is deliberately tolerated in the interest of innovation and that American governments keep American prices high in this way *because* European prices are low as a matter of rational choice (and vice-versa), seems difficult to sustain; it is also contradicted by attempts to lower drug prices by different American governments. We return to Frech et al. and the charge of free riding in Section 4, since we do not want to preclude that this charge might be formulated without establishing such a causal mechanism.

We also do not want to deny that governments may respond to one another's efforts. Empirical research suggests that countries lower their reimbursement when others pay more, and other governments reduce their funding for research on a disease when American public funding for it rises (Egan and Philipson, 2013; Pertile et al., 2018; Kyle, Ridley and Zhang, 2017; all as reported by Dubois, 2025a: 30). Such strategic substitution, where it exists, describes how other countries may respond to American payments. It does not show that American prices are set in response to European ones, and we see no evidence of the deliberate American choice that the military alliance analogy presupposes.

3.3.2. International Reference Pricing

International reference pricing creates a more direct link between international prices. When a government of a big market ties the price it will pay to prices in other countries, a manufacturer accepting a lower price in a small market may also have to accept a lower price in its big market. The negotiation with the small market's government then not only affects the revenue on that market, but also on other, bigger markets. This creates an incentive for manufacturers to seek high prices in reference countries, to delay market launch there or even to withhold the medicine altogether. A rule intended to bring the larger market's price down can consequently push the smaller market's price up.[6]

Dubois, Gandhi and Vasserman (2022) examine this mechanism in a structural model estimated on hospital sales in the United States and Canada between 2002 and 2013. Their model distinguishes American price setting from the bargaining model in Canada, which is more akin to the European system. They then introduce a rule under which the American price of a patented medicine cannot exceed its Canadian price. Crucially, they allow the Canadian price to change in response. The question is therefore where prices settle once both the manufacturer and the Canadian regulator take the American constraint into account.

In the baseline model, the manufacturer can forgo Canadian sales and retain its unconstrained American profit (Dubois, Gandhi and Vasserman, 2022: 23). Accepting an agreement in Canada must therefore be worthwhile compared with that alternative. A low Canadian price now entails a loss on American sales as well, so the manufacturer has a stronger reason

to reject it. Because the American market is much larger, the Canadian price must rise substantially before agreement becomes attractive. In the model, the two prices converge close to the original American level, rather than close to the original Canadian one.

The estimated effects are sharply asymmetric. American prices fall by about 7.5 per cent on average, and nowhere by more than 30 per cent. Canadian prices rise in all but one therapeutic class, and on average they triple (Dubois, Gandhi and Vasserman, 2022: 27–28, table 5.1). The model also simulates what happens if the US references not only Canadian prices, but a basket of six reference countries of Canadian size. In such a scenario, the effect on the American price is greater, while the effect on reference countries eases only a little: American prices fall by about 15 per cent, while prices in the reference countries still roughly triple (Dubois, Gandhi and Vasserman, 2022: 32). Combined industry profits change relatively little as a result of linking policies: across the markets included in the comparison, they fall by about 1.8 per cent with one reference country and rise by about 2.2 per cent with six (Dubois, Gandhi and Vasserman, 2022: 41, table 5.5). Much of the effect is therefore a redistribution of payments between countries.

These results depend on the rules shaping the manufacturer's alternatives. The authors also consider a policy that makes continued supply in the reference country a condition of selling in the United States. Under that rule, failure to agree in Canada would also cost the manufacturer its American sales, giving the Canadian regulator much greater leverage (Dubois, Gandhi and Vasserman, 2022: 23). Direct negotiation by an American purchaser likewise produces much larger American price reductions, of more than half on average, while Canadian prices do not change (Dubois, Gandhi and Vasserman, 2022: 32). Market size matters, but so does whether a manufacturer can escape the price constraint by withdrawing from the reference market. Note, however, that this model is static: it does not estimate the longer-term effects on innovation or launch delays, and its reference rule covers the whole American market rather than the more limited markets covered by the current measures.

The MFN agreements discussed in section 1 make this mechanism relevant to present policy. They tie prices in parts of the American market to prices abroad, giving manufacturers an additional stake in foreign negotiations. The Lilly agreement explicitly provides that, if the company stops supplying a medicine to a country in the reference basket, that country is removed from the calculation for that medicine (HHS and Eli Lilly, 2026: s. 8.2). Withdrawal can therefore remove the reference country's negotiating leverage which produced that country's price in the first place.

American prices are high primarily because of the institutions through which medicines are assessed, covered and purchased. Fragmented purchasing, limits on the ability to refuse coverage and intermediaries' incentives allow manufacturers to obtain prices that collective assessment and negotiation can bring down elsewhere. Higher European payments would leave those institutions unchanged. Conversely, lower European prices can reduce expected returns and leave some research projects unfunded, but they do not, by themselves, cause manufacturers to charge more in America. MFN creates a direct link between prices, but we can expect that this policy will produce sharply asymmetric effects: American prices will fall only modestly, while manufacturers gain a strong reason to reject lower prices abroad. European purchasers retain the right to walk away, yet lose much of the bargaining power they once had, because forgoing their market can now protect a manufacturer's much larger American revenue.

4. THE CHARGE: DOES EUROPE CONTRIBUTE LESS THAN ITS FAIR SHARE?

The charge of free riding treats high American prices as the measure of what other countries *ought* to pay. Judging Europe's contribution to innovation requires a broader account of what governments owe their citizens: how to provide care, support the development of future treatments and balance both against other societal needs. We first investigate the economic literature behind the American charge, and then turn to this broader discussion.

Economists commonly use 'free riding' in a descriptive sense. Because a small market has little influence on global innovation, its government has an incentive to set prices as low as manufacturers will tolerate (Lakdawalla, 2018: 436; Kyle, 2025: 57, 65); Lakdawalla uses Belgium as his example. We do not dispute that this incentive exists. It applies to every purchaser with market power, the United States included (Lakdawalla, 2018: 436). The charge levelled by the American administration is a different one: that Europe takes unfair advantage of a burden that Americans deliberately carry. Benefiting from what others pay for is not in itself unfair; whether a contribution is unfair requires a standard of what a fair contribution would be. That is the question we address in this section. To make our point, we zoom in on one, recent publication.

Frech et al. (2026) treat the knowledge embodied in new medicines as a global public good. They measure each country's contribution as its payments for branded medicines above production and distribution costs. To determine what countries should contribute, they draw on the Samuelson–Lindahl conditions: at the efficient level of innovation, each country's contribution reflects its marginal valuation of further innovation, which they assume rises in proportion to income per person (2026: 1160–1161). This is a benchmark for economic efficiency; whether it also provides a fair distribution of contributions is a separate question. Their data, moreover, do not support the claim that other rich countries pay little more than the cost of production and leave Americans to finance research. The other OECD countries account for about a third of the global contributions they calculate, and the authors describe these contributions as substantial (2026: 1164, table 1).[7] They nevertheless consider free riding substantial, though incomplete (2026: 1164–1165).

That conclusion rests on a further step, where they presume that American profit flows on new branded medicines are closer to the ideal (2026: 1167). In their theory, countries with an income per person similar to that of the United States, ought to contribute roughly as much per person as the US. On that basis they propose multi-country agreements leading to 'greater revenues received from countries in the rest of the world while keeping US-generated revenues at current levels' (2026: 1168). But the assumption that American revenues are closer to the ideal is stated, not established, and it is fair to ask what makes this outcome an appropriate standard. As section 3 showed, American prices reflect the organisation of the American market, and a domestic policy choice does not by itself establish an obligation for other countries to make the same choice. Judging what Europe owes is therefore a question about justice, for which we turn to American philosopher Ronald Dworkin's account of justice in health care.

4.1 Fair Choices in Health Care

Dworkin asks how much a society should spend on health care, and on what. Most of us share the intuition that health has no price, and it is a popular intuition among those who defend universal health care. Dworkin called it the ideal of 'insulation'. One of its components is the old principle of rescue, which states that 'it is intolerable when people die, though their lives could have been saved, because the necessary resources were withheld on grounds of economy' (Dworkin, 1993: 885). He took that intuition seriously, but rejected it for a simple reason. A society also needs schools and roads, and the ideal gives no guidance on how to weigh health against them. Taken literally, it would require spending on health care until an extra euro no longer bought any health at all. No society has ever done that (Dworkin, 1993: 886).

We agree with Dworkin that health care must be weighed against other goods. This argument works both ways: a government that builds roads without asking what it gives up in health makes the same mistake as one that reimburses every new medicine without asking what it gives up elsewhere. No budget is an island. For medicines, most of this weighing happens within health care itself: a euro paid for one medicine cannot be spent on another therapy, on nurses or on prevention.

So conceived, deciding on the value of a treatment is a collective, societal decision, as opposed to, for instance, the free market. Drawing on Dworkin, we argue that, against the background of a fair distribution of resources, such a decision can be just, even when it refuses a treatment, on the condition that it respects two requirements: 1) it is taken with the best available knowledge, and 2) nobody's access to insurance depends on what is known about their own health risks (Dworkin, 1993: 888–893).[8] Neither condition comes about by itself, since both run into structural problems that require an institution to intervene.

Take the second condition. People know more about their own health than an insurer does. Someone who knows that a serious illness runs in the family, for instance, knows something the insurer cannot see. The insurer only knows averages, and therefore sets its premium on the average risk of the people it covers. For people who know that their own risk is low, that premium is too high, and some of them will decide not to insure. For people with a high risk, however, the same premium is a bargain, and they will insure. The pool therefore gradually fills with high risks, the premium has to rise, more healthy people leave, and so on (Akerlof, 1970; Einav and Finkelstein, 2011). The outcome is paradoxical, as Barr notes: insurers fear that mainly bad risks will buy cover, yet it is the low risks who end up without it (Barr, 2020: 95). Insurers can only avoid this if they manage to tell the two apart. They can try to do so through medical questionnaires and examinations, and then charge high risks more or refuse them cover. The low risks then stay in the pool, but it is now the sick who go without cover, which is also a market failure. In economic terms, the remedy is compulsion. If everyone has to join, the low risks can no longer leave, and the pool remains stable. Once they cannot leave, it also becomes possible to break the link between contribution and individual risk, so that contributions can be related to income rather than to health risks (Barr, 2020: 101). This is what Dworkin's second condition requires, and it is how the European systems described in section 3.2 are organised. Universal, compulsory insurance solves problems of information that would otherwise leave part of the population uninsured.

The first condition meets a similar problem. A manufacturer knows far more about its medicine than those who pay for it, and it has an interest in presenting that knowledge favourably. A medicine can, for instance, be authorised on the basis of trials against placebo, while a payer needs to know whether it does better than the treatment patients already receive. The institution that meets this condition is a collective purchaser that assesses what a medicine adds to existing treatment and negotiates its price on that basis. That is the second feature of the European systems described in section 3.2: health technology assessment enables better price negotiations and collective reimbursement. The price does not just depend on what the seller says about its own product, but also on the purchasers' own assessment.[9]

This brings us back to the charge. Frech et al. measure Europe's contribution against the American price, as if that price were the standard of what a fair contribution would entail. Ronald Dworkin's account reframes that fairness against the conditions that a fair society must meet, namely a collective decision on what society is willing to pay for a certain treatment, taken with the best knowledge available and against the background of a fair distribution of resources.

4.2 Caring for Future Patients

Measured by Dworkin's standard, the European health system seems fairer than the American one. However, Dworkin's theory does not substantially address the question of innovation, even though it could be argued that a free and just society may also wish to invest in future cures. It is fair to argue that a society that draws up its budget must provide for innovation as well.[10]

In 3.1 we already touched upon the fact that the prospect of revenues from successful medicines gives companies a reason to undertake costly and uncertain research. The prices negotiated today therefore also affect the treatments that may become available tomorrow. Lower expected returns can leave some projects unfunded; higher expected returns can make additional research worthwhile (Acemoglu and Linn, 2004; Dubois et al., 2015). The consequences for innovation are part of the choice of what to spend on medicines.

Europe contributes to those future treatments in several ways. Medicine prices are one of them. In the data used by Frech et al., the other OECD countries pay, on average, 43 per cent of the American price for branded medicines (2026: 1163). Frech et al. put production and distribution costs at 14.2 to 24 per cent of the American price (2026: 1163, 1170). Prices in those countries are therefore, on average and by our calculation, between 1.8 and 3 times those costs. Many European markets pay above that average: Germany 53 per cent, Spain 50, Italy 47 and Belgium 46, while France and the United Kingdom are at the average of 43 (2026: 1164, table 1). The margin above supply costs is available to cover research, other costs and profits. Even if one may dispute whether that margin is 'sufficient' to fund a 'desirable' level of research (which then has to be identified, cf. infra), European payments contribute to the returns that support pharmaceutical development. Americans do not finance research alone.

Dubois (2025a) presents in his working paper some surprising findings regarding the link between revenue and innovation in the European and American markets respectively. He counts the number of new medicines registered in each therapeutic class and year, and asks how that number responds to the revenue firms can expect in that class. His earlier study looked at worldwide revenue (Dubois et al., 2015). This time he splits the expected revenue into three parts: revenue earned in the United States, in Europe and in the rest of the world. The results suggest that both American and European revenue encourage innovation, although the evidence is stronger for American revenue (2025a: 41–43, tables 3 and 4). More surprisingly, the response depends on where the firm is based. American firms respond mostly to their own market: his instrumental-variable estimates suggest that a 10 per cent rise in expected American revenue increases new registrations by American firms by about 4 per cent. A 10 per cent rise in expected European revenue increases registrations by those same American firms by about 2 per cent. European firms, by contrast, respond slightly more to revenue growth in the European market (2025a: 43, table 4). Dubois suggests that local benefits from clinical research and manufacturing may help explain this home bias. Note that these estimates concern revenue, not price. A higher price with a lower volume does not necessarily mean more revenue. The findings nevertheless matter for the charge. What Europe pays provides a reward in its own right, encouraging innovation by both American and European firms. We return to this in section 6.3.

Europe also contributes through other incentives. Public research provides the knowledge on which commercial development depends, including research into diseases for which effective treatments remain elusive, and it supports uncertain work long before a treatment's therapeutic value can be demonstrated. Measured against the size of their economies, Europe and the United States devote about the same amount to public research overall, around 0.7 per cent of GDP in 2023 (Eurostat, 2026). For health research, however, the difference is substantial. In 2022, government budgets for health-related R&D amounted to 0.19 per cent of GDP in the United States (49.5 billion dollars), against 0.07

per cent (14.9 billion dollars) in the 21 EU member states that belong to the OECD (OECD, 2025a: 216–217, figure 9.16). These data exclude general university funding subsequently allocated to health and most tax incentives (OECD, 2025a: 216), and differences in the recording of university funding complicate the comparison (NCSES, 2026: table 26, note a). On this count, nevertheless, Europe contributes markedly less than the United States. However, tax support adds to this. In 2023, Belgian tax support for business research amounted to 2.6 billion euros, or 0.43 per cent of GDP, combining a partial exemption from wage withholding tax for researchers, a tax credit for research investment and the innovation income deduction. On the comparison that includes both support for research expenditure and advantages on innovation income, this is the highest level in the OECD; comparable American measures amount to about 0.26 per cent of GDP in the latest available years (FPS Finance, 2026; OECD, 2025b; 2026). These measures apply across sectors, but pharmaceutical manufacturers are among their major users (Dumont, 2022: 33).

Europe also protects the revenues of successful development through patents, supplementary protection certificates and regulatory protection, which limit competition for specified periods. Unlike pricing and reimbursement, which remain national competences, these periods are set at European level. A manufacturer can therefore count on the same period of protected revenues throughout the Union, whatever the price differences between member states. That protection is also more generous than in the United States. A new medicine in the Union receives eight years of data protection and two years of market protection, against five years of data exclusivity in the United States; orphan medicines receive ten years of market exclusivity against seven; and the supplementary protection certificate extends the effective life of a patent to up to fifteen years after authorisation, against fourteen in the United States. Only for biological medicines does the United States protect for longer, for twelve years.[11]

The objection will be that Americans nevertheless pay more for innovation, and that Europeans benefit from it without paying their part. But American payments are not a decision to finance the world's research. As section 3 showed, they are the product of a domestic choice. The United States devotes 17.2 per cent of its GDP to health, more than any other country, and offers those who are well insured probably the best and most advanced medicine in the world, while millions of others have insecure access or none at all. European countries have made a different choice. They keep their population healthy through universal access, payment according to demonstrated value and prevention, and spend less on health care as a result. That is not unfair free riding; it is a different way of meeting an obligation to provide health care to citizens.

For sure, not accepting American prices as a benchmark for what Europe should spend on medicines does not mean that we think Europe spends 'enough'. It means that we need an independent assessment of the level of spending on medicines and pharmaceutical R&D that meets our societies' current and future needs. The authors of this paper are deeply convinced that we need to invest in healthcare and that this will require steadily increasing public budgets. However, summarising Dworkin's insight somewhat bluntly, we also think the sky is not the limit; and the economic literature does not provide an answer to questions about a sensible limit of spending on drugs. Lakdawalla (2018: 444) calls the question whether pharmaceutical innovation is too high or too low 'a first-order—perhaps the first-order—policy question', to which economists 'have not produced a definitive answer', although he thinks that the suggestive evidence points to innovators capturing only a small share of the value they create (2018: 420). Others infer from the high average returns to past pharmaceutical research that more research would be worthwhile (Ho and Pakes, 2024: 4). Notwithstanding scepticism about such arguments within the medical profession (e.g. The Lancet, 2025), we take the argument by these economists seriously. But average returns do not reveal the value of the marginal project, as Ho and Pakes (2024: 6) acknowledge, and in a health budget a euro spent on medicines is a euro not spent on other care that also saves lives. The question therefore requires an explicit answer of its own, rather than one inferred from American prices.

5. THE REMEDY: WILL MFN LOWER US PRICES AND PROVIDE FOR A MORE JUST GLOBAL DISTRIBUTION ON INNOVATION COSTS?

As a response to what it perceives as free-riding by other nations (the charge), the US government has enacted a policy of most-favoured-nation pricing, which links American medicine prices to those paid in other wealthy countries. Its appeal is straightforward. If Americans could obtain medicines at European prices, they would pay substantially less. Section 3.3 showed why that expectation is misplaced: once foreign prices act as a ceiling on the American price, manufacturers gain a strong reason to refuse lower prices abroad. In the model of Dubois, Gandhi and Vasserman (2022), reference countries' prices roughly triple while American prices fall by 7.5 to 15 per cent.[12]

What that would mean for a health system can be illustrated with Belgian figures. In 2025, compulsory health insurance in Belgium spent about 6.7 billion euros on medicines at net prices, its second-largest category of expenditure after fees for health professionals. About 4.4 billion euros, two thirds of the total, went to original medicines without generic or biosimilar competition, most of them still under patent, and about 70 per cent of the growth in net spending between 2020 and 2025 went to that segment.[13] That is the segment on which a price link would act. In the model, spending on patented medicines in the reference country rises by 43 per cent with a single reference country and by 37 per cent with a basket of six (Dubois, Gandhi and Vasserman, 2022: 71–72, tables 7.12 and 7.13). Applied to the Belgian segment, by our calculation, that would add 1.6 to 1.9 billion euros a year, depending on how the reference basket is composed, and before any further growth of the budget.[14]

Maintaining access at such prices would require substantial additional public revenue or reductions in other spending. Within health care, the additional payments would compete with staff, other treatments and prevention. If those resources were unavailable, access itself would suffer. The consequences would reach well beyond the medicines budget, putting pressure on the solidarity that universal insurance is designed to secure.

What would justify asking European patients and taxpayers to make that sacrifice? Not the fact that Americans pay more: section 3 showed that they do so because of the way their own market is organised, not because of a particular desire to support global innovation. Nor the charge of free riding: section 4 showed that a fair contribution cannot be measured by the American price, and that Europe contributes to innovation through its prices, its public research, its tax support and its protection of patents and market and data exclusivities. Nor the responsibility towards future patients: that responsibility requires a fair choice about what to devote to innovation by a government that has to make decisions about its budget at large.

The argument is symmetric, and this symmetry is a crucial point in our account of the American charge. *Should the United States choose to negotiate its own prices down, Europe could not claim that Americans are obliged to maintain high prices because European patients benefit from the innovation those revenues help support.* As the Dubois model showed, direct negotiation produces much larger American price reductions under the assumed bargaining conditions, without changing foreign prices. The Inflation Reduction Act of 2022 is an example of how the United States has pursued such policies for Medicare.

MFN thus risks imposing substantial costs on European health systems for comparatively modest American gains. Neither the difference in prices nor the responsibility to support innovation establishes an obligation to bear those costs. Europe may nevertheless have reasons of its own to invest more in pharmaceutical research and development, both to support valuable new treatments and to attract and retain the industry that develops them. That requires a European policy

directed at those objectives, with investment judged by what it achieves for patients and for Europe's capacity to develop and produce medicines.

6. IMPLICATIONS FOR EUROPEAN POLICY

Three policy implications follow from our argument, both at national and European level. The first concerns the defence of the European model; the second concerns the point at which Europe actually loses innovation; the third concerns the use of prices and levies as targeted incentives for research and production in Europe.[15]

6.1 Defending the European Health Care Model

The first implication is to defend the principles of universal access to health care and evidence-based, negotiated outcomes on pricing and reimbursement of medicines. Pricing and reimbursement are national responsibilities, but trade measures against one member state concern the Union as a whole, since commercial policy is a Union competence (TFEU, arts 3(1)(e), 168(7) and 207). A member state cannot answer a trade deterrent aimed at its health policies with its own trade deterrents. This would violate the European Treaties. The responsibility to defend the integrity of the European market thus falls to the European Commission.

As we discussed in section 1, the American administration pursues its policy on two fronts: a section 301 investigation into Germany's pricing legislation, which the Trade Representative had announced as the first of several covering most major trading partners (Reuters, 2026), and MFN agreements with manufacturers that link American prices to European ones. These agreements specifically provide for an escape clause incentivising companies to withdraw from other markets, and for a gain-sharing provision under which the US treasury gets a share of the price increases in third countries, which, as we saw, can be expected to be quite significant.

The Union has an instrument designed for this situation. Its anti-coercion instrument defines economic coercion as a third country applying or threatening a measure affecting trade or investment 'in order to prevent or obtain the cessation, modification or adoption of a particular act by the Union or a Member State, thereby interfering in the legitimate sovereign choices of the Union or a Member State' (Regulation (EU) 2023/2675, art. 2(1)).

To start the procedure, the Commission can open an investigation on its own initiative or upon a substantiated request, for instance from a member state, normally within four months (art. 4). The Council then determines, by qualified majority, whether coercion exists, within eight weeks and normally no more than ten (art. 5). The Commission must then seek a solution with the third country before any response measures are adopted (arts 6 and 8).[16]

The procedure is quite heavy, but already opening an examination would have an effect of its own. While the investigation runs, member states would hardly be in a position to strike separate deals with the USTR without undermining the European procedure. It would also signal to Washington that threatening member states for the way in which they organise their own health systems would be answered by Brussels.

The case should be built as coercion against the Union, not against Germany alone. As it stands, four member states are part of the basket of reference countries mentioned in the bilateral contracts between the administration and the companies; the Trade Representative has announced further section 301 investigations covering most major trading partners, pharmaceutical pricing among them (Reuters, 2026); and his annual report lists the pricing and reimbursement

policies of fourteen member states as a concern (USTR, 2026b: 26).[17] Moreover, the revenue-sharing clause in the Pfizer agreement gives the American government a direct financial interest in higher European prices. This gives enough reason for Brussels to act.

Complementary to this, two other tracks remain open for the EU to take, should new tariffs materialise as a result of a Section 301 investigation. The Union accepted at Turnberry an American tariff of at most 15 per cent on its medicines, and in return abolished its own duties on American industrial goods. Section 301 tariffs would come on top of that agreed ceiling. The regulation that implements the Union's side of the bargain allows the Commission to suspend those concessions if the United States fails to honour its commitments, in particular by imposing new duties on European goods (Regulation (EU) 2026/1455, art. 3(1)). The Commission should confirm that it would do so, should new duties be levied on member states.

The second track is the World Trade Organization. Tariffs that single out one member state breach the most-favoured-nation and bound-tariff obligations of the GATT (arts I and II), and the Union's legal position is strong. But the route is slow: in the Chinese case against the American section 301 tariffs, almost two and a half years passed between the request for consultations and the panel report (WTO, 2020). Even though the Appellate Body has not been functional since December 2019, the Union can take countermeasures under the enforcement regulation, but only once a panel has reported (Regulation (EU) 2021/167).

6.2 Closing the Gap in Capital and Scale

The second implication is to act where Europe actually loses innovation. Section 4 showed that Europe's contribution to innovation does not run only through prices. Where Europe does lose innovation is between discovery and development, where promising companies lack capital and scale. According to the Commission's analysis underpinning the Biotech Act, health-biotech venture funding in the Union between 2015 and mid-2025 was about 25 billion euros against 219 billion in the United States, and 66 of the 67 EU biotechnology companies that went public over the last six years listed abroad (European Commission, 2025: 2). The share of commercially sponsored clinical trials conducted in the European Economic Area fell from 22 per cent in 2013 to 12 per cent in 2023, while China's share rose from 5 to 18 per cent, and a multinational trial waits on average 113 days for a decision in the Union, against 60 days in most competing regions (European Commission, 2025: 3). These figures do not prove that European prices play no part, and there is indeed reason to believe that they do. But what these problems reveal most of all is a shortage of capital and scale, and a fragmented market that creates significant barriers to research.

The Biotech Act therefore proposes an investment pilot with the European Investment Bank that combines equity and venture debt tailored to the risks of biotechnology, a scheme to mobilise up to 10 billion euros of investment in 2026 and 2027 under InvestEU, and a late-stage capital booster meant to keep listings in Europe. It recognises strategic projects for accelerated permitting and support and shortens the authorisation of multinational clinical trials from 106 to 75 days, and to 47 days where the sponsor receives no questions (European Commission, 2025: 23–27 and recitals 44–48). The proposal also adds twelve months of supplementary protection for medicines developed by biotechnology processes and for advanced therapies (European Commission, 2025: chapter IV).

Whether these measures are sufficient is a fair question, and the answer will depend on their implementation. Belgium has argued that the financial instruments are too small and too loosely defined. But they are aimed at the right target and, if sufficiently funded, would provide a clear incentive to start-up companies to stay in Europe, rather than move

abroad with promising new technologies that are often brought about by European taxpayers' money in the first place. The Biotech Act must, of course, be seen in conjunction with other European initiatives, such as research funding, clinical research networks and usable health data, for which the European Health Data Space provides the framework (Regulation (EU) 2025/327).

6.3 A European Framework for Price Incentives?

Prices and levies can also play a part, on one condition: that they are targeted. Section 4.2 reported Dubois's estimate that European firms respond slightly more to European revenue than to American revenue, which he attributes to the local benefits of clinical research and manufacturing (2025a: 43). If that is right, part of what Europe pays reaches the firms based in Europe more directly than it reaches the others, and a reward tied to what a firm does in Europe is a far more precise instrument than the general price rise discussed in section 5. Until recently that idea was off limits: a public purchaser was to pay for what a medicine does, never for where it is made. The Critical Medicines Act, agreed in May 2026, breaks with that. For critical medicines whose supply depends heavily on one or a few third countries, it will oblige contracting authorities to favour manufacturing in the Union, by reserving part of the volume or by scoring tenders on the share of Union production (Council of the European Union, 2026c: art. 18(2)).

France and Germany are now applying the same logic to innovative medicines, but without a European framework. France grants a temporary price premium to new medicines with a demonstrated added benefit; its size depends first on the level of that benefit, and then also on how many of the hospitals that recruited patients for the pivotal trials were French (CEPS, 2026: art. 3). In Germany, an expert group convened by the federal government has proposed that the additional manufacturer rebate which the law of July 2026 imposes from 2027, the measure to which the American investigation objects (section 1), be reduced for firms that conduct clinical trials in Germany and research, invest or produce there (BMWE and BMG, 2026: 17–18). It remains to be seen whether the German proposal also gets translated into law.

Such national schemes nevertheless distort the internal market, since smaller member states can never match incentives in reimbursement schemes from bigger member states. The answer should therefore be a European framework rather than a series of national preferences: common definitions of what counts as research and production in the Union, credit for activity anywhere in the Union rather than only in the paying member state, and the Commission's control of state aid as the guardian. The French and German governments have themselves asked the Commission for a 'targeted and proportionate "European preference" in strategic sectors' (France and Germany, 2026: 3); this request warrants at least further investigation.

7. CONCLUSION

The United States' MFN policy not only risks imposing substantial costs on European health systems. The impact on European health care may be truly disruptive, both in terms of the budgetary consequences if prices rise as predicted by modelling exercises, and in terms of systemic impact, since fundamental features of European systems such as collective insurance and Health Technology Assessment are endangered. Because the stakes are so high, we have to examine the arguments deployed by the American administration carefully, without any complacency from our side. The argument boils down to three basic questions. Is it correct that Americans pay more for their medicines because Europeans pay less? Does Europe benefit unfairly from pharmaceutical innovation, leaving Americans to bear more than their fair share of its cost? Is most-favoured-nation-pricing, as the American administration sees it, the appropriate remedy?

Rational analysis shows that lower European prices do not by themselves raise American prices and that they do not reveal unfair free riding on American efforts. European medicine and health care prices, as compared to American prices are the result of a different foundational policy choice: European governments keep their population healthy through universal access, payment according to demonstrated value, and prevention; they spend less on health care as a result. Moreover, whilst MFN might disrupt European health care policies at large, the costs for Europe will come with comparatively modest American gains.

Hence, the rational analysis is both alarming for Europeans and sobering for Americans. It is also a call for action. Europe should defend its model of universal access and evidence-based, negotiated prices through the Union's instrument against economic coercion, rather than member state by member state. And it should act where it loses innovation, between discovery and development, by closing the gap in capital and scale. Finally, where prices and levies are used as incentives, they should be targeted at research and production in Europe, within a European framework rather than through national preferences.

References

Acemoglu, D. and Linn, J. (2004) 'Market size in innovation: theory and evidence from the pharmaceutical industry', Quarterly Journal of Economics, 119(3), pp. 1049–1090. doi:10.1162/0033553041502144.

Akerlof, G.A. (1970) 'The market for "lemons": quality uncertainty and the market mechanism', Quarterly Journal of Economics, 84(3), pp. 488–500. doi:10.2307/1879431.

Barr, N. (2020) The Economics of the Welfare State. 6th edn. Oxford: Oxford University Press.

BMWE and BMG (2026) Ergebnisbericht des Fachgremiums Standortklausel § 130a SGB V, 28 September. Berlin: Bundesministerium für Wirtschaft und Energie and Bundesministerium für Gesundheit.

Bunch, L.N. and Ketema, H. (2026) Health Insurance Coverage in the United States: 2025. Current Population Reports P60-291. Washington, DC: US Census Bureau. Available at: https://www.census.gov/library/publications/2026/demo/p60-291.html (Accessed: 16 September 2026).

CBO (2021) A Comparison of Brand-Name Drug Prices Among Selected Federal Programs. Washington, DC: Congressional Budget Office. Available at: https://www.cbo.gov/publication/56978 (Accessed: 22 October 2026).

CEPS (2026) Accord-cadre entre le Comité économique des produits de santé et les syndicats représentant les entreprises du médicament, 28 September. Paris: Comité économique des produits de santé.

Council of the European Union (2026a) Position of the Council at first reading with a view to the adoption of a Directive of the European Parliament and of the Council on the Union code relating to medicinal products for human use, and repealing Directives 2001/83/EC and 2009/35/EC. 7106/2/26 REV 2, 28 September. Brussels: Council of the European Union. Available at: https://data.consilium.europa.eu/doc/document/ST-7106-2026-REV-2/en/pdf (Accessed: 11 October 2026).

Council of the European Union (2026b) Position of the Council at first reading with a view to the adoption of a Regulation of the European Parliament and of the Council laying down Union procedures for the authorisation and supervision of medicinal products for human use and establishing rules governing the European Medicines Agency. 7105/2/26 REV 2, 28 September. Brussels: Council of the European Union. Available at: https://data.consilium.europa.eu/doc/document/ST-7105-2026-REV-2/en/pdf (Accessed: 11 October 2026).

Council of the European Union (2026c) Proposal for a Regulation of the European Parliament and of the Council laying down a framework for strengthening the availability and security of supply of critical medicinal products as well as the availability of, and accessibility of, medicinal products of common interest, and amending Regulation (EU) 2024/795: outcome of proceedings, final compromise text. Document 11059/26, 30 June. Brussels: General Secretariat of the Council.

Danzon, P.M., Wang, Y.R. and Wang, L. (2003) The Impact of Price Regulation on the Launch Delay of New Drugs: Evidence from Twenty-Five Major Markets in the 1990s. NBER Working Paper 9874, July. Cambridge, MA: National Bureau of Economic Research. doi:10.3386/w9874. Published in Health Economics, 14(3), 2005, pp. 269–292.

Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community code relating to medicinal products for human use, Official Journal of the European Communities, L 311, 28 November 2001, p. 67, as amended by Directive 2004/27/EC of the European Parliament and of the Council of 31 March 2004, Official Journal of the European Union, L 136, 30 April 2004, p. 34.

Draghi, M. (2024) The Future of European Competitiveness. Part B: In-depth Analysis and Recommendations, September. Brussels: European Commission. Available at: https://commission.europa.eu/topics/eu-competitiveness/draghi-report_en (Accessed: 17 September 2026).

Dubois, P. (2025a) Pharmaceutical Regulation and Incentives for Innovation in an International Perspective. TSE Working Paper 1674, December. Toulouse: Toulouse School of Economics.

Dubois, P. (2025b) 'Aligning drug prices and innovation: how global spillovers shape the future of medicines', VoxEU column, 2 December. London: Centre for Economic Policy Research. Available at: https://cepr.org/voxeu/columns/aligning-drug-prices-and-innovation-how-global-spillovers-shape-future-medicines (Accessed: 24 October 2026).

Dubois, P., de Mouzon, O., Scott-Morton, F. and Seabright, P. (2015) 'Market size and pharmaceutical innovation', RAND Journal of Economics, 46(4), pp. 844–871. doi:10.1111/1756-2171.12113.

Dubois, P., Gandhi, A. and Vasserman, S. (2022) Bargaining and International Reference Pricing in the Pharmaceutical Industry. NBER Working Paper 30053, May. Cambridge, MA: National Bureau of Economic Research. doi:10.3386/w30053.

Dumont, M. (2022) Public Support to Business Research and Development in Belgium: Fourth Evaluation. Report 12721, November. Brussels: Federal Planning Bureau.

Dworkin, R. (1993) 'Justice in the distribution of health care', McGill Law Journal, 38(4), pp. 883–898.

Egan, M. and Philipson, T.J. (2013) International Health Economics. NBER Working Paper 19280, August. Cambridge, MA: National Bureau of Economic Research. doi:10.3386/w19280.

Einav, L. and Finkelstein, A. (2011) 'Selection in insurance markets: theory and empirics in pictures', Journal of Economic Perspectives, 25(1), pp. 115–138. doi:10.1257/jep.25.1.115.

European Commission (2025) Proposal for a Regulation of the European Parliament and of the Council on establishing a framework of measures for strengthening Union's biotechnology and biomanufacturing sectors particularly in the area of health (European Biotech Act). COM(2025) 1022 final, 16 December. Strasbourg: European Commission.

Eurostat (2026) Government budget allocations for R&D by socioeconomic objectives (NABS 2007) (gba_nabsfin07). Luxembourg: Eurostat. Available at: https://ec.europa.eu/eurostat/databrowser/view/gba_nabsfin07/default/table (Accessed: 28 September 2026).

Executive Office of the President (2025) 'Executive Order 14297 of May 12, 2025: Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients', Federal Register, 90(93), pp. 20749–20751, 15 May. Available at: https://www.federalregister.gov/documents/2025/05/15/2025-08876/delivering-most-favored-nation-prescription-drug-pricing-to-american-patients (Accessed: 16 September 2026).

Federal Trade Commission (2024a) Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. Interim staff report, July. Washington, DC: FTC. Available at: https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf (Accessed: 16 September 2026).

Federal Trade Commission (2024b) FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices. Press release, 20 September. Washington, DC: FTC. Available at: https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices (Accessed: 20 October 2026).

Federal Trade Commission (2026) FTC Secures Landmark Settlement with Express Scripts to Lower Drug Costs for American Patients. Press release, 4 February. Washington, DC: FTC. Available at: https://www.ftc.gov/news-events/news/press-releases/2026/02/ftc-secures-landmark-settlement-express-scripts-lower-drug-costs-american-patients (Accessed: 20 October 2026).

FPS Finance (2026) Inventaris 2024 van de vrijstellingen, aftrekken en verminderingen die de ontvangsten van de Staat beïnvloeden. Parliamentary document DOC 56 1279/002, 28 January. Brussels: Chamber of Representatives. Available at: https://www.lachambre.be/flwb/pdf/56/1279/56K1279002.pdf (Accessed: 29 September 2026).

France and Germany (2026) Strengthening European Resilience, Addressing Global Macroeconomic Imbalances and Market Distorting Practices. French-German non-paper, 5 October. Unpublished, on file with the authors.

Frech, H.E., Pauly, M.V., Comanor, W.S. and Martinez, J.R. (2026) 'Pharmaceutical pricing and R&D as a global public good', Health Economics, 35(8), pp. 1158–1174. doi:10.1002/hec.70105. First circulated as NBER Working Paper 31272 (2023).

Haute Autorité de Santé (2026) Accès précoce à un médicament. Saint-Denis: HAS. Updated 1 September 2026. Available at: https://www.has-sante.fr/jcms/r_1500918/fr/acces-precoce-a-un-medicament (Accessed: 25 September 2026).

HHS and Eli Lilly (2026) Most Favored Nation Drug Pricing Agreement between the U.S. Department of Health and Human Services and Eli Lilly and Company, signed 18 and 23 February. Obtained by Public Citizen under the Freedom of Information Act and published, in redacted form, on 19 September 2026. Available at: https://www.citizen.org/wp-content/uploads/HHS-Eli-Lilly-MFN-Agreement-Final_2.17.2026_Fully-Executed-Redacted-Copy.pdf (Accessed: 26 September 2026).

HHS and Pfizer (2026) Most Favored Nation Drug Pricing Agreement between the U.S. Department of Health and Human Services and Pfizer Inc., signed 18 and 23 February. Obtained by Public Citizen under the Freedom of Information Act and published, in redacted form, on 19 September 2026. Available at: https://www.citizen.org/wp-content/uploads/HHS-Pfizer-MFN-Agreement-Final_2.17.26_HHS-Pfizer-Signed-Redacted-Copy.pdf (Accessed: 26 September 2026).

Ho, K. and Pakes, A. (2024) Policy Options for the Drug Pricing Conundrum. NBER Working Paper 32606, June, revised September. Cambridge, MA: National Bureau of Economic Research. doi:10.3386/w32606.

Hwang, T.J., Hediger, S., Krishnan, A., Cai, C.L., Kesselheim, A.S. and Vokinger, K.N. (2026) 'Most-favoured-nation pricing for prescription drugs in US Medicare: a cohort study', The Lancet, 408(10562), pp. 1337–1345. doi:10.1016/S0140-6736(26)01555-2.

KCE (2024) Performance of the Belgian Health System, Indicator A-1: Compulsory Health Insurance Coverage. Brussels: Belgian Health Care Knowledge Centre. Available at: https://www.belgiqueenbonnesante.be/metadata/hspa/2024/A1.pdf (Accessed: 25 September 2026).

Kyle, M.K. (2022) 'Incentives for pharmaceutical innovation: what's working, what's lacking', Journal du Droit de la Santé et de l'Assurance-Maladie, 35, pp. 24–40. doi:10.3917/jdsam.225.0024. First published in International Journal of Industrial Organization, 84, 102850. doi:10.1016/j.ijindorg.2022.102850.

Kyle, M.K. (2025) 'Lessons for the United States from pharmaceutical regulation abroad', Journal of Economic Perspectives, 39(2), pp. 53–78. doi:10.1257/jep.20241418.

Kyle, M.K., Ridley, D.B. and Zhang, S. (2017) 'Strategic interaction among governments in the provision of a global public good', Journal of Public Economics, 156, pp. 185–199. doi:10.1016/j.jpubeco.2017.10.009.

Lakdawalla, D.N. (2018) 'Economics of the pharmaceutical industry', Journal of Economic Literature, 56(2), pp. 397–449. doi:10.1257/jel.20161327.

Mulcahy, A.W., Schwam, D. and Lovejoy, S.L. (2024) International Prescription Drug Price Comparisons: Estimates Using 2022 Data. RR-A788-3. Santa Monica, CA: RAND Corporation. Available at: https://www.rand.org/t/RRA788-3 (Accessed: 16 September 2026).

Mulcahy, A.W., Whaley, C., Tebeka, M.G., Schwam, D., Edenfield, N. and Becerra-Ornelas, A.U. (2021) International Prescription Drug Price Comparisons: Current Empirical Estimates and Comparisons with Previous Studies. RR-2956-ASPEC. Santa Monica, CA: RAND Corporation.

National Center for Science and Engineering Statistics (NCSES) (2026) Federal R&D Funding, by Budget Function: Fiscal Years 2024–26. NSF 26-309, table 26, 10 March. Alexandria, VA: National Science Foundation. Available at: https://ncses.nsf.gov/pubs/nsf26309 (Accessed: 11 October 2026).

OECD (2025a) Health at a Glance 2025: OECD Indicators. Paris: OECD Publishing. doi:10.1787/8f9e3f98-en.

OECD (2025b) Income-based R&D tax incentives reduce firms' tax liabilities by 35% on average in OECD countries in 2024. Statistical release, 25 November. Paris: OECD. Available at: https://www.oecd.org/en/data/insights/statistical-releases/2025/11/income-based-rd-tax-incentives-reduce-firms-tax-liabilities.html (Accessed: 11 October 2026).

OECD (2026) Government support for business R&D approaches record highs as R&D tax incentives expand across the OECD. Statistical release, 25 June, with the OECD R&D Tax Incentives Database. Paris: OECD. Available at: https://www.oecd.org/en/data/insights/statistical-releases/2026/06/government-support-for-business-rd-approaches-record-highs-as-rd-tax-incentives-expand-across-the-oecd.html (Accessed: 11 October 2026).

Olson, M. and Zeckhauser, R. (1966) An Economic Theory of Alliances. Memorandum RM-4297-ISA, October. Santa Monica, CA: RAND Corporation. A shorter version was published in Review of Economics and Statistics, 48(3), 1966, pp. 266–279.

Pertile, P., Gamba, S. and Forster, M. (2018) Free-Riding in Pharmaceutical Price Regulation: Theory and Evidence. Discussion Papers in Economics 18/04. York: Department of Economics and Related Studies, University of York.

Regulation (EC) No 141/2000 of the European Parliament and of the Council of 16 December 1999 on orphan medicinal products, Official Journal of the European Communities, L 18, 22 January 2000, p. 1.

Regulation (EC) No 469/2009 of the European Parliament and of the Council of 6 May 2009 concerning the supplementary protection certificate for medicinal products, Official Journal of the European Union, L 152, 16 June 2009, p. 1.

Regulation (EU) 2021/167 of the European Parliament and of the Council of 10 February 2021 amending Regulation (EU) No 654/2014 concerning the exercise of the Union's rights for the application and enforcement of international trade rules, Official Journal of the European Union, L 49, 12 February 2021, p. 1.

Regulation (EU) 2023/2675 of the European Parliament and of the Council of 22 November 2023 on the protection of the Union and its Member States from economic coercion by third countries, Official Journal of the European Union, L, 7 December 2023.

Regulation (EU) 2025/327 of the European Parliament and of the Council of 11 February 2025 on the European Health Data Space, Official Journal of the European Union, L, 5 March 2025.

Regulation (EU) 2026/1455 of the European Parliament and of the Council of 25 June 2026 on the adjustment of customs duties on imports of certain goods originating in the United States of America and opening of tariff quotas for imports of certain goods originating in the United States of America, Official Journal of the European Union, L, 30 June 2026.

Reuters (2026) 'USTR expects new Section 301 probes to cover most major trading partners', 20 February. Published on Investing.com. Available at: https://www.investing.com/news/economy-news/ustr-expects-new-section-301-probes-to-cover-most-major-trading-partners-4517414 (Accessed: 22 October 2026).

Social Security Act, §1927 (42 U.S.C. §1396r-8) and §1860D-4(b)(3)(G) (42 U.S.C. §1395w-104(b)(3)(G)).

Sozialgesetzbuch Fünftes Buch (SGB V), §§130a and 130b, as amended by the Gesetz zur Stabilisierung der Beitragssätze in der gesetzlichen Krankenversicherung (GKV-Beitragssatzstabilisierungsgesetz) of 24 July 2026, Bundesgesetzblatt 2026 I No. 228, 29 July. Available at: https://www.recht.bund.de/eli/bund/bgbl-1/2026/228 (Accessed: 11 October 2026).

The Lancet (2025) 'Drug pricing and pharmaceutical innovation: a false promise', editorial, The Lancet, 406, p. 1923. doi:10.1016/S0140-6736(25)02160-9.

Trade Act of 1974, §§301 and 304 (19 U.S.C. §§2411 and 2414).

Treaty on the Functioning of the European Union (consolidated version), Official Journal of the European Union, C 202, 7 June 2016, pp. 47–388.

United States Code: 21 U.S.C. §355(j)(5)(F)(ii) and §360cc; 35 U.S.C. §156(c)(3); 42 U.S.C. §262(k)(7).

USTR (2026a) 'Initiation of Section 301 investigation; hearing; and request for public comments: Germany's persistent underpayment for innovative pharmaceutical products', Federal Register, 91(120), pp. 38072–38074, 24 June. Available at: https://www.federalregister.gov/documents/2026/06/24/2026-12671/initiation-of-section-301-investigation-hearing-and-request-for-public-comments-germanys-persistent (Accessed: 16 September 2026).

USTR (2026b) 2026 Special 301 Report. Washington, DC: Office of the United States Trade Representative, April. Available at: https://ustr.gov/sites/default/files/files/Press/Releases/2026/2026%20Special%20301%20Report.pdf (Accessed: 21 October 2026).

Vandenbroucke, F. (2026) Eerste medicijn via nieuwe Early and Equitable Fast Access-procedure goedgekeurd. Press release, 1 July. Brussels. Available at: https://vandenbroucke.belgium.be/nl/nieuws/eerste-medicijn-nieuwe-early-and-equitable-fast-access-procedure-goedgekeurd (Accessed: 25 September 2026).

White House (2026) Fact Sheet: President Donald J. Trump Announces Deal with Nine Additional Pharmaceutical Manufacturers to Lower Drug Prices for Americans, 31 August. Washington, DC: The White House. Available at: https://www.whitehouse.gov/fact-sheets/2026/08/fact-sheet-president-donald-j-trump-announces-deal-with-nine-additional-pharmaceutical-manufacturers-to-lower-drug-prices-for-americans/ (Accessed: 18 October 2026).

WTO (2020) United States – Tariff Measures on Certain Goods from China. Report of the Panel, WT/DS543/R, 15 September. Geneva: World Trade Organization.

Endnotes

1 Medicare is the federal health insurance programme primarily serving people aged 65 and over, as well as certain younger people with disabilities. Medicaid provides health coverage to eligible low-income populations and is jointly funded by the federal government and the states.

2 The Lilly and Pfizer agreements were released in redacted form following a Freedom of Information Act request. Under the Lilly agreement, the Medicaid price of covered medicines may not exceed the second-lowest net price, adjusted for national income, in a basket of eight countries, including four EU member states (HHS and Eli Lilly, 2026: ss. 1.17, 1.18, 1.24 and 2.1.1). The terms of the contract suggest that the MFN obligations extend beyond Medicaid for newly launched products. Section 5.1 of the Pfizer agreement provides for sharing additional revenue from higher net prices outside the United States from 2026 onwards, but the share is redacted. In the Lilly agreement only the heading of the corresponding section is legible; its content is redacted (HHS and Pfizer, 2026: 11; HHS and Eli Lilly, 2026: 21–23). Pfizer must also report each quarter which newly launched medicines obtained a marketing authorisation or a pricing or reimbursement decision abroad (HHS and Pfizer, 2026: s. 8.6).

3 These are the most recent comparable data. The earlier edition, for 2018 (Mulcahy et al., 2021), is the one Frech et al. (2026) use in section 4. Note that these figures come with important limitations on the quality of datasets. The adjustment for American rebates is partial, since it covers only brand-name medicines dispensed in retail pharmacies, and the confidential discounts negotiated in other countries are not observed at all. This limitation is common to all studies in the field: finding reliable data that allow for meaningful comparisons of net prices is difficult, if not impossible.

4 This pertains to respectively the European Medicines Agency (EMA) and the US Food and Drug Administration (FDA). In Europe, older medicines may still be regulated under the responsibility of national regulators.

5 Olson and Zeckhauser use 'larger' for the nation that places the higher absolute value on the collective good, and note that this need not coincide with size measured by national product (1966: 9). Their empirical test nevertheless uses gross national product as the measure of size. In practice the two usually go together: a country with more people who benefit from the good values it more in total.

6 Linkages between national markets are not an American invention, although the American MFN policy is a very brutal version of it, as explained earlier. Many European countries reference one another's prices, and parallel trade is lawful within the single market; both give manufacturers reasons to delay launches in low-price markets or to keep official prices above what is actually paid (Kyle, 2025: 62–63, 66; Dubois, 2025a: 34). Small markets such as Belgium are among those most often referenced (Kyle, 2025: 63). These linkages concern countries of comparable income that each assess and negotiate prices, and their scale bears no comparison with a link to the American market. But they confirm the point: once prices are tied together, the smaller market bears the adjustment.

7 Frech et al. take their price indices from RAND's comparison for 2018 (Mulcahy et al., 2021). The most recent edition, for 2022, is the one used in section 2. On those data the gap is wider, 308 rather than 230 per cent after the adjustment for American rebates. Incorporating the more recent figures into the authors' framework would further reduce the European share. RAND cautions, however, against comparing the two editions, since the 2022 edition applies the rebate adjustment only to brand-name medicines dispensed in retail pharmacies (Mulcahy, Schwam and Lovejoy, 2024: 26–27).

8 Dworkin develops a hypothetical insurance market in which people, knowing what medicine knows but not their own risks, decide which cover to buy under fair conditions. He is explicit that prudent people would not insure for every conceivable treatment, and gives life support for someone in a persistent vegetative state as an example (Dworkin, 1993: 888–891).

9 Many countries have independent institutions that carry out these assessments, such as NICE in England, the Zorginstituut in the Netherlands, the Haute Autorité de Santé in France and IQWiG in Germany. In Belgium the assessment is made within the national health insurance institute (RIZIV-INAMI), whose recommendations are submitted to a commission of health care providers, academics and insurers before the minister decides. The Belgian Health Care Knowledge Centre (KCE) also carries out Health Technology Assessments, on request or on its own initiative.

10 The literature on regulation and pricing of pharmaceuticals makes a distinction between the 'static efficiency' of these policies (i.e. their impact on access and affordability of existing medicines) and the 'dynamic efficiency' (i.e. its impact on innovation). Borrowing from that terminology, our section 4.1 is about 'static' aspects of justice in health care, whilst section 4.2. is about 'dynamic' aspects of justice in health care.

11 Directive 2001/83/EC, art. 10(1); Regulation (EC) No 141/2000, art. 8; Regulation (EC) No 469/2009, art. 13. United States: 21 U.S.C. §355(j)(5)(F)(ii); 21 U.S.C. §360cc; 35 U.S.C. §156(c)(3); 42 U.S.C. §262(k)(7). The revised EU pharmaceutical legislation, agreed in December 2025, retains eight years of data protection but reduces basic market protection from two years to one, with a second year for medicines addressing unmet medical needs or meeting specified conditions, and a further year for a new indication with significant clinical benefit.

Standard orphan market exclusivity falls from ten to nine years, with eleven years for breakthrough orphan medicines. These periods apply to applications submitted from two years after entry into force; earlier applications retain the existing periods (Council of the European Union, 2026a: arts 83–84 and 221(5); 2026b: arts 73, 186(10) and 187).

12 Ho and Pakes (2024) make a related argument. They estimate that if each branded medicine had a single price across the richest OECD countries, with total revenue unchanged, American prices would fall by about half while prices elsewhere would rise by 28 to more than 300 per cent; Belgian prices would roughly double (2024: 8, appendix table 1). They propose using access to Medicare as a lever to raise European prices (2024: 9–11). Their benchmark, however, holds current global revenue constant, and thereby treats the present level of payments, driven by American prices, as the right one (2024: 8). A single price also disregards differences in income. They acknowledge that many countries 'might have to find alternative ways of providing their citizens the minimal level of health care that they require' (2024: 8). That is precisely the disruption we fear.

13 RIZIV, reimbursement data per product (Farmanet and hospital data, 2025) and compensations under articles 81 and 111 of the law on compulsory health insurance; hospital data for 2025 extrapolated by RIZIV to a full year. Medicines without competition are originals for which no generic or biosimilar of the same molecule is sold in Belgium; compensations are attributed to that segment pro rata.

14 This is an illustration of scale, not a forecast. Several reservations must be made. First, the model's parameters were estimated on American and Canadian hospital sales between 2002 and 2013, not on Belgian data. Second, the model is static: it assumes that every medicine remains available and takes no account of withdrawals or launch delays. Third, the authors also stress that the size of the effect depends on the number and size of the reference countries, the competitive structure of each therapeutic class, demand elasticities, the bargaining power of regulators and the details of the rule (2022: 3, 27, 30). Importantly, they identify market size as a key driver: the smaller the reference market relative to the American one, the larger its price rise. Belgium's market is a fraction of Canada's. On that count the Canadian figures are more likely to understate the effect for Belgium than to overstate it.

15 This paper focuses on the need for an effective and strong European response to MFN. This is, in a non-cooperative world, alas a matter of urgency. But our argument does not reject international cooperation. Several economists who regard pharmaceutical innovation as a global public good propose coordinated instruments: shared financing of rewards where commercial returns are low, as for new antibiotics; coordinated exclusivity extensions; coordinated value-based pricing; and agreements on launch sequencing (Dubois, 2025a: 44; 2025b; Kyle, 2022: 38–39). Such cooperation differs fundamentally from most-favoured-nation pricing. It starts from agreed objectives and shared assessments of value, rather than from a unilateral price link enforced through trade pressure.

16 Response measures are adopted by the Commission by implementing act under the examination procedure, so that the member states can block them by qualified majority (arts 8(1) and 18(2)). Annex I lists the possible measures: customs duties, restrictions on trade in goods and services, on investment, on intellectual property rights, on access to public procurement and on financial services. The regulation presents response measures as a last resort; its first aim is deterrence (art. 1(2) and recital 8).

17 The report names Austria, Belgium, the Czech Republic, France, Greece, Germany, Hungary, Ireland, Italy, Poland, Romania, Slovakia, Spain and Sweden. Referring to the executive order on most-favoured-nation prices, it objects to 'non-transparent procedures' in pricing and reimbursement and to 'clawback' regimes that require companies to reimburse the government when spending on medicines exceeds a budgetary cap, and it describes the British agreement of 1 December 2025 as 'a positive development' that 'may serve as model for other trading partners' (USTR, 2026b: 26).



The opinions expressed in this Publication are those of the author(s) alone, and they do not necessarily reflect the views of the Egmont Institute. Founded in 1947, EGMONT – Royal Institute for International Relations is an independent and non-profit Brussels-based think tank dedicated to interdisciplinary research.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the permission of the publishers.

www.egmontinstitute.be

© Egmont Institute, October 2026
© Author(s), October 2026