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Information on the Market Environments of Asian Economies

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## Abbreviation

Abbreviation	Description
A*STAR	Agency for Science, Technology and Research (Singapore)
AADHAR	The name of "Personal Identity Card"
ABHIM	Ayushman Bharat Health Infrastructure Mission (India)
ACE	Agency for Care Effectiveness
ALPS	Agency for Logistics and Procurement Services (Singapore's central procurement agency)
AMED	Japan Agency for Medical Research and Development
APEC	Asia-Pacific Economic Cooperation
ASCI	Advertising Standards Council of India
BioPIPS	Biologics Pharma Innovation Programme Singapore
BIS	Bureau of Indian Standards
BMP	Corporate Benefit Weight (Indonesia)
BPJS	Badan Penyelenggara Jaminan Sosial (National Health Insurance System)
BPL	Below Poverty Line
B POM	the National Agency of Drug and Food Control in Indonesia
BPS	Statistics Indonesia
CAGR	compounded annual growth rate
CAPA	Chinese Association for Pharmaceutical Agents
CDE	Center for Drug Evaluation
CDF	Cancer Drug Fund (Taiwan)
CDSCO	Central Drugs Standards Control Organization
CEA	cost-effectiveness analysis
CECA	Comprehensive Economic Cooperation Agreement
CGHS	Central Government Health Scheme
CGMH-LK	Chun-Guang Memorial Hospital
CHAS	Community Health Assist Scheme
CL	Compulsory Licenses
CMA	cost minimization analysis
CME	Continuing Medical Education (India)
CMO	Contract Manufacturing Organization
CoB	Coordination of Benefit (Indonesia)
CPC	Communist Party of China
CPF	Central Provident Fund
CPI	Consumer Price Index
CPTPP	Comprehensive and Progressive Agreement for Trans-Pacific Partnership
CRO	Contract Research Organization
CSM	Coalition for Safe Medicines
CSMBS	Civil Servants Medical Benefit Scheme in Thailand
CUA	Cost Utility Analysis
DAC	Drug Advisory Committee
DAV	Drug Administration of Vietnam
DAVA	Drugs Authentication and Verification Application
DCA	Drug and Cosmetics Act
DCGI	Drug Controller General of India
DCR	Drugs and Cosmetic Rules
DE	Data Exclusivity
DET	Drug Expenditure Target

Abbreviation	Description
DGFT	Directorate General of Foreign Trade
DHR	Department of Health Research
DI	Drug Intermediates (India)
DIP	Department of Intellectual Property
DIPP	India Department of Industrial Policy & Promotion
DOH	Department of Health
DPCO	Drugs Price Control Order
DPRB	Drug Price Regulatory Board
DRG	Diagnosis Related Groups
EDB	Economic Development Board (Singapore)
EPCG	Export Promotion Capital Goods
EPF	Employees Provident Fund
ESIS	Employment State Insurance Scheme
FDA	Food and Drug Administration
FDI	Foreign Direct Investment
FIE Importer	Foreign Investment Enterprise
FORNAS	National Formulary (Indonesia)
FTA	US Free Trade Agreement
GAMOT	Guaranteed and Accessible Medications for Outpatient Treatment (Philippines)
GCP	Good Clinical Practice
GDP	Good distribution practices
GDUFA	Generic Drug User Fee Act
GFATM	Global Fund to fight AIDS, TB and Malaria
GLP	Good Laboratory Practice
GoM	Group of Ministers
GPFI	GP Farmasi
GPO	Group Procurement Office
GPP	Good Pharmacy Practice
GSP	Good Supply Practice
GTIN	global trade identification number
HIRA	Health Insurance Review and Assessment Service
HITAP	Health Intervention Technology Assessment Program
HKAPI	Hong Kong Association of the Pharmaceutical Industry
HKSAR	Hong Kong special administrative region
HPS	Self-estimated price
HSA	Health Science Authority
HTA	Health technology assessment
IA	Insurance Authority
ICER	Incremental cost-effectiveness ratio
ICMR	Indian Council of Medical Research (India)
ICP	Internet content provision
IDMA	Indian Drug Manufacturers 'Association
IFPMA	International Federation of Pharmaceutical Manufacturers & Associations
IJSRM	International Journal of scientific research and management
INA-CBG	Indonesia Case Based Groups
INDQC	National Institute of Drug Quality Control of Vietnam
IP	Intellectual Property

Abbreviation	Description
IPD	Individual Participant Data
IPMG	International Pharmaceutical Manufacturers Group
IPO	Intellectual Property Office
IPOPHL	Intellectual Property Office of the Philippines
IPR	Intellectual Property Rights
IRPMA	International Research-Based Pharmaceutical Manufacturers Association
JAMSOSTEK	Jaminan Sosial Tenaga Kerja (Indonesia)
JETRO	Japan External Trade Organization
JHIA	Japan Health Insurance Association
JKMA	Japan Kampo Medicine Manufacturers Association
JKN	Jaminan Kesehatan Nasional (National Health Insurance)
JST	Japan Science and Technology Agency
KHIDI	Korea Health Industry Development Institution
KIPO	Korean Intellectual Property Office
KKI	Indonesian Medical Council
KOSIS	Korean Statistical Information Service
KPBMA	Korea Pharmaceutical and Bio-Pharma Manufacturers Association
KRPIA	Korean Research -based Pharmaceutical Industry Association
KSM	Key Starting Materials (India)
LKPP	The Government Goods / Services Procurement Policy Institution in Indonesia
LPNK	a Non-Ministry Government Institution in Indonesia
LTCI	Long Term Care Insurance
MA	marketing authorisation
MAF	Medication Assistance Fund
MAH	Marketing Authorization Holder
MCDA	MultiCriteria Decision Analysis
MCI	Medical Council of India
MDD / GAD	Major Depressive Disorder / Generalised Anxiety Disorder (Singapore)
MEA	Managed Entry Agreement
MFDS	Ministry of Food & Drug Safety
MHLW	Ministry of Health and Welfare
MIDA	Malaysian Industry Development Authority
MOH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MoLHR	A Ministerial regulations in Indonesia
MoPH	Ministry of Public Health in Thailand
MRP	Maximum Retail Price
MTAB	medical technology assessment board
MWP	Maximum Wholesale Price
MyIPO	Intellectual Property Corporation of Malaysia
NADFC	National Agency of Drug and Food Control in Indonesia
NAIS	National Adult Immunisation Schedule
NCIS	National Childhood Immunisation Schedule
NCKUH	National Cheng Kung University Hospital in Taipei
ND-CP	Government Decree (Nghị định Chính phủ)
NDSDC	National Drug System Development Committee
NEDO	New Energy and Industrial Technology Development Organization

Abbreviation	Description
NEML	National Essential Medicines List
NHC	National Health Commission of China
NHI	National Health Insurance
NHIA	National Health Insurance Administration
NHIS	National Health Insurance Service
NHS	National Health Security
NHSA	National Healthcare Security Administration
NIC	National Informatics Center
NICE	National IP Center for Enforcement
NLEM	National List of Essential Medicines
NMC	National Medical Commission (India)
NMPA	National Medical Products Administration
non-SSI	non-small scale industry
NPCA	National Pharmaceutical Commercial Association of R.O.C
NPPA	National Pharmaceutical Pricing Authority
NRDL	National Reimbursement Drug List
NRL	National Reimbursement List
NTU / NUS / SIT	Nanyang Technological University / National University of Singapore / Singapore Institute of Technology
NTUH	National Taiwan University Hospital
OECD	Organization for Economic Cooperation and Development
OOP	Out of Pocket
OPD	OutPatient Department
OPPI	Organization of Pharmaceutical Producers of India
OTC	Over the counter
PAN	Personal Identity Card
PBI	Medical insurance for low-income people in Indonesia
PBRIS	Pharmaceutical Benefit and Reimbursement Scheme
PCHI	Per Capita Household Income
PCN	Primary Care Network
PCPI	Philippine Chamber of Pharmaceutical Industry
PCT	Patent Cooperation Treaty
PE	Pharmacoeconomics evaluation
PHAP	Pharmaceutical and Healthcare Association of the Philippines
PhIRDA	China Pharmaceutical Innovation and Research Development Association
PLI	Production Linked Incentive (India)
PMS	Post Marketing Surveillance
PPDS	Pharma Promotion and Development Scheme
PPMA	Philippine Pharmaceutical Manufacturers Association
PPMIs	Privately Purchased Medical Items
PPP	Purchasing Power Parities
PReMA	Pharmaceutical Research & Manufacturers Association
Private Insurance	Organization issuing private insurance
PSP	Pharmaceutical Services Program
PSS	Pharmaceutical Society of Singapore
PVA	Price Volume Agreement
PVS	Price & Volume survey
QALY	Quality Adjusted Life Year

Abbreviation	Description
RCEP	Regional Comprehensive Economic Partnership Agreement
RDP	Regulatory Data protection
RDPAC	R&D-based Pharmaceutical Association Committee
ROC	Republic Of China
RSA	Risk Sharing Agreements
RSBY	Rashtriya Swasthiya Bima Yojana
SCL	Special Comprehensive License
SDL	Standard Drugs List
SHI	social health insurance
SMEs	Small and Medium-sized Enterprises
SMP	Safety Monitoring Period
SOP	standard operating procedures
SRA	Stringent Regulatory Authority
SSS	Social Security Scheme
State Insurance	Respective State Government
TCMs	Traditional Chinese Medicines
TFDA	Taiwan Food and Drug Administration
TGPA	Taiwan Generic Pharmaceutical Association
THAIMED	The Medical Device Technology Industry Association
TIPO	Taiwan Intellectual Property Office
TKDL	Traditional Knowledge Digital Library
TKDN	Local Content Requirement in Indonesia
TNMSC	Tamilnadu State Medical Services corporation
TPA	Third-Party Agents (Malaysia)
TPADA	Taipei Pharmaceutical Agents and Distributors Association
TPIL	Therapeutic Products Importer's Licence
TPMA	Thai Pharmaceutical Manufacturers Association
TPMDA	Taiwan Pharmaceutical Manufacture & Development Association
TPMMA	Taiwan Pharmaceutical Marketing & Management Association
TPWL	wholesaler's licence for therapeutic products
TRIPS	TradeRelated Aspects of Intellectual rights
TRPMA	Taiwan Research-based Biopharmaceutical Manufacturers Association
TSMIA	Thai Self Medication Industry Association
UCPMP	Uniform code for Pharmaceutical Marketing Practices
UCS	Universal Health Coverage Scheme
UHC	Universal Health Coverage
UMA(A)O	Undesirable Medical Advertisements (Amendment) Ordinance
VAT	Value Added Tax
VNPCA	Vietnam Pharmaceutical Companies Association
WHO	World Health Organization

## EXECUTIVE SUMMARY

China	RDPAC/PhIRDA	1. 2025 NRDL was carried out and the results was released by the National Healthcare Security Administration on December 7, 2025. A total of 114 drugs will be added to a revised NRDL, including 50 Category-1 innovative drugs. In addition, 19 drugs will be included into the first edition of Commercial Health Insurance List for Innovative Drugs.
Hong Kong	HKAPI	
India	OPPI	No major changes from 2018
Indonesia	IPMG	Further progress made in Indonesia throughout 2025: 1. Universal health coverage has hit 281.6 million people (98.7% of total Indonesian population). Newer coordination of benefit (CoB) scheme is now in place, which will allow private insurance providers as the secondary payer in the system, opening up access to previously unaffordable treatments, despite challenges in its implementation. 2. Directorate General for Pharmaceutical and Medical Devices Decree No. HK.02.02/E/1786/2025 formalizing the Working Group for the Availability, Accessibility and Affordability of Innovative Medicines signed on 2 October 2025. Drafting of the National Strategy is underway, involving cross-ministry, academia, and practitioner consultations. The National Strategy is aimed to be legalized at the level of a Presidential Decree in Q2 2026. 3. The Stakeholder-Led Submission (SLS) HTA piloting process has concluded, paving the way for the drafting of a formal technical guidance for the SLS process. The guidance is aimed to be legalized at the level of a Ministerial Decree at early 2026. 4. Regulatory: formalization of the e-labeling practice after the end of its pilot phase and acceleration of drug registration process utilizing the reliance pathway with an expansion of acknowledged reference countries (7 countries).
Japan	JPMA	Since 2024, the Japanese government has designated the pharmaceutical industry capable of driving economic growth, recognizing it to be “a value-added” and “knowledge-intensive ” industry that leverages leading-edge basic and applied research and digital technologies across its entire value chain from R&D to manufacturing and distribution. The newly inaugurated Takaichi Cabinet has declared its intention to further advance this policy.
Korea	KPBMA/KRPIA	In late 2025, the Korean Government announced a comprehensive reform package aimed at rebalancing the pharmaceutical pricing system toward innovation and essential medicines, while strengthening cost containment for generics and patent-expired products. The reform agenda reflects growing fiscal pressure on the National Health Insurance (NHI) system alongside policy recognition of the need to improve patient access to innovative therapies. Key policy directions include recalibration of generic pricing toward approximately 40% of originator prices, the introduction of step-down mechanisms in highly saturated generic markets, and measures to secure fiscal space for new and innovative medicines through reform of pricing for already-listed products. The Government also signaled plans to accelerate reimbursement pathways for rare and severe diseases, aiming to shorten listing timelines and streamline evaluation and negotiation processes for medicines addressing high unmet medical needs. In parallel, policy discussions advanced on the introduction of a flexible pricing contract model, which would allow differentiation between list prices and transaction (net) prices, balancing international price referencing considerations with domestic budget management.
Malaysia	PhAMA	In 2025, Malaysia’s innovator pharmaceutical industry is <b>growing yet constrained</b> within a healthcare ecosystem that prioritises <b>generic and biosimilar medicines under a generic-first policy</b> , which the Ministry of Health applies to cost-containment in public procurement. This policy supports affordability and broad access but <b>dampens market incentives for originator drug launches</b> , as government tenders and price controls exert downward pressure on margins and reduce commercial returns for innovator companies, potentially delaying or deterring new product introductions. Cost-containment policies, including generic-first procurement practices, will continue to exert margin pressure on originator products in 2026. Competitive pressures from global generics and regional producers may further encourage Malaysian companies to <b>focus on niche, high-value segments and export markets</b> to sustain profitability, with success hinging on regulatory clarity, investment in talent and technology, and stronger global integration of local innovators by late 2026
Philippines	PHAP	As of Q4 2025, roll-out of UHC continues with the official launching of GAMOT – the expanded medicine benefit package from Philippine Health Insurance Corporation. Government has also officially released its proposed policy to address the HTA-PNF issue, proposing a facilitated procedure hasten the process.
Singapore	SAPI	From October 2025, <i>MediShield Life</i> and <i>MediSave</i> coverage were extended to include eligible Cell, Tissue and Gene Therapy Products (CTGTPs) listed on MOH’s CTGTP List, each with product-specific claim limits. This initiative reflects continued policy support for advanced therapeutics and their integration into Singapore’s financing framework. In the primary care sector, <i>Healthier SG</i> clinics will implement new Care Protocols for Major Depressive Disorder (MDD) and Generalised Anxiety Disorder (GAD) from January 2026. These protocols aim to strengthen early detection and coordinated care across primary and community settings, influencing prescribing pathways and the management of mental health conditions in the community. From January 2026, the Government will launch the Matched MediSave Scheme, which provides dollar-for-dollar matching of cash top-ups to MediSave accounts, up to S\$1,000 per year, for eligible Singapore Citizens aged 55 to 70. This initiative aims to encourage retirement healthcare savings and strengthen financial preparedness for future medical needs. In July 2026, long-term care subsidies will be enhanced, with subsidy rates rising to as much as 80% and higher per-capita household income thresholds introduced to improve affordability. Complementing this change, the Home Caregiving Grant will be increased to up to S\$600 per month from April 2026, providing greater support for families caring for loved ones at home. From June 2026, fertility preservation coverage will be expanded. <i>MediShield Life</i> will cover the surgical components of medically necessary embryo, egg, and ovarian tissue freezing, while <i>MediSave</i> may be used for all components of embryo and ovarian tissue freezing. This policy supports individuals requiring fertility preservation as part of medical treatment. In April 2026, revised Integrated Shield Plan (IP) riders will take effect. New riders sold from that date cannot cover the deductible, must include a minimum co-payment cap of S\$6,000 per policy year, and will adopt cost-sharing designs determined by the Ministry of Health (MOH) and insurers. These adjustments are intended to strengthen individual co-payment responsibility and moderate healthcare cost growth. Separately, MOH has announced plans to establish genetic testing as a distinct category within its subsidised test framework. Under this policy, genetic tests that are proven to be clinically and cost-effective and serve defined MOH use cases will qualify for subsidies and MediSave support. In addition, any necessary downstream interventions resulting from such tests—such as drug treatments or intensified clinical surveillance—will also be supported under existing financing schemes. While implementation details have not yet been announced, this policy direction underscores Singapore’s move toward the integration of genomic medicine and personalised healthcare within its public health financing system.
Taiwan	IRPMA	The Ministry of Health and Welfare (MOHW) has approved a total global health insurance budget of NT\$988.335 billion for 2026, marking a record-high growth rate of 5.5%. According to the NHIA, the 2025 Drug Expenditure Target (DET) growth rate, based on this year’s dental, clinic, and hospital general medical service budget (GMSB), is set at 5.288%. The allocation for new medical technologies and expanded drug benefits remains nearly flat at NT\$4.988 billion (compared with NT\$4.691 billion in 2025). This budget supports the introduction of new drugs, devices, diagnostic and treatment items, expanded indications, and improved public access to innovative therapies. To further assist patients with urgent medical needs, NHIA has earmarked NT\$0.7 billion for breakthrough and innovative drugs with clinical or financial uncertainty under the “conditional listing budget,” though this is significantly reduced from NT\$2.4299 billion in 2025. NHIA will continue to fund NT\$5 billion in 2026 for conditional listing of cancer drugs under the Cancer Drug Fund (CDF), introduced in 2025, and will roll over approximately NT\$3 billion of unspent 2025 CDF funds, bringing the total to NT\$8 billion in 2026. Since 2013, NHIA has implemented the DET Pilot Program to manage rising drug expenditures driven by new therapies and increasing patient demand. The program sets annual expenditure targets, with price adjustments triggered if spending exceeds the threshold. For 2025, the DET growth rate is 5.288%, slightly higher than 5.179% in 2024, suggesting a moderate price cut effective April 1, 2026. The exact scale will be announced in early 2026. Notably, new drug approval rates improved significantly in 2025, following concerns raised in PwC’s 2023 Taiwan Health Investment Report about lengthy reimbursement reviews and low approval rates. In early 2025, NHIA also announced amendments to drug price regulations, effective April 2026. These reforms aim to enhance supply resilience, incentivize innovation, and ensure fairer reimbursement. Key measures include preferential pricing for domestically manufactured drugs launched within two years of their debut in A10 countries, favorable pricing for new medicines with novel ingredients approved abroad within five years, allowing locally produced generics and biosimilars to be priced at the original drug’s initial level, and introducing parallel review and proactive listing processes to accelerate access to breakthrough therapies. In summary, the outlook for Taiwan’s pharmaceutical market in 2026 will ultimately hinge on three decisive factors: the extent of annual DET price adjustments, the pace of global budget growth, and the effectiveness of PBRS together with TFDA and NHIA’s new drug approval processes. Collectively, these elements will determine the resilience of Taiwan’s drug supply and shape the industry’s trajectory in the coming year.

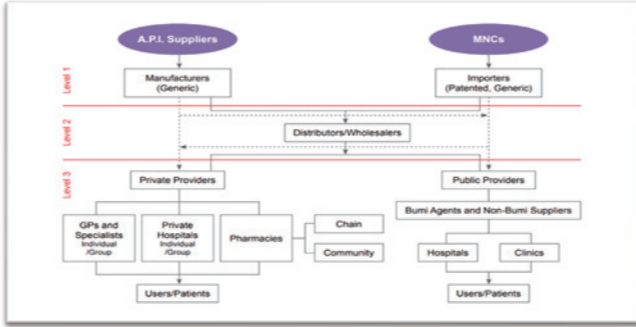
Thailand	PReMA	<p>The value of the domestic market for pharmaceuticals is expected to grow by 4.5-5.0% In 2022 relative to the 2021 figure, from the easing of fears about COVID-19 and the return of the Thai economy. This has helped to encourage patients to return to hospitals and clinics as they seek treatment for health issues, resulting in greater overall demand for medicines and medical supplies. Beyond this, the reopening of the country to foreign arrivals has further boosted demand for pharmaceutical products, especially within tourist areas.</p> <p>Over 2023 to 2025, the market is expected to continue to grow. One of the key factors that aid the growth in the healthcare sector is the rise in the ageing population. This has created an increasing incidence of chronic diseases, which will in turn, create ongoing demand for healthcare spending from the government. Another reason is the government’s goal of becoming a leader in medical tourism. The government has positioned thailand as a leader in medical tourism due to its competitive pricing and great medical facilities.</p>
Vietnam	PG	<p>The Vietnamese pharmaceutical market is currently expanding quickly, rising from USD5.4 billion in 2018 to an estimated USD6.5 billion in 2021, with a compound annual growth rate (CAGR) of 6.5%. This reflects growing demand for pharmaceuticals and related products. This ecosystem has now expanded to include more than 250 manufacturing plants, 200 import-export facilities, 4,300 wholesale agents, and more than 62,000 retail outlets. Between 2018–2021, Vietnam’s pharmaceutical sector added an estimated 7,000 high-skilled jobs.</p> <p>The healthcare sector in Vietnam is at a crossroads: as per capita income rises, infrastructure investments by the Government are increasing, and demand for quality healthcare products and services continue to rise. At the same time, Universal Healthcare Coverage and limited private sector financing are putting pressure on the State budget. Vietnam targets double-digit growth for the next decade in order for Vietnam to overcome the middle-income trap and become a high-income country by 2045. Innovation in general and the pharmaceutical sector specifically are identified in this vision potentially allowing an opportunity for the industry to play an important role and contribute positively towards the development aspiration of the country.</p> <p>2026 also marks the beginning of Resolution 72 (09 September 2025) of the Politburo which asserts that “health is the most valuable asset and the most importation for the prosperous and sustainable development of the country” , suggesting a shift in the healthcare objectives from treatment to prevention by adopting a holistic, life-course approach to health and strengthening preventive health across all aspects (funding, infrastructure, service quality, reach, and workforce). Resolution 72 emphasized improvement to primary care, reformation of health financing, mobilization and efficient use of diverse resources, among other policies.</p> <p>Key legislations were issued in 2025 included Law on Disease Prevention, Law on Intellectual Property, subsidiary regulations under the 2024 revised Pharmaceutical Law, including Circular 12/2025/TT-BYT regarding drug registration, Circular 28/2025/TT-BYT on GMP, among others. Tender Circular 40/2025/TT-BYT was issued to replace Circular 07/2024/TT-BYT, and momentum can be observed in the drafting of National Reimbursement Drug List (NRDL) Circular, aiming for issuance in 2026. Although some challenges remain in the implementation of regulations, the industry is committed to frequent dialogue for shared understanding and provide proactive support, especially regarding the introduction of Reliance mechanism &amp; implementation in Vietnam, when applicable.</p>

Category	Item	China 2026	Hong Kong 2026	India 2026	Indonesia 2026	Japan 2026	Korea 2026	Malaysia 2026	Philippines 2026	Singapore 2026	Taiwan 2026	Thailand 2026	Vietnam 2026
		RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PRReMA	PG
Economic Status	Population	1,404.89 million (2025), National Bureau of Statistics of China National Economy Pushed Forward with Innovation-led and High-quality Development and Expected Targets Achieved Successfully in 2025	7527.5million (mid 2025) Source – <a href="#">Census &amp; Statistics Department HKSAR</a>	In India, <b>the current population is 1,438,069,596</b> as of 2023 with a <b>projected increase of 17% to 1,679,589,259</b> by 2050. <b>Source:</b> WHO population data <a href="https://data.who.int/countries/356">https://data.who.int/countries/356</a>	284 million people (2025), Source: BPS Statistics Indonesia <a href="https://www.bps.go.id/id/statistics-table/2/MTK3NSMy/jumlah-penduduk-pertengahan-tahun-ribu-jiwa-.html">https://www.bps.go.id/id/statistics-table/2/MTK3NSMy/jumlah-penduduk-pertengahan-tahun-ribu-jiwa-.html</a>	123.1 million people (2025) [United Nations Statistics]	51.68 million people (2025) Source: Korean Statistical Information Service (KOSIS)	34,052.1 million people Source: Department of Statistics Malaysia ( <a href="https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/HEALTH%20FACTS/HEALTH_FACT_S_2025.pdf">https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/HEALTH%20FACTS/HEALTH_FACT_S_2025.pdf</a> )	112.7 Million (as of 2024) Philippine Statistics Authority <a href="https://pco.gov.ph/news_releases/pbbm-declares-112-7m-philippine-population-count-as-official/">https://pco.gov.ph/news_releases/pbbm-declares-112-7m-philippine-population-count-as-official/</a>	6.11 million (Singapore Department of Statistics, 2025) <a href="https://www.singstat.gov.sg/find-data/search-by-theme/population/population-and-population-structure/latest-data">https://www.singstat.gov.sg/find-data/search-by-theme/population/population-and-population-structure/latest-data</a>	23.306 million [Source: Ministry of the Interior, Nov 2025]	71,585,080 [cited 2025 FEB 26 <a href="https://worldpopulationreview.com/">https://worldpopulationreview.com/</a> ]	102 million people (est. 2025) [ <a href="#">Viet Nam Population Authority</a> ]
	Elderly population ratio ( ≥ 65 yrs)	15.9% of the total population (223.65 million, 2025), National Bureau of Statistics of China National Economy Pushed Forward with Innovation-led and High-quality Development and Expected Targets Achieved Successfully in 2025	23.9% Source – <a href="#">Census &amp; Statistics Department HKSAR</a>	India is undergoing a rapid demographic transition, with the elderly population (60 years and above) projected to more than double from 100 million in 2011 to 230 million by 2036  India's senior citizen population is projected to surge to around <b>230 million by 2036</b> , making up about 15% of the total population.  <a href="https://www.pib.gov.in/PressReleasePage.aspx?PRID=2183196">https://www.pib.gov.in/PressReleasePage.aspx?PRID=2183196</a>	7.59% (2025) Calculated from: <a href="https://www.bps.go.id/id/statistics-table/3/WVc0%20MGEyMXBkVFUxY25KeE9HdDZkbTQzWkVkb1p6MDkjMw==/jumlah-penduduk-menurut-kelompok-umur-dan-jenis-kelamin--2023.html">https://www.bps.go.id/id/statistics-table/3/WVc0%20MGEyMXBkVFUxY25KeE9HdDZkbTQzWkVkb1p6MDkjMw==/jumlah-penduduk-menurut-kelompok-umur-dan-jenis-kelamin--2023.html</a>	29.3% (2024) [Ministry of Internal Affairs and Communications]	20.3% (2025) Source: Korean Statistical Information Service (KOSIS)	0-14 years (young age) 22.2% 15-64 years (working age) 70.1% 60 years and above 11.6% 65 years and above (old age) 7.7% [Source: <a href="#">Department of Statistics Malaysia</a> ]  Life expectancy at birth: male: 73.1 years; female: 77.9 years Source: [ <a href="https://open.dosm.gov.my/dashboard/life-expectancy">https://open.dosm.gov.my/dashboard/life-expectancy</a> ]	5.86 Million (5.4%) (as of 2020)  Philippine Statistics Authority <a href="https://psa.gov.ph/system/files/phcd/2022-12/1_Press%2520Release%2520on_Age%2520Sex_RML_18July22_rev_mpe_RRDH_CRD-signed.pdf">https://psa.gov.ph/system/files/phcd/2022-12/1_Press%2520Release%2520on_Age%2520Sex_RML_18July22_rev_mpe_RRDH_CRD-signed.pdf</a>	783,600 – 2025: Singapore Citizens and Permanent Residents (Singapore Department of Statistics, 2025) <a href="https://www.singstat.gov.sg/find-data/search-by-theme/population/population-and-population-structure/latest-data">https://www.singstat.gov.sg/find-data/search-by-theme/population/population-and-population-structure/latest-data</a>	19.99% [Source: Ministry of the Interior, Nov 2025]	15% [2024 World Bank]	9% (male 3,394,674/ female 5,136,832) (2021) [World Bank] 9.3% (2024) [NATIONAL STATISTICS OFFICE of Vietnam]
	No. of physicians (per 1,000 people)	3.6 (2024)—National Bureau of Statistics of China <a href="https://data.stats.gov.cn/search.htm?s=%E5%8C%BB%E7%94%9F">https://data.stats.gov.cn/search.htm?s=%E5%8C%BB%E7%94%9F</a>	Total and healthcare professionals to Population Doctors: 16,180 (1:464) Registered Chinese medicine practitioners: 8,423 (1:891) Dentist: 2,876 (1: 2,609) Nurses: 68,752 (1:109) Pharmacists: 3,317(1: 2,262) Source: <a href="#">Health Facts of Hong Kong 2024 Edition (dh.gov.hk)</a>	According to National Medical Commission (NMC), there are 13,86,150 allopathic doctors registered with the State Medical Councils and the National Medical Commission (NMC) as on July, 2024. The doctor-population ratio in the country is around 1:811.  <b>Source:</b> Lok Sabha Q/A dated February 7, 2025	0.80 doctors* 0.18 dentist* Total : 278,133 (Doctors: 172,323; Dentists: 44,654; Doctors Specialist: 55,016; Dentists Specialist: 6,140) Source Link : <a href="http://www.kki.go.id/index.php">http://www.kki.go.id/index.php</a> [See Info Statistic] *Data is calculated from the Indonesian Medical Council (KKI) website by December 15, 2025	2.75 (2022) ["Survey of Physicians, Dentists and Pharmacists," Ministry of Health, Labour and Welfare] 2.76 Total: 0.34 million (2022) [Ministry of Health, World Labour and Welfare]	2.66 per 1,000 people in 2023 Source: OECD Health Statistics 2025 114,699 (2025 Dec.) Source: Korean Statistical Information Service (KOSIS)	1:406 (Source: Malaysia Health Facts 2024)	0.8 per 1,000 population (as of 2021)  World Bank <a href="https://data.worldbank.org/indicator/SH.MED.PHY.S.ZS?locations=PH">https://data.worldbank.org/indicator/SH.MED.PHY.S.ZS?locations=PH</a>	2.9 (MOH, 2024) <a href="https://www.singstat.gov.sg/publications/reference/ebook/society/health">https://www.singstat.gov.sg/publications/reference/ebook/society/health</a>	3.41 (2024) [Source: <a href="#">Statistics of Medical Care Institution &amp; Hospital Utilization 2024</a> , Department of Statistics, Ministry of Health and Welfare]	0.5 [2021 World Bank]	1.4 (est. 2024) [ <a href="#">Ministry of Health's Work Report 2024</a> ]
	No. of hospitals	38,700 (2024) National Bureau of Statistics of China <a href="https://data.stats.gov.cn/search.htm?s=%E5%8C%BB%E9%99%A2">https://data.stats.gov.cn/search.htm?s=%E5%8C%BB%E9%99%A2</a>	Public Hospitals: 43 Private Hospitals: 14 Source: <a href="#">Health Facts of Hong Kong 2024 Edition (dh.gov.hk)</a>	The number of hospitals has jumped from 43,500 in 2019 to 54,000 in 2024  <b>Source:</b> <a href="https://www.linkedin.com/posts/pharmaracktech_healthcare_reinnovation-digitalpharmaceutical-activity-7265259156503154689-r_a5">https://www.linkedin.com/posts/pharmaracktech_healthcare_reinnovation-digitalpharmaceutical-activity-7265259156503154689-r_a5</a>	Total number of hospitals : 3,290 (private & public) General vs specialized hospitals: • General hospital: 2,773 (84.3%) • Specialized hospital: 517 (15.7%) Public vs private hospitals: • Public hospital: 1,227 (37.3%) • Private hospital: 2,063 (62.7%)  Source Link : <a href="https://sirs.kemkes.go.id/fo/home/dashboard_rs">https://sirs.kemkes.go.id/fo/home/dashboard_rs</a> (National Hospital Information System by the MoH) Total number of health care centers : 10,180 as per 2023 [See Figure 2.1 in the report] Source Link : <a href="https://www.kemkes.go.id/app_asset/file_content_download/172231123666a86244b83fd8.51637104.pdf">https://www.kemkes.go.id/app_asset/file_content_download/172231123666a86244b83fd8.51637104.pdf</a>	Total: 179,645 (2024) ["Medical Care Facility Survey, Hospital Report", Ministry of Health, Labour and Welfare]	Total: 100,396 (2022) Source: Korean Statistical Information Service (KOSIS)	1. Total number of Government Hospitals- 150 2. Total number of Government Hospital Beds- 46,855 3. Covid-19 Hospital Bed Capacity (no longer being allocated) 4. Total number of Government Health Clinics-3,069 5. Total number of Private Clinics- 11,067 6. Total number of Private Hospitals: 214  Source: (Health Facts 2025)	1,333 hospitals (as of January 2025)  National Health Facility Registry <a href="https://nhfr.doh.gov.ph/St atPhHfStatsList">https://nhfr.doh.gov.ph/St atPhHfStatsList</a>	(MOH, 2023) Total number of hospitals 30 Acute hospitals 19 (public 10, not-for-profit 1, private 8) Psychiatric hospitals 1 (public) Community hospitals 10 (public 6, not-for-profit 4) Public polyclinics 23, private general practitioner clinics 2,493 Public dental clinics 245, private dental clinics 1079 Pharmacies 261 (public 72, private 189) <a href="https://www.singstat.gov.sg/publications/reference/ebook/society/health">https://www.singstat.gov.sg/publications/reference/ebook/society/health</a>	468 (2024) [Source: <a href="#">Statistics of Medical Care Institution &amp; Hospital Utilization 2024</a> , Department of Statistics, Ministry of Health and Welfare]	1,318 [2022 Ministry of Public Health, Thailand]	In 2025, Vietnam restructured its health system in line with the new two-tier local government model, resulting in changes to administrative classifications; therefore, updated statistics on the number of hospitals are currently unavailable. Total (2017): 13,583 General hospital 1,085; Regional polyclinic 579; Medical service unit in commune, precincts offices and enterprises 11,830 [GENERAL STATISTICS OFFICE Vietnam]

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		RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PRReMA	PG
Economic Status	Hospital beds (per 1000 people)	7320 (2024) --National Bureau of Statistics of China <a href="https://data.stats.gov.cn/s_earch.htm?s=%E5%BA%8A%E4%BD%8D">https://data.stats.gov.cn/s_earch.htm?s=%E5%BA%8A%E4%BD%8D</a>	Total number of hospital beds: 36,782 Public Hospitals: 30,636 Private Hospitals: 5,294 Under Correctional Institutions: 852 Source: <a href="https://www.hkstat.gov.hk/eng/factsheets/2024-edition">Health Facts of Hong Kong 2024 Edition</a> (dh.gov.hk)	Number of Government Hospitals Beds in Rural and Urban Areas as on December 31,2022 was 8, 40, 455 Source: National Health Profile 2023 <a href="https://cbhidghs.mohfw.gov.in/WriteReadData/1892s/Final_Central%20Bureau%20of%20Health%20Intelligence%20July%202024.pdf">https://cbhidghs.mohfw.gov.in/WriteReadData/1892s/Final_Central%20Bureau%20of%20Health%20Intelligence%20July%202024.pdf</a>	no change: 1.38 [Indonesia Health Profile 2023] <a href="https://www.kemkes.go.id/app_asset/file_content_download/172231123666a86244b83fd8.51637104.pdf">https://www.kemkes.go.id/app_asset/file_content_download/172231123666a86244b83fd8.51637104.pdf</a>	11.9 (2024) [“Medical Care Facility Survey, Hospital Report”, Ministry of Health, Labour and Welfare]	12.5 (2024) Source: Trading Economics	2.0 beds (March 2025) (Source: <a href="https://www.hospitalmanagementasia.com/hospital-management/snapshot-of-hospital-bed-crunch-in-asean/?utm_source=HMA&amp;utm_medium=socials&amp;utm_id=HMA+Digital">https://www.hospitalmanagementasia.com/hospital-management/snapshot-of-hospital-bed-crunch-in-asean/?utm_source=HMA&amp;utm_medium=socials&amp;utm_id=HMA+Digital</a> )	1.0 (as of 2021) World Bank <a href="https://data.worldbank.org/indicator/SH.MED.BED.S.ZS?locations=PH">https://data.worldbank.org/indicator/SH.MED.BED.S.ZS?locations=PH</a>	(MOH 2024) 2.8 – Total hospital beds: 17,123 Acute Hospitals:12,620 (Public:10,611, Not-for-Profit:348, Private:1,661) Psychiatric Hospitals:1,950 (Public: 1,950) Community Hospitals:2,553 (Public:1,577, Not-for-Profit: 976) <a href="https://www.moh.gov.sg/resources-statistics/singapore-health-facts/beds-in-inpatient-facilities-and-places-in-non-residential-long-term-care-facilities">https://www.moh.gov.sg/resources-statistics/singapore-health-facts/beds-in-inpatient-facilities-and-places-in-non-residential-long-term-care-facilities</a>	7.29 (hospital beds + clinical beds; 2024) [Source: <a href="https://www.moh.gov.sg/resources-statistics/singapore-health-facts/beds-in-inpatient-facilities-and-places-in-non-residential-long-term-care-facilities">Statistics of Medical Care Institution &amp; Hospital Utilization 2024</a> , Department of Statistics, Ministry of Health and Welfare]	2.41 [2019 export.gov]	3.38 beds/1,000 population (2023) [Statistical Yearbook of Vietnam 2024]
	GDP (Current USD, Billion)	19,884.81 billion USD (2025, 1 USD ≈ 7.05 RMB, 140,187.9 billion yuan) National Bureau of Statistics of China National Economy Pushed Forward with Innovation-led and High-quality Development and Expected Targets Achieved Successfully in 2025	383.5billion (Hong Kong TDC 2024 data)	USD 4.187.03 Billion (2025) Source: Statista <a href="https://www.statista.com/statistics/268173/countries-with-the-largest-gross-domestic-product-gdp/">https://www.statista.com/statistics/268173/countries-with-the-largest-gross-domestic-product-gdp/</a>	1.4 trillion [2024] (current US\$, World Bank Website) <a href="https://data.worldbank.org/country/indonesia">https://data.worldbank.org/country/indonesia</a>	4,026 billion (2024) [World bank]	1.871 billion (2023) Source: Korean Statistical Information Service (KOSIS)	USD 97.14 billion (RM430.7 billion) (Q4 2024) (Source: Department of Statistics Malaysia)	461.6 (as of 2024) Banko Sentral ng Pilipinas <a href="https://www.bsp.gov.ph/statistics/keystat/sefi.pdf">https://www.bsp.gov.ph/statistics/keystat/sefi.pdf</a>	547.39 billion [World Bank 2024] <a href="https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=SG">https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=SG</a>	905.0 billion (December 15, 2025) [Source: <a href="https://www.moh.gov.sg/resources-statistics/singapore-health-facts/beds-in-inpatient-facilities-and-places-in-non-residential-long-term-care-facilities">National Statistics, Taiwan</a> ]	US\$514.8 billion (cited 2025 FEB 14 <a href="https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=TH">https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=TH</a> )	484.73 billion (2025) [IMF] <a href="https://www.imf.org/external/datamapper/NGDPD@WEO/VNM?zoom=VNM&amp;highlight=VNM">https://www.imf.org/external/datamapper/NGDPD@WEO/VNM?zoom=VNM&amp;highlight=VNM</a>
	GDP Growth Rate (annual %)	2025 GDP growth rate: 5.0% National Bureau of Statistics of China National Economy Pushed Forward with Innovation-led and High-quality Development and Expected Targets Achieved Successfully in 2025	2023: +3.2% 2024: +2.5% <a href="https://research.hktdc.com/en/article/MzlwNjkzNTY5">https://research.hktdc.com/en/article/MzlwNjkzNTY5</a>	Real GDP has been estimated to grow by 6.5% in FY 2024-25. Nominal GDP has witnessed a growth rate of 9.8% in FY 2024-25. Ministry of Statistics and Programme Implementation (MoSPI) Press Release May 31, 2025 <a href="https://mospi.gov.in/sites/default/files/press_release/NA_D_PR_30may2025.pdf">https://mospi.gov.in/sites/default/files/press_release/NA_D_PR_30may2025.pdf</a>	5% (2024) Source : World Bank Supported Link : <a href="https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=ID">https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=ID</a> Forecast : 4.9%(from 2024 - 2026 y/y) ▪ Indonesia’s economic growth remains resilient, with inflation on a declining trend, and a stable currency, the World Bank said in its semi-annual Indonesia Economic Prospects report. GDP growth is projected to ease slightly to an average of 4.9% over 2024-2026 from 5% this year as the commodity boom loses steam. Private consumption is anticipated to be the primary driver of growth in 2024. Business investment and public spending are also expected to pick up as a result of reforms and new government projects. Inflation is expected to ease to 3.2% in 2024 from an average of 3.7% this year, within the target band of Bank Indonesia. Falling inflation reflects the softening in commodity prices and a return to normal rates of growth in domestic demand after the post-pandemic bounce-back. At the same time, there is some upward pressure on food prices due to the effects of the El-Niño weather pattern, which could disrupt food production in some places. Services exports are expected to benefit from a continued recovery in tourism, while lower commodity prices and weaker global growth will hamper exports of goods. Government revenues as a share of GDP are expected to rise as the effects of tax reforms materialize, while government spending is expected to gradually return to pre-pandemic levels. Although Indonesia’s economy is larger today than at any time before, like many other countries it has yet to fully recover to its pre-pandemic trajectory. This reflects scarring effects from the pandemic, including in labor markets and productivity growth. The overall economic outlook is subject to downside risks, primarily ones that could emanate from outside Indonesia: higher-for-longer interest rates in major economies could weigh on global demand, raise borrowing costs, and make it harder to borrow on world markets. Global geopolitical uncertainty could disrupt value chains. Source :World Bank	0.1% (2024) [World bank]	1.8% (2025) Source: Trading Economics	5.2% (Q3 2025) 4% (2026 projection) Source: Department of Statistics Malaysia	8.8% (as of 2024) Banko Sentral ng Pilipinas <a href="https://www.bsp.gov.ph/statistics/keystat/sefi.pdf">https://www.bsp.gov.ph/statistics/keystat/sefi.pdf</a>	4.0% [2024, Department of Statistics, Singapore] <a href="https://www.singstat.gov.sg/find-data/search-by-theme/economy/national-accounts/latest-data">https://www.singstat.gov.sg/find-data/search-by-theme/economy/national-accounts/latest-data</a>	7.37% (December 15, 2025) [Source: National Statistics, Taiwan]	1.9% (cited 2025 FEB 14 <a href="https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=TH">https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=TH</a> )	6.5 % (2025) [IMF] <a href="https://www.imf.org/external/datamapper/NGDPD@WEO/VNM?zoom=VNM&amp;highlight=VNM">https://www.imf.org/external/datamapper/NGDPD@WEO/VNM?zoom=VNM&amp;highlight=VNM</a>

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		RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PRReMA	PG
Economic Status	Consumer prices (annual %)	In 2025, the consumer price index (CPI) maintained the same level as that of the previous year. National Economy Pushed Forward with Innovation-led and High-quality Development and Expected Targets Achieved Successfully in 2025	2024: +1.7 (Composite Consumer Price Index) Source: <a href="#">CP indices, Census and Statistics Dept.</a>	6.21 % in October 2025 Source: MoSPI Press Release dated November 12, 2025 <a href="https://www.pib.gov.in/PressReleaseFramePage.aspx?PRID=2189186#:~:text=Corresponding%20inflation%20rates%20for%20rural.in%20comparison%20to%20September%2C%202025.">https://www.pib.gov.in/PressReleaseFramePage.aspx?PRID=2189186#:~:text=Corresponding%20inflation%20rates%20for%20rural.in%20comparison%20to%20September%2C%202025.</a>	Consumer Price Index CPI in Indonesia increased to 109.22 points in November 2025 from 109.04 points in October. CPI in Indonesia averaged 68.35 points from 1996 until 2025, reaching an all time high of 113.59 points in December of 2022 and a record low of 14.20 points in January of 1996. Cited from: <a href="https://tradingeconomics.com/indonesia/consumer-price-index-cpi">https://tradingeconomics.com/indonesia/consumer-price-index-cpi</a>	2.7%(2024) [World bank]	Consumer price inflation: 2.3% (2024) Source: World Bank Group	1.8% (Dec 2024) Source: <a href="#">Department of Statistics Malaysia</a>	1.7% (October 2025) Philippine Statistics Authority <a href="https://psa.gov.ph/content/summary-inflation-report-consumer-price-index-2018100-october-2025">https://psa.gov.ph/content/summary-inflation-report-consumer-price-index-2018100-october-2025</a>	2.4% [2024, Department of Statistics, Singapore] <a href="https://www.singstat.gov.sg/modules/infographics/consumer-price-index">https://www.singstat.gov.sg/modules/infographics/consumer-price-index</a>	1.69% (December 15, 2025) [Source: National Statistics, Taiwan]	1.7%(2025 Jan <a href="https://tradingeconomics.com/thailand/consumer-confidence">https://tradingeconomics.com/thailand/consumer-confidence</a> )	3.63% (2024) [GENERAL STATISTICS OFFICE Vietnam]
	Unemployment, total (% of total labor force) (national estimate)	5.5% (2025), National Bureau of Statistics of China National Economy Pushed Forward with Innovation-led and High-quality Development and Expected Targets Achieved Successfully in 2025	2024: 3.0% Source: <a href="#">Unemployment, Census and Statistics Dept.</a>	Unemployment Rate (UR) in India has been on a Declining Trend in Indis. The estimated UR on usual status for persons of age 15 years and above was 4.2%, 4.1% and 3.2% during 2020-21, 2021-22 and 2022-23, respectively. In fact on a quarterly basis also, <b>UR declined to 5.2% in July-September, 2025 from 5.4% in the previous quarter</b> Source: Ministry of Labor and Employment data July 22, 2024 <a href="https://pib.gov.in/PressReleaseFramePage.aspx?PRID=2035278">https://pib.gov.in/PressReleaseFramePage.aspx?PRID=2035278</a> Source – Periodic Labour Survey- July – September, 2025 <a href="https://static.pib.gov.in/WriteReadData/specificdocs/document/s/2025/nov/doc20251110688701.pdf">https://static.pib.gov.in/WriteReadData/specificdocs/document/s/2025/nov/doc20251110688701.pdf</a>	The unemployment rate in Indonesia declined to 4.85% in Q3 2025 from 4.91% in the same period a year earlier, while the number of unemployed remained steady at around 7.46 million. Employment rose 1.31% to 146.54 million, driven mainly by gains in agriculture, accommodation, and manufacturing sectors. Meanwhile, the labor force participation rate edged down slightly to 70.53% from 70.63% in the same period last year. In Q1, the jobless rate stood at 4.76%. The country's unemployment rate is reported only twice a year, specifically in Q1 and Q3. Source: <a href="https://tradingeconomics.com/indonesia/unemployment-rate">https://tradingeconomics.com/indonesia/unemployment-rate</a> .	2.5% (2025) [OECD]	2.7% (2025) Source: Trading Economics	3% (Jan 2025) Source: <a href="https://www.dosm.gov.my/site/download/release?id=principal-statistics-of-labour-force-malaysia-second-quarter-2025&amp;lang=English&amp;admin_view=">https://www.dosm.gov.my/site/download/release?id=principal-statistics-of-labour-force-malaysia-second-quarter-2025&amp;lang=English&amp;admin_view=</a>	4.1% (April 2025) Philippine Statistics Authority <a href="https://psa.gov.ph/content/unemployment-rate-april-2025-was-estimated-41-percent">https://psa.gov.ph/content/unemployment-rate-april-2025-was-estimated-41-percent</a>	2.1% [As of 2025, Department of Statistics, Singapore] <a href="https://www.singstat.gov.sg/find-data/search-by-theme/economy/labour-employment-wages-and-productivity/latest-data">https://www.singstat.gov.sg/find-data/search-by-theme/economy/labour-employment-wages-and-productivity/latest-data</a>	3.35% (December 15, 2025) [Source: National Statistics, Taiwan]	1.02% in Q3 of 2024 (cited 2025 FEB 14 <a href="https://tradingeconomics.com/thailand/unemployment-rate">https://tradingeconomics.com/thailand/unemployment-rate</a> )	1.84% (2024) [GENERAL STATISTICS OFFICE Vietnam]
Pharmaceutical distribution	Pharmaceutical market size (US\$ x100mil.) US dollars (× 1 million) (only uncopyrighted, disclosable information)	2022: 1,658.6 Billion RMB = 228,772 Million USD (1 USD ≈ 7.25 RMB) 2023: 1,797.7 Billion RMB =247,959 Million USD (1 USD ≈ 7.25 RMB) 2024: 2135.9 Billion RMB = 294,606 Million USD (1 USD ≈ 7.25 RMB) 2025: 2242.7Billion RMB = 318,113 Million USD (1 USD ≈ 7.05 RMB) <a href="https://mp.weixin.qq.com/s/kFpkph9mz4_0pVT15TEpcw">https://mp.weixin.qq.com/s/kFpkph9mz4_0pVT15TEpcw</a>	20,586,636,004USD (2022, Ex-Manufacturer, 1USD=7.8 HKD, IQVIA Constant rate) Source: IQVIA Market Prognosis Q3-2023	Indian Pharmaceutical market stood at Rs. 4,71,295 crore (US\$ 55 billion) in 2025 and is expected to grow to Rs. 10,28,280-11,13,970 crore (US\$ 120-130 billion) by 2030 Source- Healing the World: A Roadmap for Making India a Global Pharma Exports Hub -Bain and Company Report Feb 2025. <a href="https://www.bain.com/insights/healing-the-world-a-roadmap-for-making-india-a-global-pharma-exports-hub/">https://www.bain.com/insights/healing-the-world-a-roadmap-for-making-india-a-global-pharma-exports-hub/</a>	MAT Q4/2022 IDR 129,542B Source: <i>IQVIA ITMA Q4 2022 in HNA/Volume</i>	11,487.4 Billion JPY (2024) ["IQVIA Pharmaceutical market statistics 2023" Copyright © 2024 IQVIA]	23.2 billion USD (2025) Source: Mordor Intelligence	Malaysia's pharmaceutical market forecasted to expand from MYR15.7 billion (USD3.4 billion) in 2025 to MYR21.4 billion (USD4.5 billion) by 2029, reflecting a compound annual growth rate (CAGR) of 6.4% in local currency terms. Malaysia's pharmaceutical market is experiencing a surge in demand for generic drugs due to rising healthcare costs. Source: <a href="https://www.businesstoday.com.my/2025/11/03/malysias-pharma-market-set-for-growth-amid-us-trade-deal-bmi/">https://www.businesstoday.com.my/2025/11/03/malysias-pharma-market-set-for-growth-amid-us-trade-deal-bmi/</a>	4,701 million USD (2025, at 1 USD=57.43 PHP, exchange rates) Source: IQVIA	1.587 billion USD (2025, Ex-Manufacturer, 1 USD = 1.32 SGD, IQVIA Constant rate) Source: IQVIA Market Overview Q3 2025	8,016 million USD (2024, 1USD=31.5TWD) [Source: IQVIA]	6,189 million USD [Total Market Sales 2022 IQVIA, exchange rate Bt:US\$ 34.88]	7.7 billion USD (2021) [BMI Research] 7.8 billion USD (2024) [Drug Administration of Vietnam (DAV)]

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Pharmaceutical distribution	Generic ratio in the market	<p>The share of chemical generic drugs in the overall pharmaceutical market: 51% (2023) and 50% (2024)</p> <p>The share of chemical generic drugs in the chemical drug market: 73% (2023) and 71% (2024)</p> <p>The share of antibody biosimilars in the biosimilars market: 52% (2024)</p> <p>According to The Development Report on Generic Drugs in China (2025 Edition), which is compiled by the Institute of Materia Medica, Chinese Academy of Medical Sciences and the China Pharmaceutical Industry Information Center, and the National Institutes for Food and Drug Control</p> <p><a href="https://pdf.dfcw.com/pdf/H3_AP202511101778796725_1.pdf?1762869356000.pdf">https://pdf.dfcw.com/pdf/H3_AP202511101778796725_1.pdf?1762869356000.pdf</a></p>	<p>(by value) 28.67% (by volume) 70.48% (2023)</p> <p>Source: IQVIA</p>	<p>89.3% (2020) Source: IQVIA</p> <p><i>The India generic drugs market size reached USD 28.06 Billion in 2024.</i></p> <p>Source – IMARC REPORT- India Generic Drugs Market Size, Share, Trends and Forecast</p> <p><a href="https://www.imarcgroup.com/india-generic-drugs-market">https://www.imarcgroup.com/india-generic-drugs-market</a></p>	<p>"The generic market share (including unbranded and branded generics) accounts for approximately 75% of the market, leaving the remaining 25% for innovative medicines.</p>	<p>80.9% (Quantity base: 2023), 56.7% (Value term: 2023) [Ministry of Health, Labour and Welfare]</p>	<p>The South Korean generics market recorded revenues of \$5.5 billion in 2023, representing a compound annual growth rate (CAGR) of 4.7% between 2018 and 2023. Market consumption volume increased with a CAGR of 3.6% between 2018 and 2023, to reach a total of 65.3% of total pharma volume in 2023. Source: Generics in South Korea 2023</p>	<p>55%</p> <p>Source: BMI (2011). Malaysia: Pharmaceuticals &amp; Healthcare Report, Q1 (2011), 2012, Q4 (2013), Q3 (2017)</p>	<p>78.0% (2023)</p> <p>Source: IQVIA, cited by the Department of Health</p> <p><a href="https://drive.google.com/file/d/1yeWGN1-8dkrihMvJd28NNDrvP6fhM5az/view">https://drive.google.com/file/d/1yeWGN1-8dkrihMvJd28NNDrvP6fhM5az/view</a></p>	<p>56% (by volume) Source: IQVIA Market Prognosis 2023-2027</p>	<p>68% in volume and 28% in value [Source: Taiwan Generic Pharmaceutical Association Report in Legislative Yuan]</p>	<p>51% [2021 IQVIA]</p>	<p>58.8 % (est 2024) Source: KPMG</p> <p><a href="https://assets.kpmg.com/content/dam/kpmg/vn/pdf/2025/10/future-value-of-vietnam-generics-market-eng.pdf">https://assets.kpmg.com/content/dam/kpmg/vn/pdf/2025/10/future-value-of-vietnam-generics-market-eng.pdf</a></p>

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Pharmaceutical distribution	Overview of pharmaceutical distribution	N/A	Major wholesalers such as Zuellig, DKSH, and DCH account for the main part (70%); Public market: public Hospitals and Department of Health: 59.7% Private: Hospitals, clinic and Pharmacies: 40.3% No separation of dispensing and prescription	Before 1990, pharmaceutical companies used to establish their own depots and warehouses that are now replaced by clearing and forwarding agents (CFAs). CFAs Organisations are primarily responsible for maintaining storage (stock) of the company's products and forwarding SKUs to the stockist on request. Most companies keep 1–3 CFAs in each Indian state. On an average, a company may work with a total of 25–35 CFAs. Unlike a CFA that can handle the stock of one company, a distributor can simultaneously handle more than one company (usually, 5–15 depending on the city area), and may go up to even 30–50 different manufacturers. The distributor, in turn, after 30–45 days (a typical credit or time limit) pays for the products directly in the name of the pharmaceutical company. The CFAs are paid by the company yearly, once or twice, on a basis of the percentage of total turnover of products. The pandemic cemented the advantages of the leading players. Many smaller wholesalers have been forced to cease trading completely in the face of staffing and cash flow problems. This has enabled remaining players to reduce discounting levels, helping them to offset increases in the cost of doing business during the pandemic. [Source: MP India Q3 2020]	Pharmaceutical Distribution technical guidelines are regulated under NADFC regulation No. 6 of 2020 (with standards and certification regulated in the NADFC regulation No.20 of 2025 . Online registration via <a href="http://www.sertifikasi.pom.go.id">http://www.sertifikasi.pom.go.id</a> NADFC exercises overall supervision and control through the Food and Drug Administration (FDA) of the state governments.	Ethical drugs account for the majority of distribution to medical institutions and dispensing pharmacies, are mostly distributed through drug wholesalers. There are 2 forms of OTC drugs for consumers, distribution by drug wholesalers and direct sales from manufacturers to drug stores. GMP (Good Manufacturing Practice) is established mainly for the manufacture of ethical drugs, and drugs manufactured according to the GMP with regulated quality are shipped. In the distribution stage such as storage, unloading, and transportation of drugs, the utmost attention is paid to the maintenance of drug quality, such as designation of storage method and transportation in a refrigerator, in accordance with JGSP (Japanese Good Supplying Practice on quality and safety management of drug supply) as a voluntary standard revised based on PIC/S GDP. Drugs with assured quality, efficacy, and safety are delivered to 180,000 medical institutions and more than 6,000 insurance pharmacies through wholesalers nationwide. With ethical drugs, which account for the majority of distribution, there is a mechanism to investigate the actual market price and revise the drug price based on the results. The Ministry of Health, Labour and Welfare, which is the supervisory authority, executed the "Guidelines for the Improvement of Commercial Transaction Practices of Ethical Drugs for Manufacturers, Wholesalers, and Medical Institutions/ Pharmacies" in April 2018 for the purpose of appropriately conducting the drug price survey and improving the efficiency of distribution for a better distribution environment. In March 2024, a second revision was made to further improve distribution and has been implemented. <a href="https://www.mhlw.go.jp/content/10800000/000861022.pdf">https://www.mhlw.go.jp/content/10800000/000861022.pdf</a>	· Drugs distributed to medical institutions in 2020 were worth 30.3 trillion won which was up by 4.8% compared to 28.9 trillion won the year before. Among these, prescription drugs accounted for 89% or 27 trillion won. - By medical institution, general hospitals accounted for 6.6 trillion won (21.8%), hospitals for 1.8 trillion won (5.8%), clinics for 2.3 trillion won (7.7%), pharmacies for 19.3 trillion won (63.7%), and others for 0.3 trillion won (1.0%). - Drug sales price in total for each distribution stage were: 2.8 trillion won from manufacturers/importers to medical institutions, 23.6 trillion won from manufacturers/importers to wholesalers, 20.9 trillion won between wholesalers to medical institutions. · As of the end of December, the number of finished drug product distributors was 3,654, and among them, 3,170 (86.8%) were wholesalers, 484(13.2%) were drug manufacturers/importers. · Companies that account for the top 5% of annual supply account for 71% of the drug distribution market. - By business type, manufacturers accounted for 85% followed by 76% of importers and 63% of wholesalers. · There were 13 items of OTCs sold at convenience stores as of 2020 and their total sales amount were 45.7 billion won. Source: Korea Pharmaceutical Information Service		The manufacture, distribution, and sale of pharmaceutical products is regulated by the Food and Drug Administration (FDA). For an establishment to manufacture and distribute products, a License to Operate must be secured from the FDA. Subsequently, the product may be applied to be registered. Once completed, products may now be distributed and sold in FDA-licensed distributors, retailers and hospital pharmacies. The Department of Health (DOH), on the other hand, is responsible for ensuring access. For the DOH, access will include accessibility (access programs), availability (supply), and affordability (pricing). The DOH also exercises overall supervision of the FDA. Quick facts: <ul style="list-style-type: none"> <li>Relies heavily on importation (100% of APIs are imported)</li> <li>Major sources of drug products; India (28.4%), Europe (11.8%), East Asia (10%), Other South Asia (4.8%), ASEAN (4.1%)</li> <li>25.1% of market share is from one big local company</li> <li>2 major wholesaler distributors</li> <li>Retail channel dominates distribution (88% vs 12% from hospitals)</li> <li>Country of generics: 78% by volume and 59% by sales</li> </ul> Philippine Competition Commission, 2018, with updated data from the Department of Health <a href="https://drive.google.com/file/d/1Ys1rX6gMpHqINkrBX586T0YZoyemW3L/view">https://drive.google.com/file/d/1Ys1rX6gMpHqINkrBX586T0YZoyemW3L/view</a> IQVIA, cited by the Department of Health <a href="https://drive.google.com/file/d/1yeWGn1-8dkrihMvJd28NNDrvP6fhM5az/view">https://drive.google.com/file/d/1yeWGn1-8dkrihMvJd28NNDrvP6fhM5az/view</a>	Most multinational brands are distributed through one of the three regional wholesaler/distributors -Zuellig Pharma Singapore, DKSH, and DCH Auriga.	In Taiwan, makers have direct sales system to many large hospitals and use wholesalers in some case of sales including private clinics and pharmacies which accounts for about 30 percent of the market.	Thailand's two leading distributors are DKSH and Zuellig. These companies handle most of the distribution and importation for multinational companies, as well as some local generic companies. As in other parts of the healthcare market, distributors are facing downward pressure on margins. Larger players are seeking to grow their business through the provision of added-value services, including sales and marketing activities for multinational companies looking to minimize investment in the market.	For imported pharmaceutical products, the distribution chain typically begins with foreign invested enterprise (FIE) carry out customs clearance and regulatory compliance before supplying products to licensed distributors. Under the Pharmaceutical Law 2024, FIE importers have the following rights: <ul style="list-style-type: none"> <li>To transport drugs from FIE warehouse to wholesaler's warehouse</li> <li>To deliver, transport drugs under aid, donation, humanitarian and epidemic support programs to receiving healthcare establishment.</li> <li>To buy back and sell drugs the FIE tech transferred in VN; sell drugs the FIE contract manufactured in VN to wholesaler.</li> <li>To import drug raw materials to supply to contract manufacturer/tech transferred entity</li> <li>To transport drugs imported and used in clinical trial conducted by the FIE to clinical trial testing facilities.</li> <li>Nevertheless, Vietnam reserves distribution rights to hospitals for local companies. Local distributors supply medicines through two main channels: the public (ETC) channel and the private (OTC) channel. The hospital segment makes up more than two-thirds of the Vietnam pharma market and will continue its dominance as social health insurance (SHI) coverage increases. Until June 2026, 95.2% of the population is covered by the SHI system. The retail channel, though not as large, has demonstrated faster volume growth (15%).</li> </ul>

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Pharmaceutical distribution	GDP, GSP, GPP implementation status	No license grant but still need implementation	N/A	<p>On April 2, 2024 (recirculated on August 9, 2024), the Indian Government issued a draft Good Distribution Practices (GDP) Guidelines through Central Drugs Standards Control Organisation (CDSCO) for pharmaceutical products to ensure the quality and identity of pharmaceutical products during all aspects of the distribution process like procurement, purchasing, storage, distribution, transportation, documentation and record-keeping practices. The Guidelines is yet to be firmed up. At present transportation of drugs are carried out by third parties like contractors and sub-contractors in most cases. Contamination, cross contamination, mix-ups, adulteration and presence of spurious drugs are an issue in the unregulated distribution chain. Involvement of organization entities in the distribution chain is also a concern. The draft, in total, has 22 clauses on various aspects. It outlines steps to help entities fulfil their responsibilities throughout the supply chain, aiming to prevent the introduction of substandard and spurious products into the market and applies to all entities involved in the storage and distribution of pharmaceutical products, from manufacturers to those directly dispensing to patients. This includes manufacturers of bulk and finished products, wholesalers, suppliers, distributors, government institutions, international procurement organizations, donor agencies, certifying bodies, logistics providers, traders, transport companies, forwarding agents, their employees, and health workers. It also covers biological products, but for specific details reference to GDP for biological products has been recommended.</p> <p>The draft specifies the roles that different entities play in the storage and distribution of medical products and emphasizes the importance of protecting the supply chain from such risks. The guideline applies to all entities involved in any aspect of medical product storage and distribution, from manufacturers to those directly dispensing products to patients. This includes manufacturers, wholesalers, brokers, suppliers, distributors, logistics providers, traders, transport companies, forwarding agents, and their employees. The guideline serves as a tool to prevent the distribution of substandard and spurious products.</p>	<p><b>GDP (Good Distribution Practice):</b> The National Agency of Drug and Food Control (BPOM) govern the GDP of pharmaceutical manufacturers and subsequent distributors through these mechanisms:</p> <p>a. <b>Regulation and Standardization:</b> BPOM establishes regulations (such as PerBPOM No. 20 of 2025) that serve as technical guidelines, covering all aspects of drug distribution from suppliers to healthcare facilities, including donated medicines and special medicines.</p> <p>b. <b>Certification:</b> Pharmaceutical Wholesalers (PBF) are required to have a GDP (CDOB) Certificate issued by BPOM as proof of compliance. This process involves an assessment of conformity with CDOB standards.</p> <p>c. <b>Supervision and Guidance:</b> BPOM conducts routine supervision and provides technical guidance to improve the competence of distribution actors, such as Government Pharmacy Installations (IFP) and PBF, and ensures the implementation of quality management systems and Corrective Action and Preventive Action (CAPA).</p> <p>d. <b>Law Enforcement:</b> BPOM imposes administrative sanctions, including certificate revocation, if serious violations are found, such as misuse or failure to meet GDP requirements.</p> <p><b>Good Storage Practice (GSP):</b> GSP is an integral part of the GDP regulation (please refer to PerBPOM No. 20 of 2025).</p> <p><b>Good Pharmacy Practice (GPP):</b> GPP is regulated in the MoH Decree No. 73 of 2016, which mandates all pharmacy to implement the standard. Technical guidelines for pharmacists in implementing GPP are elaborated in the Competency Standards of Indonesian Pharmacists (SKAI). Ideal implementation example:</p> <p>a. Service for patients: having a patient counseling room to provide a private environment for patient consultations</p> <p>b. Drug management: FIFO – FEFO in drug storage to minimize expiry</p> <p>c. Documentation: Use of digital application(s) to capture transactions, prescriptions, and patient consultations</p> <p>d. Adherence to regulations: biannual internal audits to ensure implementation of GPP standards.</p> <p>Source:</p> <p>1. BPOM CDOB FAQ book: <a href="https://sertifikasidob.pom.go.id/sertif/materilain/FINAL%20e-book%20FAQ%20CDOB%20Update%202025%20%28reviewed%20Nov%2023%29.pdf">https://sertifikasidob.pom.go.id/sertif/materilain/FINAL%20e-book%20FAQ%20CDOB%20Update%202025%20%28reviewed%20Nov%2023%29.pdf</a></p> <p>2. <a href="https://www.pusdiklatpemda.com/penerapan-good-pharmacy-practice-gpp-di-apotek-modern-langkah-dan-tantangannya/#:~:text=Apa%20itu%20Good%20Pharmacy%20Practice,aktif%20dalam%20pemantauan%20terapi%20obat.">https://www.pusdiklatpemda.com/penerapan-good-pharmacy-practice-gpp-di-apotek-modern-langkah-dan-tantangannya/#:~:text=Apa%20itu%20Good%20Pharmacy%20Practice,aktif%20dalam%20pemantauan%20terapi%20obat.</a></p>	<p>GDP available</p> <p>The supervisory authority is General Affairs Division, Pharmaceutical Safety and Environmental Health Bureau, Ministry of Health, Labour and Welfare. GDP guideline in Japan is prepared on the basis of PIC/S GDP, and it is operated as a voluntary standard for the time being and not as a ministerial ordinance. However, since the Guidelines include the provisions of current ministerial ordinances on transportation and storage (GMP Ordinance, GQP Ordinance, Pharmaceutical and Medical Device Act, Regulations for Buildings and Facilities for Pharmacies), the minimum compliance requirements are included. There are 2 licenses related to GDP, a marketing license (for drug manufacturers) and a wholesale license (for distribution warehouses of pharmaceutical manufacturers, wholesalers, etc.).</p>	<p>· An individual who intends to be a drug wholesaler, pursuant to Article 45 of the Pharmaceutical Affairs Act and Article 36 of the Enforcement Regulation of the Pharmaceutical Affairs Act, shall be approved by the head of local government.</p> <p>· Article 31-2, Enforcement Decree of the Pharmaceutical Affairs Act : A pharmaceutical wholesaler shall be equipped with the business area and warehouse prescribed by the Ministerial Decree of Health and Welfare by the Minister of Health and Welfare</p> <p>· Article 47, Pharmaceutical Affairs Act &amp; Article 44, Enforcement Regulation of the Pharmaceutical Affairs Act : Drug providers(individual who received MA approval of drug, drug importers, drug wholesalers) shall comply with the Observances for Managing the Distribution and Maintaining Order in the Sales of Drugs.</p> <p>· Drug providers shall comply with the matters prescribed in the Specification for Management of Distribution Quality of Drugs(Attachment 6, Enforcement Regulation on the Safety of Drugs, etc.)</p>	<p>NPRA is the regulatory authority for certifications of GDP and GMP. According to the Controls of Drugs and Cosmetics Regulations 1984, any company that intends to manufacture, import or wholesale any registered product needs to have the following types of licenses respectively</p> <ul style="list-style-type: none"> <li>Manufacturer's License, an Import License or a Wholesale License.</li> </ul> <p><a href="https://www.npra.gov.my/index.php/en/guidelines-for-compliance-licensing/1608-licensing-manufacturer-importer-and-wholesaler.html">https://www.npra.gov.my/index.php/en/guidelines-for-compliance-licensing/1608-licensing-manufacturer-importer-and-wholesaler.html</a></p>	<p>The FDA implements WHO GDP and GSP as part of the licensing requirements for distributors and retailers. In addition, a local cold chain management standard is implemented.</p> <p>(Administrative Order No. 2013-0027, FDA Advisory No. 2022-1895 (<a href="https://www.fda.gov/ph/wp-content/uploads/2022/12/FDA-Advisory-No.2022-1895.pdf?fbclid=IwAR383VClBRpdU7wwmWRdtGwQ8aFpCTWYhh2nBJ33-zpINUrTC-YjH8lJvOc">https://www.fda.gov/ph/wp-content/uploads/2022/12/FDA-Advisory-No.2022-1895.pdf?fbclid=IwAR383VClBRpdU7wwmWRdtGwQ8aFpCTWYhh2nBJ33-zpINUrTC-YjH8lJvOc</a>) FDA Circular No. 2021-003 (<a href="https://www.fda.gov/ph/wp-content/uploads/2021/02/FDA-Circular-No.2021-003.pdf">https://www.fda.gov/ph/wp-content/uploads/2021/02/FDA-Circular-No.2021-003.pdf</a>))</p>	<p>• The Health Sciences Authority (HSA)'s "GUIDANCE NOTES ON GOOD DISTRIBUTION PRACTICE" are implemented as GDP guidelines. The guidelines were revised on 15 December 2023. (<a href="https://www.hsa.gov.sg/chinese-proprietary-medicines/dealers-licence/gmp-gdp-standards">https://www.hsa.gov.sg/chinese-proprietary-medicines/dealers-licence/gmp-gdp-standards</a>)</p> <p>• The Pharmaceutical Society of Singapore (PSS)'s "GOOD PHARMACY PRACTICE GUIDE" is implemented as a GPP guideline. The latest version was released in April 2018.</p> <p>• GUIDANCE NOTES ON SUPPLY OF REGISTERED THERAPEUTIC PRODUCTS THROUGH E-PHARMACY was published by HSA (<a href="https://www.hsa.gov.sg/docs/default-source/hprg-ald/guide-mqa-032.pdf">https://www.hsa.gov.sg/docs/default-source/hprg-ald/guide-mqa-032.pdf</a>)</p>	<p>GDP guidelines exist. The Western Pharmaceuticals Good Distribution Practice Regulations which were promulgated pursuant to the Paragraph 4 of Article 53-1, <a href="#">Pharmaceutical Affairs Act</a> had been approved by The Legislative Yuan and issued on December 28, 2017 by TFDA. The Article 53-1 defined the companies who wholesale, import or export the medicinal products (including cold chain products) shall comply GDP. TFDA has also announced in 2019 (TFDA official letter No. 1081102318) that companies distributed, imported, or exported the medicinal products (including cold chain products) must apply for the evaluation of GDP and meet the standards of the good distribution practice for western medicines before 31 Dec 2021.</p>	<p>Thai FDA has announced the GDP for modern drugs on 21 May 2021 which took effect from 1 January 2022. Manufacturers and importers are required to arrange their warehouses and equipment and distribute drugs to comply with the GDP regulation. The pharmacist on duty must also oversee and control the activities as required. Reference: <a href="#">การตรวจประเมิน GDP - กอชยา</a></p> <p>No regulation on GSP</p> <p>The Good Pharmacy Practice (GPP) standards in Thailand have been legally implemented for all drugstores since 2014. However, the drugstores which were registered before the law enforcement were required to pass the GPP inspection within eight years. Ultimately, all modern drugstores in Thailand need to provide facilities and services as required by the GPP standards in 2022. Reference: <a href="#">อย.อภ.ออกตรวจร่าง กำหนดมาตรฐานให้ร้านขายยาต้องปฏิบัติตามหลักวิธีปฏิบัติ</a></p> <p>...</p>	<p>GDP: mandatory license for wholesaler/distributor of pharmaceuticals</p> <p>GSP: mandatory license for exporters, importers of pharmaceuticals, or providers of storage services</p> <p>GPP: mandatory license for pharmacies (retailers)</p>

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Pharmaceutical distribution	Central logistical management requirement (e.g. Serialization/ barcode requirement)	<p><i>Measures for the Quality Supervision and Administration of the Distribution and Use of Medicinal Products</i> officially came into force on January 1, 2024. To enhance the supervision of drug distribution, regulate the administration of drug distribution licenses, and ensure the quality and safety of drugs in the distribution process, <i>The Announcement on Further Strengthening the Supervision and Administration of Drug Distribution</i> was issued as No. 48 of 2024 by National Medical Products Administration <a href="https://www.gov.cn/zhengce/zhengceku/202404/content_6947934.htm">https://www.gov.cn/zhengce/zhengceku/202404/content_6947934.htm</a></p>	N/A	<p>Vide GSR 823 (E) dated November 17, 2022, MoH issued the Drugs (Eighth Amendment) Rules, 2022 mandating QR code/ barcode for top 300 brands. The notification will come into force from August 1, 2023. The GSR amended labelling requirements (Rule 96 of the Drugs Rules 1945) requiring the manufacturers of drug formulation products as specified in Schedule H2 to print or affix Bar Code or Quick Response Code on its primary packing label or, in case of inadequate space in primary package level, on the secondary package level that store data or information legible with software application to facilitate authentication.</p> <p>Vide GSR 757(E) dated October 16, 2025, the Health Ministry has notified draft Drugs (Amendment) Rules 2025 proposing to add Table 2 containing – 1) All Vaccines; 2) All Antimicrobials; 3) All Narcotic and Psychotropic drugs listed under the Narcotic and Psychotropic drugs Act, 1985; and 4) All Anticancer drugs in the existing Schedule H2 of the Drugs Rules, 1945</p> <p>As regards exports, the Directorate General of Foreign Trade (DGFT), vide public notice dated January 31, 2025, decided to withdraw the provisions related to the Track and Trace System for pharmaceutical exports under the Foreign Trade Policy (FTP). The Track and Trace System, introduced via Public Notice dated January 10th, 2011, mandated barcoding at various packaging levels. While tertiary and secondary packaging requirements were successfully implemented in 2011 and 2013, primary-level barcoding and parent-child data uploading faced operational challenges and were repeatedly deferred, with the last extension valid until February 1, 2025.</p> <p>According to DGFT, the step has been taken to streamline export regulations by aligning with the evolving regulatory framework of the MoH.</p> <p>The decision to withdraw these provisions was based on the following key considerations:</p> <ul style="list-style-type: none"> <li>• MoH has already implemented barcode/QR code requirements for 300 drug brands under the Drugs Rules, 1945, effective August 1, 2023, with plans for further expansion.</li> <li>• Most export destinations have their own serialization requirements, ensuring product traceability without additional domestic regulations.</li> <li>• MoH as the primary regulatory authority, provides a unified framework through the Central Drugs Standard Control Organization (CDSCO), ensuring consistency and eliminating duplication.</li> </ul> <p>The stated aim was to enhancing ease of doing business for pharmaceutical exporters while ensuring regulatory coherence. Accordingly, the provisions under Para 2.76 of the Handbook of Procedures (HBP) 2023 were also withdrawn.</p>	(same as above)	<p>It is organized as "Traceability (display of distribution barcode, etc.)." For ethical drugs, labeling of GS1 code is required to ensure medical safety. Recently, the Ministry of Health, Labour and Welfare released the "Partial Revision of "Guidance for Barcode Labeling of Ethical Drugs" as on August 30, 2016 for the promotion of traceability and efficiency of drug distribution, obligating those products to be shipped after April 2021 (April 2023 under special circumstances) to label a new barcode including variable information (such as expiration dates and lot numbers) in addition to the product code which has been obligatory from before.</p> <p>Moreover, the "Law for Partial Revision of the Law Concerning Quality, Effectiveness, and Safety of Pharmaceuticals and Medical Devices" promulgated on December 4, 2019, legally mandated barcode display, which came into effect in December 2022. Moreover, labeling of JAN code (GTIN) is required for OTC drugs.</p> <p>The revised Logistics Efficiency Act mandates pharmaceutical manufacturers, as consignors, to enhance transportation efficiency to address the "2024 logistics problem." Companies must appoint a Logistics Management Officer and implement mid-to-long-term plans. Specific requirements include reducing truck waiting times for loading and unloading, improving loading rates through standardized packaging and palletization, and promoting modal shifts to rail or sea. Furthermore, manufacturers are expected to pursue joint distribution to optimize delivery routes. These measures aim to ensure sustainable logistics by reducing driver burdens and increasing overall supply chain productivity while maintaining the stable supply of medicines.</p>	HIRA implemented central serialization for ETC.	Serialised Track & Trace system on track, expected for roll-out in 2026	Currently, serialization is implemented on a voluntary basis. However, there are initiatives from the DOH to institutionalize traceability.	(FDA Circular No. 2016-011, Administrative Order No. 2022-0025)	<p>The first phase of the National Central Fill Pharmacy (NCFP) was rolled out in early 2022. NCFP will fulfill medication delivery orders received from healthcare institutions in a central location. This model will boost efficiency by consolidating the picking and packing of pharmaceutical drugs and delivering them direct to patients' homes or their preferred collection points island-wide. The co-location with Central Warehouse coupled with the centralization of logistic processes also allows better synergies in supply chain, and public healthcare institutions to focus more on direct patient care delivery.</p> <p><a href="https://www.alpshealthcare.com.sg/national-central-fill-pharmacy/">https://www.alpshealthcare.com.sg/national-central-fill-pharmacy/</a></p>	QR code for all OTC drugs before end of 2019. All OTC drugs newly launched in or after 2017 need to be compliant with QR code requirement.	<p>There are no regulatory requirements concerning serial numbers. However, the Thai FDA Track and Trace system initiative was communicated to relevant stakeholders in 2024. The Thai FDA implementation plan will begin in 2025 for specific product groups only, with serialization and e-labeling included as part of this initiative. Broader implementation is not yet planned.</p>	<p>Vietnam has issued <i>Decree 37/2026/ND-CP Guiding the Law on Product and Goods Quality</i>. The Decree provides clearer definition and legal framework for e-labelling while assignment responsibility for relevant regulations for e-labelling of corresponding ministries (hereby the Ministry of Health), per initial analysis. Meanwhile, Circular 01/2018/TT-BYT, amended by Circular 23/2023/TT-BYT and supplemented by Circular 12/2025/TT-BYT which regulate the labeling of pharmaceutical products, package insert, and drug materials, is still in effect. Changes are anticipated.</p>

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Promotion	Promotion code	No update of PhIRDA Code <RDPAC Digital Health Compliance Guideline> was released to members in June 2023.	HKAPI Code of Practice <a href="http://www.hkapi.hk/home/code-of-practice/">http://www.hkapi.hk/home/code-of-practice/</a> Prevention of Bribery Ordinance enforced by Independent Commission Against Corruption Trade Description Ordinance enforced by Custom and Excise Department	There are many Laws & Codes referred for Marketing & Ethical promotion of drugs in India 1.UCPMP (Uniform Code for Pharmaceutical Marketing Practices) 2024 2.The Code of Pharmaceutical Practices, 2019 by Organisation of Pharmaceutical Producers of India (OPPI) 3.Drugs & Cosmetics Act, 1940 4.Drugs & Magic Remedies (Objectional advertisement) Act, 1954 (DMRA) 5.Code of Self-regulation in Advertising by The Advertising Standards Council of India (ASCI) 6.IFMA Code of Pharmaceutical Marketing Practices 7.The Competition Act, 2002 However, 2 most followed codes are: 1)Uniform Code of Pharmaceuticals Marketing Practices, 2024("UCPMP Code") 2)The Code of Pharmaceutical Practices, 2012 by Organisation of Pharmaceutical Producers of India (OPPI)  The Department of Pharmaceuticals (DoP) notified the Uniform Code for Pharmaceutical Marketing Practices (UCPMP) 2024 on March 12, 2024 effective immediately. UCPMP 2024 has provisions on samples to be handed out to the HCPs, claims and comparisons, engagement of pharmaceutical and medical devices industry with HCPs, medical representatives (MR), gifts, informational and educational items for HCPs etc. It also has provisions on disclosure of the expenditure incurred towards CMEs, CPDs etc. and also empowers the Government to conduct independent audits. On September 1, 2025, the DoP revised the UCPMP that <i>inter alia</i> provided simplified formats for disclosures to be made by pharma companies in respect of the expenditure incurred towards free samples and travel and hospitality etc. extended to HCPs.	IPMG CODE OF ETHICS April 2025 Revision. IPMG's latest Code of Ethics is aligned with the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) standards and have been socialized in April 2025. Changes from the previous version are mainly in the increase of the maximum allowed value of accommodation and honorarium fair market value (FMV). IPMG's repository of previous and current codes of ethics: <a href="https://ipmg-online.com/en/resources">https://ipmg-online.com/en/resources</a>	JPMA member companies must always ensure high ethical standards and transparency in their business activities, fulfill their accountability in interactions with researchers, healthcare professionals, patient groups, etc., and respond to the trust of society. JPMA Code of Practice is an industry voluntary code that further develops the "Ethical Drug Promotion Code" and provides standards of conduct for interactions between all officers and employees of member companies and researchers, healthcare professionals, patient groups, etc. Promotion Code, a part of the JPMA Code of Practice was formulated in January 2013 and revised in October 2017. It was subsequently revised based on the revision of the IFPMA in June 2018 Code, and based on the "Guidelines for Provision of Sales Information on Prescription Drugs" in September 2018. In May 2025, the JPMA revised the definition of "Promotion" in the JPMA Code of Practice to ensure consistency with the definition of "Promotion" in the IFPMA Code of Practice and the definition of "Provision of Sales Information" in the Guidelines for Provision of Sales Information. The revised definition of "Promotion" is "to engage with healthcare professionals in the provision, collection, and communication of pharmaceutical product information for promoting the proper use and broader adoption of prescription drugs based on those interactions." This includes all activities implemented by member companies that may influence the prescribing decisions of healthcare professionals. JPMA Code of Practice also requires compliance with the "Fair Competition Code concerning Restriction on Provision of Premiums in Ethical Drug Marketing Industry" established by the Fair-Trade Council of Ethical Drug Marketing Industry. The JPMA Code of Practice also requires compliance with "the Fair Competition Code" established by "The Fair Trade Council of the Ethical Pharmaceutical Drug Marketing Industry" regarding restrictions on the provision of prizes in the promotion of the sale of prescription drugs.  JPMA Code of Practice also requires compliance with the "Fair Competition Code concerning Restriction on Provision of Premiums in Ethical Drug Marketing Industry" established by the Fair-Trade Council of Ethical Drug Marketing Industry. JPMA Code of Practice <a href="https://www.jpma.or.jp/english/code/practice/eki4g60000003js0-att/eki4g60000003jy9.pdf">https://www.jpma.or.jp/english/code/practice/eki4g60000003js0-att/eki4g60000003jy9.pdf</a>  Guidelines on Information Provision in Connection with Promotional Activities for Ethical Drugs. <a href="https://www.mhlw.go.jp/content/000359881.pdf#search=%27%E5%8C%BB%E7%99%82%E7%94%A8%E5%8C%BB%E8%96%AC%E5%93%81%E3%81%AE%E8%B2%A9%E5%A3%B2%E6%83%85%E5%A0%B1%E6%8F%90%E4%BE%9B%E6%B4%BB%E5%8B%95%E3%81%AB%E9%96%A2%E3%81%99%E3%82%8B%E3%82%AC%E3%82%A4%E3%83%89%E3%83%A9%E3%82%A4%E3%83%B3%27">https://www.mhlw.go.jp/content/000359881.pdf#search=%27%E5%8C%BB%E7%99%82%E7%94%A8%E5%8C%BB%E8%96%AC%E5%93%81%E3%81%AE%E8%B2%A9%E5%A3%B2%E6%83%85%E5%A0%B1%E6%8F%90%E4%BE%9B%E6%B4%BB%E5%8B%95%E3%81%AB%E9%96%A2%E3%81%99%E3%82%8B%E3%82%AC%E3%82%A4%E3%83%89%E3%83%A9%E3%82%A4%E3%83%B3%27</a>	See advertising regulations	PhAMA Code of Practice Edition 23- published on 27 Feb 2025  <a href="https://www.phama.org.my/index.cfm?&amp;menuid=6">https://www.phama.org.my/index.cfm?&amp;menuid=6</a>	The DOH, through the FDA implements a code of ethics for the promotion and marketing of prescription pharmaceutical products and medical devices. The said policy builds on two APEC documents: the Mexico City and Kuala Lumpur Principles which deals with codes on business ethics. As these APEC documents are voluntary, the issuance of the DOH-FDA policy makes the code of ethics mandatory for the Philippines.  From the industry sector, the Pharmaceutical and Healthcare Association of the Philippines established its Code of Practice following the IFPMA Code.  (Administrative Order No. 2015-0053, PHAP Code of Ethics)	In addition to SAPI Code of Conduct 2025 (SAPI Code) by the Singapore Association of Pharmaceutical Industries (SAPI) promotion code, there are domestic laws relevant to anti-corruption, such as the Prevention of Corruption Act. <a href="http://www.sapi.org.sg">www.sapi.org.sg</a> [PREVENTION OF CORRUPTION ACT [https://sso.agc.gov.sg/Act/PCA1960]	A Code of Practice was established by IRPMA in July 2003, and the most update version was published in October 2024 and can be accessed through the <a href="http://www.irpma.org.sg">IRPMA website</a> .	Ministry of Public Health notification: Ethics on Drug Procurement and Promotion effective in May 2021. The National Ethical Framework developed by the National Drug System Development Committee (NDSDC) and announced in 2015. A revised 2nd edition was issued in 2016. PReMA's Code of Practice has been revised with issuance of the 12th edition in 2019. The Thai Pharmaceutical Manufacturers Association (TPMA) has also adopted and implemented their code of practice with a revised 2nd edition issued in 2018.	Pharma Group, European Chamber of Commerce in Vietnam Pharma Group Code of Ethical Practices <i>Adopted on 1 January 2014; Amended for the first time by the Pharma Group General Assembly on 27 January 2016, effective 1 June 2016</i> <i>Amended for the second time by the Pharma Group General Assembly on 6 December 2018, effective 1 January 2019</i> <i>Amended for the third time by the Pharma Group General Assembly on 7 August 2020, effective 1 October 2020</i> <i>Amended for the fourth time by the Pharma Group General Assembly on 20 June 2024, effective 20 June 2024</i> <i>Amended for the fifth time by the Pharma Group General Assembly on 7 February 2025, effective 1 May 2025</i> <a href="https://eurochamvn.org/wp-content/uploads/2025/03/PG-Code-of-Ethics_effective-1-May-2025_R.pdf">https://eurochamvn.org/wp-content/uploads/2025/03/PG-Code-of-Ethics_effective-1-May-2025_R.pdf</a>

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Promotion	Hospital visit regulations	<p>On January 14, 2025, China's State Administration for Market Regulation issued the <i>Compliance Guidelines for Pharmaceutical Enterprises on Preventing Commercial Bribery Risks</i>. The guidelines stipulate 32 explicit "prohibitions," with key provisions including: prohibiting the assignment of sales tasks to medical representatives, forbidding them from interfering with the rational use of pharmaceuticals, banning the tracking of prescription volumes, and prohibiting the offering of improper benefits to healthcare professionals. These measures aim to standardize industry practices, maintain fair competition, and safeguard public interests.</p> <p><a href="https://www.samr.gov.cn/zw/zfxqgk/fdzdgknr/jijzs/art/2025/art_0cee28b1eba84820addc024b351b7bac.html#:~:text=%E5%B8%82%E5%9C%BA%E7%9B%91%E7%AE%A1%E6%80%BB%E5%B1%80%E5%85%B3%E4%BA%8E%E5%8F%91%E5%B8%83%E3%80%8A%E5%8C%BB%E8%8D%AF%E4%BC%81%E4%B8%9A%E9%98%B2%E8%">https://www.samr.gov.cn/zw/zfxqgk/fdzdgknr/jijzs/art/2025/art_0cee28b1eba84820addc024b351b7bac.html#:~:text=%E5%B8%82%E5%9C%BA%E7%9B%91%E7%AE%A1%E6%80%BB%E5%B1%80%E5%85%B3%E4%BA%8E%E5%8F%91%E5%B8%83%E3%80%8A%E5%8C%BB%E8%8D%AF%E4%BC%81%E4%B8%9A%E9%98%B2%E8%</a></p>	Not in Hong Kong but yes in Macao.	<p>UCPMP 2024 lays down that the MRs are not to employ any inducement or subterfuge to gain an interview with the HCPs. They must not pay, under any guise, for access to an HCP.</p> <p>On May 28, 2025, DGHS issued an Office Order vide which few identified Government hospitals in New Delhi were prohibited from permitting MRs in their respective hospital premises.</p> <p>Previously on May 12, 2023 DGHS vide an addressed to all doctors, in the central government hospitals/CHGS wellness centers/polyclinic, stated that visits of MRs to hospital premises are completely curtailed and that information about launch of new drugs may be made via email only.</p>	<p>Some hospitals in the metropolis have established their own regulations on visits by pharmaceutical companies. In sales by agencies, contact with doctors and nurses is prohibited. This restriction was reinforced due to prevention measure for COVID-19 transmission. However, this is no longer relevant in the post-pandemic era. Nowadays, representatives of the pharmaceutical industry may be able to visit hospitals, but it depends on the policy or the agreement with each hospital that might differ from one to another. On the contrary, there are no such restrictions on medical devices. Some hospitals have rules for MR visit by internal rules, which includes prohibition of visiting, or specifying the meeting place.</p>	<p>Basic Principles of JPMA Code of Practice state that "Advances in medical and pharmaceutical science and improvements in public health depend on the information-sharing interactions by the entire medical community, which includes researchers, healthcare professionals, patients, wholesalers, and JPMA member companies. Integrity is essential to these interactions, and there must always be confidence that decisions are made on an ethical and patient-focused basis." Under the Principles, the JPMA member companies comply with the visit regulations specified by medical institutions. In addition, as the number of medical institutions adopting a complete appointment system as part of the visiting regulations is increasing, member companies are devising methods of information service, such as the use of the Internet, in response to environment changes.</p>	<p>It depends on each companies' compliance guideline</p>	<p>Government hospitals: Visit times differ from one hospital to another, typically 12.30 pm to 2 pm and 5 pm to 7 pm. Children below 12 are not allowed to enter hospital wards, and some hospitals only permit 2 visitors at one time, restricted to 30 minutes per visit.</p> <p>Private hospitals: Flexible visiting hours</p>	<p>Hospital visits are allowed, provided the engagements with healthcare professionals are ethical and focuses on the provision of medical information.</p> <p>(Administrative Order No. 2015-0053)</p>	<ul style="list-style-type: none"> <li>• There are no barriers impeding access to doctors at private medical institutions. Other self-regulation of interactions with medical institutions is as set forth in detail in Article 7 of the promotion code.</li> <li>• Some restrictions imposed during the Covid-19 pandemic control in place. Specified in detail in SAPI Code of Conduct 2023</li> </ul>	<p>Some hospitals have established their own regulation on visits by the pharmaceutical companies but no clear policy in most hospitals. Only few hospitals have announced/ verbally informed to industry about their policy on regulating MR visiting, e.g., CGMH-LK, NTUH, NCKUH.</p>	<p>There are no legal regulations. Some of the hospitals have own regulations e.g., a prohibition to carry a bag with a brand name when visiting a hospital or waiting areas to wait for doctors to come out of his office.</p>	<p>Drug introducers (med reps) that employed by a pharmaceutical business establishment (manufacturers, importers, wholesalers) and are issued a "Drug introducer" card by the head of the establishment are allowed provide drug information on that pharmaceutical business establishment's drug to medical and pharmacy practitioners. Drug introducers must meet the following requirements:</p> <ol style="list-style-type: none"> <li>Holding an associate degree or higher in medicine or pharmacy;</li> <li>Employed and developed, trained by a pharmaceutical business establishment in skills and professional competencies pertinent to drug introducing activities and pharmaceutical legal normative documents. Responsibilities of drug introducers</li> </ol> <ol style="list-style-type: none"> <li>To wear the "drug introducer" card issued by the pharmaceutical business establishment and comply with the internal rules set out by medical service establishments when introducing drugs. Drug introducers may only introduce drugs at the consent of medical and pharmacy practitioners.</li> <li>To introduce drugs already licensed for marketing in Vietnam strictly according to the list of drugs assigned to him/her by the pharmaceutical business establishment and only disseminate drug information printed on the drugs' label, package insert that have been registered for marketing and documents specified in paragraph 3, Article 76 of the Pharmaceutical Law.</li> <li>To show legal documents proving the drug information contents are regulatory-conforming when requested by the heads of medical service establishments, medical practitioners, or pharmacy practitioners.</li> <li>To collect information on adverse reactions of drugs and report to pharmaceutical business establishment reports related to the quality of drugs while introducing drugs in order for the pharmaceutical business establishment to synthesize and report the information to Ministry of Health's competent authority according to Ministry of Health-promulgated National guidance on pharmacovigilance.</li> <li>Not to commit the following acts: <ol style="list-style-type: none"> <li>Introducing drugs not assigned to him/her by the pharmaceutical business establishment;</li> <li>Using material incentives in any form to influence physicians, pharmacists, drug users in order to promote the prescribing, sales and use of drugs;</li> <li>Introducing, providing drug information not consistent with the documents prescribed in Clause 3 Article 76 of the Pharmaceutical Law;</li> <li>Comparing and introducing drugs of his/her business establishments as better than those of other establishments without supporting scientific literature approved by the competent authority to use as evidence;</li> <li>Introducing non-drug products;</li> <li>Engaging in activities related to the purchase, sale and consignment sale of drugs with medical practitioners;</li> <li>Approaching patients, gaining access to medical records, prescriptions, discussing or requesting patient-related information;</li> <li>Provide drug information material to wrong target subjects.</li> </ol> </li> </ol> <p>Responsibilities of the heads of medical service establishments where there are drug introducers operating:</p> <ol style="list-style-type: none"> <li>To permit only the persons holding "Drug introducer" card and are named on the List of people issued Drug Introducer card (the List is published on the website of Provincial Health Authority website) to carry out drug introduction activities and to provide drug information materials that met the requirements of relevant regulations.</li> <li>To set out and implement internal regulations specifying participant composition, venue and timing for the holding of drug information sessions for medical practitioners and other relevant regulations so as to enable drug introducers to carry out drug information activities on the premises in compliance with the provisions of this Circular.</li> <li>To inspect and monitor regularly and to institute measures to prevent the establishment's medical practitioners from prescribing and providing medication counseling for personal profits under the influence of material, financial or any other form of incentives offered by drug introducers.</li> <li>To immediately suspend drug introducers' activities on the establishment premises if the latter are found not performing according to the terms of responsibility of a drug introducer and to notify the head of the pharmaceutical business establishment of the violating rug introducer. (Circular 31/2025/TT-BYT dated 01 July 2025)</li> </ol>

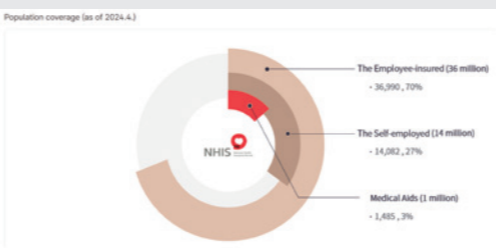
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		RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PRMA	PG															
Promotion	Advertising regulations	N/A	The Undesirable Medical Advertisements Ordinance (UMAO), Cap. 231, was first enacted in 1953. It aims to protect public health through prohibiting or restricting the publication of advertisements for medicine, surgical appliance or treatment that may induce the seeking of improper management of certain health conditions. In order to widen the scope of the UMAO, the Undesirable Medical Advertisements (Amendment) Ordinance 2005 (UMA(AO)) was enacted by the Legislative Council in 2005. The amendments related to the Schedules 1 and 2 under the UMA(AO) have been implemented since 2006 while the remaining provisions have come into force since 1st June 2012. <a href="https://www.drugoffice.gov.hk/eps/doi/en/pharmaceutical_trade/other_useful_information/umao.html">https://www.drugoffice.gov.hk/eps/doi/en/pharmaceutical_trade/other_useful_information/umao.html</a> Broadcast Codes of Practice by Communications Authority Trade Description Ordinance enforced by Custom and Excise Department	List of Codes/Regulations/Laws Regulating Advertisements in India: 1. Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954: Prohibits advertisements of magical cures and certain drugs. 2. Drugs and Cosmetics Act, 1940: Regulates advertising claims related to drugs and cosmetics. 3. Consumer Protection Act, 2019 (CPA): Regulates and penalizes misleading advertisements to protect consumer rights. 4. Advertising Standards Council of India (ASCI) Code: A self-regulatory code ensuring truthful, decent, and non-offensive advertisements. 5. Cable Television Networks (Regulation) Act, 1995: Governs advertisement standards on cable TV networks. 6. Food Safety and Standards Act, 2006: Prohibits misleading advertisements related to food products. 7. Information Technology (Intermediary Trade Description Ordinance) Rules, 2021: Regulates digital advertisements and ensures compliance with the Code of Ethics.	Advertising restrictions are implemented under the guidance of BPOM.A draft of a new BPOM regulation on Promotion and Advertisement was issued in September 2025 and is currently undergoing public hearing. IPMG CODE OF ETHICS April 2025 version also notes several key considerations in the medicine promotion and advertisement to both HCP and the general public.	Considering inadequate advertisement of drugs, quasi-drugs, cosmetics, medical devices, or regenerative medical products may greatly affect public health and hygiene, the Ministry of Health, Labour and Welfare, together with the Pharmaceutical and Medical Device Act, issued the "Revision of the Code of Fair Practices in the Advertising of Drug and Related Product" in September 2018, which regulates advertisements of drugs, etc. <a href="https://www.mhlw.go.jp/stf/seisakunit/suite/bunya/kenkou_iryou/iyakuhin/koukokukisei/index.html">https://www.mhlw.go.jp/stf/seisakunit/suite/bunya/kenkou_iryou/iyakuhin/koukokukisei/index.html</a> In addition to JPM A Code of Practice, the Association has established "Guidelines for Preparation of Ethical Drug Product Information Brochure" as an industry voluntary code and provides points to consider in preparing promotional materials, etc. <a href="http://www.jpma.or.jp/about/basis/drug_info/">http://www.jpma.or.jp/about/basis/drug_info/</a>	<KRPIA Fair Competition Code> A member company may conduct exhibitions or advertisements targeting HCPs for the purpose of expanding and spreading medical or pharmaceutical knowledge, and for maximizing patients' benefit by disseminating various knowledge and experience regarding pharmaceuticals. However, member companies shall report to KRPIA the details of the exhibitions or advertisements every quarter in the form designated by KRPIA. When a member company installs display shelves or booths, the payment shall comply with normal business practices. A member company shall not provide compensation for HCPs visiting its exhibition hall. <Working Guideline> Advertising media for which a member company may pay advertising fee to medical institutions shall be limited to (i) printed materials or electronic documents equivalent to printed materials prepared by medical institutions, (ii) websites operated by academia societetic, and (iii) educational materials. In the case of advertisement for websites operated by academic societies, member companies may pay advertising fees of up to KRW 1 million per month (excluding taxes) within the limit of KRW 10 million per year (excluding taxes). As for other print or electronic advertising media, member companies shall pay an appropriate amount of advertising fees within the limits stated in the below table after taking into consideration the publisher, circulation size, and advertisement effect. <table border="1" data-bbox="1121 972 1472 1136"> <thead> <tr> <th>Publisher</th> <th>Table 2</th> <th>Table 3</th> <th>Table 1,4</th> <th>Inside Page or Electronic Docs</th> </tr> </thead> <tbody> <tr> <td>Medical Institution</td> <td>100</td> <td>70</td> <td>150</td> <td>60</td> </tr> <tr> <td>Academic Societies, etc</td> <td>150</td> <td>100</td> <td>200</td> <td>70</td> </tr> </tbody> </table> Member companies shall use one booth per academic conference in principle and shall not use more than two booths. In the case of academic conferences hosted by academic societies, booth fees of up to KRW 3 million (excluding taxes) may be paid for one booth. In the case of academic conferences hosted by medical institutions, booth fees of up to KRW 1 million (excluding taxes) may be paid for one booth. Member companies shall report to KRPIA details of payments made each quarter determined by the date on which each payment is made by the 20th day of the following month. A member company may provide promotional materials of a minimal value for exhibitions held for over-the-counter drugs of the member company and a pen and a notepad with the company's name, but not the product's name, inscribed on them. For any case, the member company shall not provide promotional materials exceeding the minimum quantity and economic value required for permitted use. <COVID-19 Guideline> has expired as of the July of 2024.	Publisher	Table 2	Table 3	Table 1,4	Inside Page or Electronic Docs	Medical Institution	100	70	150	60	Academic Societies, etc	150	100	200	70	The Guidelines on Advertising Medicines and Medicinal Products to the Public was revised in 2022, with stricter regulations for pharmaceutical companies to advertise. In 2024, PhAMA will be working with the MOH for the revision of the Medicines Advertisements & Sales Act 1956 to make it more relevant to the healthcare sector. One of the key challenges is the prohibition of advertisements or advertorials on 20 diseases which includes NCDs such as cancer, diabetes, etc. (Source: <a href="https://pharmacy.moh.gov.my/en/documents/medicines-advertisement-sale-act-1956-and-regulations.html">https://pharmacy.moh.gov.my/en/documents/medicines-advertisement-sale-act-1956-and-regulations.html</a> )	Only products that are classified as over-the-counter may be advertised. For prescription drugs, advertisement is limited to medical journals. Content of advertisements must be compliant with existing approved labeling materials. (Administrative Order No. 65 s. 1989)	Self-regulation of advertising is similarly described in detail in Article 5,6 of the aforementioned SAPI Code. Guidelines on advertising of ethical pharmaceuticals are set forth in detail in the Health Sciences Authority (HSA)'s following guides: <ul style="list-style-type: none"> <li>• <b>Medicinal Products &amp; Health Supplements:</b> GUIDE ON ADVERTISEMENTS AND SALES PROMOTION OF MEDICINAL PRODUCTS (2019) <a href="http://www.hsa.gov.sg/docs/default-source/hprg-vcb/medical-advertisements-sales-promotion-guidelines_2apr19r.pdf">http://www.hsa.gov.sg/docs/default-source/hprg-vcb/medical-advertisements-sales-promotion-guidelines_2apr19r.pdf</a></li> <li>• <b>Therapeutic Products:</b> <ul style="list-style-type: none"> <li>◦ EXPLANATORY GUIDANCE TO THE HEALTH PRODUCTS (ADVERTISEMENT OF THERAPEUTIC PRODUCTS) REGULATIONS (2016) <a href="https://www.hsa.gov.sg/docs/default-source/hprg-vcb/medical-advertisements-sales-promotion-guidance_hcsa_tm_7nov2024.pdf?sfvrsn=1ab89d8e_1">https://www.hsa.gov.sg/docs/default-source/hprg-vcb/medical-advertisements-sales-promotion-guidance_hcsa_tm_7nov2024.pdf?sfvrsn=1ab89d8e_1</a></li> <li>◦ Guidance for HCSA Licensees and Telemedicine Service Providers on Advertisement Controls of Health Products <a href="https://www.hsa.gov.sg/docs/default-source/hprg-vcb/medical-advertisements-sales-promotion-guidance_hcsa_tm_7nov2024.pdf?sfvrsn=1ab89d8e_1">https://www.hsa.gov.sg/docs/default-source/hprg-vcb/medical-advertisements-sales-promotion-guidance_hcsa_tm_7nov2024.pdf?sfvrsn=1ab89d8e_1</a></li> </ul> </li> <li>• <b>Medical Devices:</b> GN-08: GUIDANCE ON MEDICAL DEVICE ADVERTISEMENT AND SALES PROMOTION (2018) <a href="http://www.hsa.gov.sg/docs/default-source/hprg-mdb/gn-08-r2-guidance-on-medical-device-advertisements-and-sales-promotion.pdf">http://www.hsa.gov.sg/docs/default-source/hprg-mdb/gn-08-r2-guidance-on-medical-device-advertisements-and-sales-promotion.pdf</a></li> </ul>	The advertising regulations are defined and regulated in Article 24, and 65 to 70 of <a href="#">Pharmaceutical Affairs Act</a> and more detail regulations are in Article 44 to 47 of <a href="#">Pharmaceutical Affairs Act Enforcement Rules</a> . <a href="https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcod=e=L0030001">https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcod=e=L0030001</a> <a href="https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcod=e=L0030002">https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcod=e=L0030002</a>	Thailand has pharmaceutical advertising regulations: <ul style="list-style-type: none"> <li>- Specially Controlled Drugs and Dangerous Drugs: <ul style="list-style-type: none"> <li>◦ Advertising is restricted to healthcare professionals only.</li> <li>◦ Must be submitted to the Thai FDA via the e-submission route beforehand.</li> <li>◦ Auto-permission is granted upon submission.</li> </ul> </li> <li>- Non-Specially Controlled and Non-Dangerous Drugs and Household Remedies: <ul style="list-style-type: none"> <li>◦ Can be advertised to the general public.</li> <li>◦ Requires prior approval from the Thai FDA before advertising.</li> </ul> </li> </ul>	<b>Advertising</b> The advertising of pharmaceutical products must comply with the advertising content approved by the Ministry of Health and with the relevant advertising laws and regulations (i.e., the Advertisement Law and its subsidiary regulations). Only the following drugs can be advertised <ul style="list-style-type: none"> <li>• Drugs in the List of Non-prescription Drugs</li> <li>• Drugs whose use should be restricted or should be supervised by a doctor, as recommended in writing by the competent state administrative body</li> <li>• Drugs without a valid marketing authorisation (MA) number in Vietnam.</li> </ul> The advertising of drugs can be in the following forms (Article 17 of Advertisement Law): <ul style="list-style-type: none"> <li>• Newspapers.</li> <li>• Electronic information websites, electronic devices, terminals, and other telecommunication equipment.</li> <li>• Printed products, sound and video recordings, and other technological devices.</li> <li>• Billboards, banners, signs, light boxes, and advertising screens.</li> <li>• Transportation vehicles.</li> <li>• Fairs, seminars, conferences, events, exhibitions, cultural and sports programs.</li> </ul> Persons transporting advertising products; advertising objects. Other advertising media as prescribed by law. It is strictly prohibited to use any material or financial benefits in any form to influence doctors or drug users in order to motivate the prescription and use of drugs. Accordingly, providing consumers with free samples or any special offers is prohibited. Regulations on advertising content of pharmaceutical products, prohibited information and images in drug advertisement, and responsibilities of organizations, individuals engage in drug advertisement is stipulated in Article 103, 104, and 111, respectively of the Decree 163/2025/ND-CP guiding the implementation of Pharmaceutical Law, Furthermore, Vietnam is in the process of developing and revising regulations on drug advertisement in light of the new regulations in the Advertisement Law and online drug advertisement trend (Decree 342/2025/ND-CP guiding Advertisement Law). <b>Drug information activity</b> Drug information activity is considered a separate activity from drug advertisement according to Vietnamese regulations. Drug information aims to guide the rational, safe, and effective use of medications for healthcare professionals, pharmacists, and drug users. <b>Providing drug information to healthcare professionals, pharmacists</b> Pharmaceutical Business Establishment, representative offices of foreign traders operating in pharmaceutical field in Vietnam, drug registrant are permitted to be introduced drug to healthcare professionals (i.e., medical and pharmacy practitioner) via 3 methods: i) drug introducer (also known as medical representative in other nations); ii) by providing drug information materials; and iii) via drug conference. The information to be provided to healthcare professionals must include the following contents: <ul style="list-style-type: none"> <li>• Drug name.</li> <li>• Active ingredients.</li> <li>• Strength/concentration.</li> <li>• Form of preparation.</li> <li>• Indications.</li> <li>• Contraindications.</li> <li>• Dosage.</li> <li>• Method of administration.</li> <li>• Use of the drug by special subjects.</li> <li>• Information relating to drug warnings and safety and other essential information.</li> </ul> <b>Providing drug information to drug users</b> The information to be provided to drug users must include the following contents: <ul style="list-style-type: none"> <li>• Drug name.</li> <li>• Drug use</li> <li>• Indications.</li> <li>• Contraindications.</li> <li>• Dosage.</li> <li>• Method of administration.</li> <li>• Precautions for use.</li> </ul> (Pharmaceutical Law No 44/2024, Decree No. 163/2025/ND-CP dated June 29, 2025 on elaborating certain articles and measures for the implementation of the Pharmaceutical Law; Circular No. 31/2025/TT-BYT dated July 01, 2025 on elaborating certain articles of the Law on pharmacy and Decree No. 163/2025/ND-CP elaborating certain articles and measures for the implementation of the Pharmaceutical Law; Advertisement No 75/2025; Decree 342/2025/ND-CP guiding Advertisement Law)
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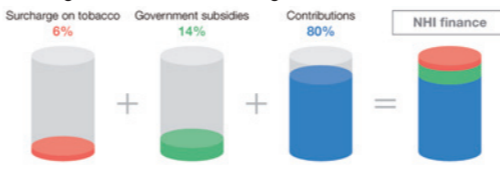
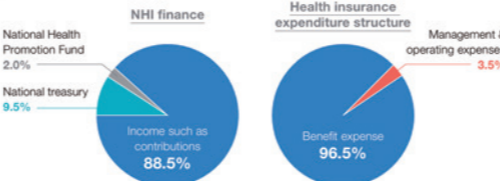
Category	Item	Types	China 2026	Hong Kong 2026	India 2026	Indonesia 2026	Japan 2026	Korea 2026	Malaysia 2026	Philippines 2026	Singapore 2026	Taiwan 2026	Thailand 2026	Vietnam 2026
			RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PRReMA	PG
Insurance & drug pricing system/ Public healthcare system	Current status of medical insurance system		Basic Medical Insurance for Employees and Urban & Rural Residents	There is no mandatory public medical insurance system. The Voluntary Health Insurance Scheme (VHIS) is a policy initiative implemented by the Health Bureau to regulate indemnity hospital insurance plans offered to individuals by insurance companies. The participation by insurance companies and consumers is voluntary.	Types of Health Insurance in India The National Health Policy formulated in 2017 envisages to provide universal access to good quality healthcare services through increasing access, increasing affordability by lowering the cost of healthcare delivery and equity. The Government of India runs several health insurance schemes through its various ministries. Government-subsidised health insurance schemes: Government subsidised health insurance schemes provide fully or partially subsidised insurance coverage to specific targeted segments of the population. These schemes predominantly target the poor and the informal sector. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), launched in September 2018, is the single largest health insurance scheme. AB-PMJAY provides subsidised and comprehensive secondary and tertiary healthcare packages with annual coverage of Rs. 5 lakhs per family on a floater basis. In September 2024 Government decided to include all senior citizens above the age of 70 under ABPMJAY irrespective of their income with an aim to benefit approximately six (6) crore senior citizens	The 2004 National Social Security Law (Law No. 40/2004) envisages coverage of the entire population through JKN, a mandatory program evolving from existing insurance programs. Until the end of 2013, Indonesia was supported by three major social health insurance programs: Jamkesmas (Jaminan Kesehatan Masyarakat/the government-financed health coverage program for the poor and near-poor); Jamsostek Health (the social health insurance program for formal sector workers); and Askes (the social health insurance program for civil servants). The 2011 BPJS (Badan Penyelenggara Jaminan Sosial/Social Security Administration) Law (Law 24/2011) declared the transformation of PT Askes into Health BPJS.	1. Health Insurance (JHIA (Japan Health Insurance Association), Health Insurance Societies) 2. Seamen's Insurance 3. Mutual aid associations (national and local government officers, etc., and teaching faculty of private educational institutions) 4. National Health Insurance (NHI) 5. Medical care system for the elderly aged 75+	N/A	Medical insurance was highly debated in 2025 due to increased premiums and instructions from Third-Party Agents (TPAs) for generic-first or generic-only approach to control cost of claims. However, this has received a serious backlash from medical providers who regard this an interference in clinical decisions which may impact patient outcomes. As a result, the Central Bank has been tightening governance for TPAs in light of claim delays and denials.	N/A	Singapore's healthcare financing system is founded on a multi-tier framework designed to promote individual responsibility, shared risk, and targeted state support. The system combines mandatory medical savings, basic universal insurance, and a public safety net to ensure affordability and sustainability across the population. <b>1. Core Components</b> <b>MediSave</b> • Introduced in 1984, MediSave is a compulsory medical savings account funded by contributions from employers and employees under the Central Provident Fund (CPF). • Savings can be used to pay for hospitalisation, day surgery, certain outpatient treatments, and approved insurance premiums (e.g., MediShield Life, CareShield Life, Integrated Shield Plans). • Annual contribution rates range from 8–10.5% of wages, depending on age. <b>MediShield Life (MSHL)</b> • Implemented in 2015, MediShield Life provides universal basic health insurance for all Singapore Citizens and Permanent Residents, regardless of age or pre-existing conditions. • It covers large hospital bills and selected outpatient treatments, including dialysis, cancer drug treatments, and cell/gene therapies listed on MOH-approved lists. • Premiums are payable via MediSave, with government subsidies of up to 60% for lower-income households and Additional Premium Support for those unable to pay even after subsidies. • As of October 2025, key enhancements include: ◦ An annual claim limit of S\$200,000 (up from S\$150,000). ◦ Higher inpatient and ICU claim limits. ◦ Coverage for selected Cell, Tissue and Gene Therapy Products (CTGTPs) and non-cancer High-Cost Drugs through the CTGTP List and High-Cost Drug List (HCDL) frameworks. <b>MediFund</b> • Established in 1993, MediFund serves as a financial safety net for Singaporeans who cannot afford their medical bills even after subsidies, MediSave, and MediShield Life claims. • Assistance is means-tested and applied through public hospitals and intermediate- and long-term care institutions. <b>2. Supplementary and Private Coverage Integrated Shield Plans (IPs)</b> • Administered by private insurers, IPs combine the basic MediShield Life component with a private insurance component offering coverage for higher-class wards (A/B1) or private hospitals. • About 70% of Singapore Residents hold an IP as of 2025, according to MOH statistics. • From April 2026, new IP riders will: ◦ Exclude coverage of deductibles; ◦ Include a minimum co-payment cap of S\$6,000 per policy year; ◦ Align cost-sharing structures with MOH guidelines to maintain affordability and reduce over-utilisation. <b>3. Supporting Schemes</b> • <b>CareShield Life</b> provides basic long-term care insurance for severe disability, with enhancements and subsidy expansions coming into effect from 2026. • <b>CHAS (Community Health Assist Scheme)</b> and <b>Healthier SG enrolment subsidies</b> provide additional outpatient and chronic disease support at participating clinics. • <b>Matched MediSave Scheme (2026–2030)</b> will match cash top-ups to MediSave for eligible seniors aged 55–70, up to S\$1,000 annually, to strengthen personal savings. <b>4. Recent and Emerging Policy Developments (2025–2026)</b> • <b>CTGTP Financing Frameworks (from Oct 2025):</b> MediShield Life and MediSave coverage now apply to selected cell, tissue and gene therapies, based on MOH-approved clinical and cost-effectiveness criteria. • <b>Cancer Drug List (CDL) and Subsidised Drug List (SDL) Updates:</b> Lists are reviewed regularly, with the latest CDL update in <b>November 2025</b> guiding claim limits and inclusion for 2026. • <b>Genetic Testing Policy Direction (announced 2025):</b> MOH will create a separate subsidised category for clinically and cost-effective <b>genetic tests</b> , with corresponding MediSave and subsidy support. Downstream interventions—such as targeted drug treatments or enhanced surveillance—will also be supported. Implementation details are forthcoming. • <b>Primary Care Mental Health Protocols (from Jan 2026):</b> <i>Healthier SG</i> clinics will adopt new protocols for Major Depressive Disorder and Generalised Anxiety Disorder, strengthening early management and coordination with community teams.  [MOH Healthcare schemes & subsidies: <a href="https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies">https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies</a> ]	National Health Insurance: compulsory social insurance program for all citizens with official residency or foreign national citizens with Alien Resident Certificate. The National Health Insurance program classifies the insured into six categories depending on their employment status. [Source: <a href="#">Handbook of Taiwan's National Health Insurance 2020–2021</a> ]	Universal Health Coverage Scheme (UCS) Civil Servants Medical Benefit Scheme (CSMBS) Social Security Scheme (SSS) Private insurance	1. Social health insurance following the insurance law (compulsory insurance) - At designated medical institutions, 80 to 100% of medical expenses are covered by insurance 2. Private insurance / commercial health insurance

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Insurance & drug pricing system/ Public healthcare system	Current status of medical insurance system	Responsible Organizations	National Healthcare Security Administration. (NHSA)	The Insurance Authority (IA), which is an independent statutory body, administers the Insurance Ordinance which has provisions governing the regulation of insurers and insurance intermediaries (agents and brokers) in Hong Kong	RSBY: Central Government of India (Ministry of Labour and Employment, Government of India) ESIS: State Insurance Corporation CGHS: Central Government of India State Insurance: Respective State Government Private Insurance: Organisation issuing private insurance Ayushman Bharat Scheme: National Health Authority	1.BPJS Health is a JKN implementing institution to serve National Health Security of Indonesian citizen which was used to be PT ASKES (health insurance public corporation PT Asuransi Kesehatan). - Based on Bill No.24/2011 about BPJS, ASKES changed to BPJS Kesehatan as of January 1, 2014 BPJS-K is doing the premium collection & polling, carrying out active purchasing for health services. 2.DJSN:The National Social Security Council is formulating the general policy, doing the supervision and control of programs and institutions, also developing budget proposal for contribution assistance and operational costs of BPJS-K Other relevant ministries, e.g Ministry of Finance, MoH, Ministry of Internal Affairs, Social Ministry, local governments etc	1. JHIA (Japan Health Insurance Association), Health Insurance Societies 2. JHIA (Japan Health Insurance Association) 3. Mutual Aid Associations 4. Municipalities, National Health Insurance Union 5. Association of Medical Care Services for Older Senior Citizens	MoHW: Control overall drug pricing and reimbursement policy.	1. Ministry of Health (MOH) 2. Ministry of Finance (MOF) 3. Central Bank (BNM) 4. Association of Private Hospitals Malaysia (APHM) 5. Life Insurance Association Malaysia (LIAM) 6. Private Insurance Association Malaysia (PIAM)	Philippine Health Insurance Corporation (PhilHealth)	<ul style="list-style-type: none"> <li>• <b>Ministry of Health (MOH)</b> – Leads national healthcare financing policy and regulation; oversees MediSave, MediShield Life, CareShield Life, MediFund, and drug subsidy lists.</li> <li>• <b>Central Provident Fund (CPF) Board</b> – Administers MediSave accounts, MediShield Life and CareShield Life premium payments, and MediSave withdrawals.</li> <li>• <b>Ministry of Finance (MOF)</b> – Provides fiscal oversight and budget funding for subsidies, MediFund, and national schemes.</li> <li>• <b>Agency for Care Effectiveness (ACE)</b> – Conducts health technology assessments (HTA) and advises MOH on inclusion of drugs, tests, and therapies for subsidy or coverage.</li> <li>• <b>Integrated Shield Plan (IP) Insurers</b> – Offer MediShield Life-complementing private plans; regulated by MOH and the Monetary Authority of Singapore (MAS).</li> <li>• <b>Public Healthcare Clusters (NHG, NUHS, SingHealth)</b> – Administer subsidies, MediShield Life and MediSave claims, and MediFund applications at point of care.</li> </ul>	Department of Social Insurance, Ministry of Health and Welfare National Health Insurance Administration, Ministry of Health and Welfare	UCS: National Health Security Office (Independent agency affiliated with the Ministry of Public Health) CSMBS: Comptroller General's Department, Ministry of Finance SSS: Social Security Office, Ministry of Labor Private insurance: Insurance companies	1. Vietnam Social Security 2. Private corporation

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Insurance & drug pricing system/ Public healthcare system	Current status of medical insurance system	Insurance coverage	Up to the end of 2024: More than 1.33 billion covered by basic medical insurance: Basic Medical Insurance for Employees (379.48 million) Basic Medical Insurance for Urban & Rural Residents (947.14 million) <a href="https://www.gov.cn/lianbo/bumen/202507/content_7031956.htm">https://www.gov.cn/lianbo/bumen/202507/content_7031956.htm</a>	In 2023/24, ●10.0% (HK\$25,222Mn) of the current health expenditure is paid via privately purchased insurance schemes ●6.1% (HK\$15,202Mn) of the current health expenditure is paid via employer-based insurance schemes <a href="https://www.hkdhha.gov.hk">Hong Kong's Domestic Health Accounts (HKDHA)</a> Some 3 453 500persons (49.7%) were entitled to medical benefits provided by employers/companies or were covered by individually purchased medical insurance or had both kinds of medical protection. Among them, 1 147 000persons (33.2%) were entitled to medical benefits from employers/companies only, including 328 400 persons entitled to medical benefits provided by civil service/Hospital Authority only. While another 1 261 200persons (36.5%) were covered by individually purchased medical insurance only, the remaining 1 045 300 persons (30.3%) had both kinds of medical protection Source : Thematic Household Survey Report <a href="#">Report No.78-</a> Census and Statistics Department (Data released in Jan 2024)	AB-PMJAY and State Government extension schemes cover around 70 crore individuals. Around 20% of the population – 25 crore individuals – are covered through social health insurance, and private voluntary health insurance. The remaining 30% of the population is devoid of health insurance coverage. Source – Health Insurance for the Missing Middle – Niti Aaypg Report 2021.	Target Universal Healthcare Coverage 2025: 98% participants of total population. Achievement per August 2025 (BPJS-K): 281.6 million registered participants or 98.7% of total Indonesian population, out of which close to 117 million are PBIs or 41.54% of the total membership Active membership is recorded at 227 million participants or 79.8% of total Indonesia population or 80.62% of the total membership. Source: <a href="https://kes.ehatan.djsn.go.id/kesehatan/doc/laporan-bulanan/Monthly_Report_JK_N_08_2025.pdf">https://kes.ehatan.djsn.go.id/kesehatan/doc/laporan-bulanan/Monthly_Report_JK_N_08_2025.pdf</a>	100%. All Japanese citizens, permanent residents, and any non-Japanese residing in Japan with a visa lasting three months or longer are required to be enrolled in either National Health Insurance or Employees' Health Insurance. <a href="https://www.mhlw.go.jp/bunya/iryuhoken/iryuhoken01/dl/01_eng.pdf">https://www.mhlw.go.jp/bunya/iryuhoken/iryuhoken01/dl/01_eng.pdf</a>	National reimbursement coverage in 2023 dropped down to 64.9% compared to 65.7% the year before. Source: NHIS <2020-2023 Healthcare insurance coverage>	Mysalam B40 Scheme for B40 remains unchanged. In Oct 2023, a new scheme known as "Insurance Rahmah" was launched, which provides personal accident coverage of up to RM50,000 due to death, dengue and dengue death, and total permanent disability. Premium is at RM50 (USD 10.50 per year). The initiative is under the purview of the Development of Human Resources for Rural Areas (DHRRA) Malaysia. As long-term measure, the Min of Health and Min of Finance will be introducing a basic medical and health insurance scheme (MHIT), set to be introduced in early 2027 for middle-income population. For low-income families, the government sponsors the People's Welfare Insurance Scheme (SIKR) which was initially launched in 2022. In December 2025, the program to offer enhanced coverage to provide even stronger protection for low-income families. The coverage is managed by Prudential BSN Takaful Berhad (PruBSN). (Source: <a href="https://www.thestar.com.my/metro/metro-news/2023/10/17/insurance-rahmah-for-b40-folk">https://www.thestar.com.my/metro/metro-news/2023/10/17/insurance-rahmah-for-b40-folk</a> )	100% population coverage PhilHealth <a href="https://www.philhealth.gov.ph/about_us/statsncharts/SNC_2025_1stSem_v1.pdf">https://www.philhealth.gov.ph/about_us/statsncharts/SNC_2025_1stSem_v1.pdf</a>	MediShield Life is a basic health insurance plan that protects all Singapore Citizens and Permanent Residents against large medical bills for life, regardless of age or pre-existing conditions. Roughly 2.9 million people here, or some 70 per cent of Singaporeans and permanent residents, have IPs to cover stays in higher-class A or B1 wards in public hospitals, or private hospital stays. Of this group, two in three have an add-on rider plan to reduce their out-of-pocket expenses such as deductibles and co-insurance.	99.9% (March 2022) [Source: National Health Insurance Administration, Ministry of Health and Welfare]	100%. Under the system, all citizens are covered by public insurance (UCS, CSMB, and SSS)	According to Ministry of Finance, by the end of June 2025, the percentage of population joining social health insurance is 95.2%. <a href="https://www.qdnd.vn/xa-hoi/tin-tuc/hon-95-dan-so-da-tham-gia-bao-hiem-y-te-836636">https://www.qdnd.vn/xa-hoi/tin-tuc/hon-95-dan-so-da-tham-gia-bao-hiem-y-te-836636</a>						
								<table border="1"> <thead> <tr> <th>Year</th> <th>National Reimbursement coverage</th> <th>co-payment</th> <th>Non-reimbursement rate</th> </tr> </thead> <tbody> <tr> <td>2020</td> <td>65.3%</td> <td>19.5%</td> <td>15.2%</td> </tr> <tr> <td>2021</td> <td>64.5%</td> <td>19.9%</td> <td>15.6%</td> </tr> <tr> <td>2022</td> <td>65.7%</td> <td>19.7%</td> <td>14.6%</td> </tr> <tr> <td>2023</td> <td>64.9%</td> <td>19.9%</td> <td>15.2%</td> </tr> </tbody> </table>							Year	National Reimbursement coverage	co-payment	Non-reimbursement rate	2020	65.3%
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Insurance & drug pricing system/ Public healthcare system	Current status of medical insurance system	Target population	1. Basic medical insurance for employees: Centers on workers in urban corporations 2. Basic Medical Insurance for urban & rural residents: residents in urban and agricultural areas, including non-employees, i.e. children and elders	All	<b>Type of insurance</b>	<b>Target Population Covered</b>	BPJS Kesehatan being the universal health coverage programme of Indonesia targets the whole population of the country (>284 million people by mid-2025). Source : <a href="https://bpjs-kesehatan.go.id/#/">https://bpjs-kesehatan.go.id/#/</a>	1.General employees and family members (67.98 million) 2. Seamen and family members (0.11 million) 3. National and local government officers, etc., and teaching faculty of private educational institutions and family members (8.36 million) 4. Farmers, self-employed and other retirees of employees' insurance (26.60 million) 5. Persons aged 75+, etc. (19.77 million) [As of April 2023]	Health Security System is included "National Health Insurance scheme", "Medical Aid Program" and "Long-term Care Insurance program". · National Health Insurance (NHI) scheme: The NHI scheme of Korea covers the whole population residing within in territory of Korea. The major source of financing is contributions from the insured and government subsidies. · Medical Aid Program: Medical Aid program by the government is policy assistance scheme to secure the minimum living standard of low-income householders and to assist with the self-help by providing medical service. The major source of financing is general tax of local government but review and payment process is handling by HIRA and NHIS. · Long-term Care Insurance program (LTCI): The LTCI program was first introduced in July in 2008 to alleviate financial burden on nursing and to encourage health promotion and living stabilization. The program aims at the elderly with difficulties in activities of daily living due to geriatric disease or old age by supporting physical activities and household.	B40 (socio-economic classification) 1. Enrollees in pension system for civil servants: 1.6 million people (principal, retiree, spouse, children up to age of 18) 2. EPF: employees of private corporations, the self-employed, housewives, etc. Even civil servants can select EPF 3. Middle 40% income group. <i>Bantuan Sara Hidup</i> recipient aged between 18 – 65 years old who earned less than MYR24,000 annually also qualified for the scheme.	All Filipinos (employed, informal/ self-earning, overseas Filipinos, lifetime members, kasambahay, indigents, senior citizens)  PhilHealth <a href="https://www.philhealth.gov.ph/about_us/statsnchar ts/SNC_2025_1s tSem_v1.pdf">https://www.philhealth.gov.ph/about_us/statsnchar ts/SNC_2025_1s tSem_v1.pdf</a>	1. Medisave: Employees and their families. Compulsory enrolment; personal medical account. 2. MediSave Care: Severe disability insurance scheme for Singaporeans aged 30 and above facing severe disabilities 3. MediShield Life: Compulsory insurance that supplements part of the high-cost inpatient treatment that is not completely covered by Medisave, all Singapore citizens and Permanent residents are eligible regardless of age and health condition. 4. MediFund: endowment fund set up by government to help needy Singaporeans with their remaining bills after receiving prior government subsidies, eligibility includes being a Singaporean, a subsidized patient who has received or will be receiving treatment from a MediFund-approved institution 5. CareShield Life: Basic long term care insurance scheme for people who are severely disabled, implemented on October 1, 2020. Singaporeans born in 1980 or later and those were born between 1970-1979 and insured under the ElderShield400 scheme and are automatically enrolled. Otherwise, they could choose to join CareShield Life in 2021. 6. ElderShield: CPF enrollees aged 40 or older (automatic enrolment unless elderly who are unable to perform 3 or more of the 6 activities of daily living. Closed for new applications since 2020. 7. CHAS (Community Health Assist Scheme) is eligible for lower-to-middle income households, as well as Pioneers to receive subsidies for medical and dental care at GP and dental clinics 8. ElderFund, a new discretionary assistance scheme targeted at assisting severely disabled lower-income Singapore Citizens aged 30 and above, eligible for Singaporean elderly who are unable to perform 3 or more of the 6 activities of daily living, Singaporeans aged 30 and above and residing in Singapore, Household monthly income per person is \$1,200 or less and Medisave balance of less than \$10,000. 9. Vaccination and Childhood Developmental Screening Subsidies, eligible to all Singapore Citizens who meet all criteria stipulated in the latest NCIS, NAIS or CDS guidelines 10. Medical Assistance Fund (MAF): For all Singapore Citizens and Permanent Residents receiving subsidized care at public healthcare institutions, under particular care settings (i.e. acute inpatient, day surgery, specialist outpatient clinic, polyclinic) 11. Government Subsidies at public healthcare institutions, for Singapore citizen and permanent residents who receive treatment in public hospitals, they receive up to 80% subsidy of the total bill. The monthly PCHI criteria for each subsidy tier will be raised, with increases ranging from \$100 to \$300.	All citizens with official residency or foreign national citizens with Alien Resident Certificate. At the end of 2021, there were 23,861 thousand beneficiaries. [Source: <a href="https://www.health.gov.sg/2021-12-23-national-health-insurance-annual-statistical-report-2021">National Health Insurance Annual Statistical Report 2021</a> ] The National Health Insurance Administration has revised the regulations for citizens who have been abroad for more than 6 months to apply for suspension of insurance. Starting from December 23, 2024, applications for insurance suspension will no longer be accepted. As long as citizens have household registration, they should continue to pay insurance premiums. For people who have applied for suspension of insurance before December 22, 2024 (inclusive), if they have been abroad for more than 6 months, the suspension of insurance will continue to be effective until the date of return to Taiwan; if they have been abroad for less than 6 months, the suspension of insurance should be cancelled, and the health insurance premiums during the suspension period must be paid. (NHIA's press release on December 23, 2024)	Civil Servants Medical Benefits Scheme (CSMBS): Civil servants and government employees, retired civil servants, and their dependents. Usage 9% of Population. Social Security Scheme (SSS): All formal private sector employees. Usage 16% of Population. Universal Coverage Scheme (UCS): Thai citizens not covered by CSMBS or SSS. Usage 71% of Population.	Detail list of subjects participating in social health insurance is stipulated in Article 12 of the Social Health Insurance Law and is categorized in the following based on how the contribution to the social health insurance is paid: 1. Subjects whose contributions are paid by the employer, the employee, or jointly by both employer and employee 2. Subjects whose contributions are paid by the Vietnam Social Security 3. Subjects whose contributions are paid by the state budget 4. Subjects whose contributions are subsidized by the state budget 5. Subjects who is self-paid Other subjects											
					Rashtriya Swasthya Bima Yojna (RSBY)	Below Poverty Line (BPL) families included in the district BPL list prepared by State government																				
					Employees State Insurance Scheme (ESIS)	All the employees from Any establishment having more than 10 employees who earn up to Rs 21000 per month + Their dependants.																				
					Central Government Health Scheme	Central government employees+ Certain autonomous, semiautonomous and semi – government Organisations. + Members of parliament, governors, Accredited journalists.																				
					Private Health Insurance	Pan India Mostly urban population with minimal reach in rural area																				



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Insurance & drug pricing system/ Public healthcare system	Current status of medical insurance system	Financing of Healthcare	In 2025, Per capital government subsidies for Urban & Rural Residents were not less than 700 yuan. National Healthcare Security Administration <a href="https://ybj.ah.gov.cn/public/7071/150289711.html">https://ybj.ah.gov.cn/public/7071/150289711.html</a>	The provision of healthcare services is mainly structured around a public healthcare system that is heavily subsidized (subsidy level reached 96% of the cost for most services) by public fund i.e. general taxation and other government revenue. In 2023/24, ●51.6% (HK\$12 9,675Mn) of the current health expenditure was paid via the government schemes ●31.9% (HK\$80,019Mn) was by household out-of-pocket payment ●10.0% (HK\$25,222Mn) of the current health expenditure is paid via privately purchased insurance schemes ●6.1% (HK\$15,202Mn) of the current health expenditure is paid via employer-based insurance schemes ●0.1% (HK\$354Mn) was paid via Non-Profit institutions serving households Health Bureau - <a href="https://www.hkdha.gov.hk/">Hong Kong's Domestic Health Accounts (HKDHA)</a>	<b>Type of insurance</b> Rashtriya Swasthya BiMayojna (RSBY) Employees State Insurance Scheme (ESIS) Central Government Health Scheme Private Health Insurance State schemes PMJAY	<b>Target Population Covered</b> 75% by Central Government, 25% by state government And Nominal 30 Rs annual payment by family Funded by employee and employer contributions equivalent, respectively, to 1.75% and 4.75% of gross salaries. Payroll-based contributions range from Rs250 to Rs1,000 a month, but cover only a fraction of the scheme's costs, which are funded predominantly by the central government. Self-Paid Often supplemented by local 'sin' taxes (on alcohol or tobacco, for example) costs split between central (60%) and state (40%) governments.	[1] PBI: Government funded (national treasury). Covers poor and near poor people of 96.6 million members at Rp 42.000/pm/capita (premium is all subsidized by the government for poor and near poor or PBI member) [2] Non-PBI: Civil servants and wage earners pay 5% of the salary, out of which 4% is borne by the employer Informal sector pays according to hospital classes per month per capita as of July 1, 2020 (PresDecree 64/2020) Class 3 Rp 25.500 Rp 42.000 (Rp 35.000 paid by member and Rp 7.000 subsidized by the Government) Class 2 Rp 51.000 Rp 100.000 Class 1 Rp 80.000 Rp 150.000 The MoH has issued a ministerial decree no 51/2018 on cost-sharing and co-payment which would alleviate the financial burden of the government, but is however not yet implemented due to legal and technical considerations	Regarding 1-4, in addition to the financial resources from insurance premiums, there are government funding and subsidies as follows. 1. Japan Health Insurance Association (16% of benefits, etc.), Health Insurance Societies (fixed amount) 2. seamen's Insurance (fixed amount) 4. Municipal National Health Insurance (41% of benefits, etc.), National Health Insurance Union (32-45% of benefits, etc.) Regarding 5., 10% from insurance premiums, 40% from support money, and 50% from public funds (State: 4; Prefecture: 1; Municipality: 1)	NHIS receives subsidies from the government, corresponding to 14% of the contribution revenue expected for that year. The NHIS also receives subsidies from the National Health Promotion Fund, which corresponds to 6% of the contribution revenue expected for that year. This, however, is limited up to 65% of estimated tobacco surcharges, the source of funding.  Source: NHIS, 2022 Expenditures for the NHI include insurance benefit payments, management and operation costs, and others. In 2020, 96% of the expenditures were used for the insurance benefit payments for subscribers and dependents, and management and operation payments took up 4%. By type of health-care facilities, general hospitals received 36% of the medical expense payments, hospitals 17%, clinics 27%, and pharmacies 20%. In 2022, 88.5% of the NHI budget was funded with contributions and other revenues, 9.5% was subsidized by the national treasury, and 2.0% by the National Health Promotion Fund.  Source: NHIS, 2022 (Source: 2022 Booklet for the Introduction of NHI System 2024 National Health Insurance & Long-Term Care Insurance System Republic of Korea)	Health Ministry gets an allocation of RM46.5 billion for 2026, up from RM45.27 billion for 2025. (Source: Budget 2026)  Out of this allocation, only 16.5% goes to pharmaceuticals. Source: <a href="https://www.bernama.com/en/news.php/world/general/news.php?id=2477489#:~:text=1n%20a%20state%20the%20MOH,27%20billion%20in%202025.">https://www.bernama.com/en/news.php/world/general/news.php?id=2477489#:~:text=1n%20a%20state%20the%20MOH,27%20billion%20in%202025.</a>	1. Government schemes and compulsory contributory health care financing schemes 2. Household out-of-pocket 3. Voluntary health care payment schemes  Philippine Statistics Authority <a href="https://psa.gov.ph/statistics/pnha/nod/e/1684077816">https://psa.gov.ph/statistics/pnha/nod/e/1684077816</a>	• Under the CPF system as a whole, a savings fund accumulates with enrollees paying in 7.5–17% of their salary and companies paying in 5–20%, depending on the age of the enrollee. • Under the medical account component of the system, enrollees pay in 8-10.5% of their wage which will supplement both Medisave and Medishield Life. ◦ MediShield Life is a basic health insurance plan, administered by the Central Provident Fund (CPF) Board, which helps to pay for large hospital bills and selected costly outpatient treatments, such as dialysis and chemotherapy for cancer. It is structured so that patients pay less MediSave/cash for large hospital bills. ◦ Medifund: Entire endowment fund set up by national treasury • ElderShield: provides monthly payouts of \$300 or \$400 per month for up to 5 or 6 years, insurance premiums are still paid from Medisave up until the age of 65 CPF Contribution Website on Medisave <a href="https://www.cpf.gov.sg/member/faq/healthcare-financing/medisave">https://www.cpf.gov.sg/member/faq/healthcare-financing/medisave</a> CPF contribution website on EldersShield <a href="https://www.cpf.gov.sg/member/healthcare-financing/eldersshield">https://www.cpf.gov.sg/member/healthcare-financing/eldersshield</a> CPF contribution website <a href="https://www.cpf.gov.sg/member/cpf-overview">https://www.cpf.gov.sg/member/cpf-overview</a>	The system mainly derives its revenue from the premiums paid collectively by the insured, employers, and the government. Other revenues come from outside sources, such as fines on overdue premiums, public welfare lottery contributions, and a health and welfare surcharge on tobacco products.	UCS: general tax CSMBS: general tax (General account held by Ministry of Finance) SSS: tripartite: payroll contribution from employee (5% of salary) + company (5% of salary) + government: (Ministry of Labor - may not be paid, depending on economic conditions (2.75% of salary), at the maximum of 15,000 THB. Private Insurance: out of pocket / welfare Self-pay: overlap with CSMBS, SSS and UCS.	The exact amount of contribution to social health insurance varies depending on the subjects as stipulated in Article 13 of the Social Health Insurance Law. The maximum contribution per law is 6 percent of monthly salary. As of hitherto, employees working in the formal labor market, who have signed labor contracts and participate in mandatory social insurance contribute 4.5 of their monthly salary to social health insurance (in which the employer contributes 3% and the employee contributes 1.5%). The Ministry of Health is proposing to raise the contribution amount from 4.5% of the basic income to 5.1% starting from 2027 and to maximumly 6% after 2030.  <a href="https://tuoitre.vn/bo-y-te-de-xuat-nang-muc-dong-bao-hiem-y-ten-5-1-6-luong-co-so-nhung-se-theo-lo-trinh-2025-120211-0508731.htm">https://tuoitre.vn/bo-y-te-de-xuat-nang-muc-dong-bao-hiem-y-ten-5-1-6-luong-co-so-nhung-se-theo-lo-trinh-2025-120211-0508731.htm</a>

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Insurance & drug pricing system/ Public healthcare system	Current status of medical insurance system	Payment and coverage of healthcare expenses	In general a standard deductible, co-pay and ceiling are set and vary by regions. Employee medical insurance inpatient expenses within the scope of NRDL, the fund payment ratio is 84.8%; Resident medical insurance inpatient expenses within the scope of NRDL, the fund payment ratio is 68.6%. <a href="https://www.nhs.a.gov.cn/ar/2025/7/14/art_7_17248.html#:~:text=2024%E5%B9%B4%E8%81%8C%E5%B7%A5%E5%8C%BB%E4%BF%9D%E5%8F%82%E4%BF%9D%E4%BA%BA%E5%91%98%E5%8C%BB%E8%8D%AF%E6%80%B9%E7%94%A82058746%E4%BA%BF%E5%85%83%EF%BC%8C%E6%AF%94%E4%B8%8A%E5%B9%B4%">https://www.nhs.a.gov.cn/ar/2025/7/14/art_7_17248.html#:~:text=2024%E5%B9%B4%E8%81%8C%E5%B7%A5%E5%8C%BB%E4%BF%9D%E5%8F%82%E4%BF%9D%E4%BA%BA%E5%91%98%E5%8C%BB%E8%8D%AF%E6%80%B9%E7%94%A82058746%E4%BA%BF%E5%85%83%EF%BC%8C%E6%AF%94%E4%B8%8A%E5%B9%B4%</a>	<p><b>Public Sector</b> Medical services provided by HA hospitals/clinics are charged as per the Gazette. People who have financial difficulties in paying medical expenses at the public sector may apply for medical fee waiver. There are 3 categories of charges:</p> <p><b>1. Public Charges – Eligible Persons</b></p> <table border="1"> <tr><td>Accident &amp; Emergency</td><td>\$180 per attendance</td></tr> <tr><td>Inpatient (acute general beds)</td><td>\$75 admission fee, \$120 per day</td></tr> <tr><td>Inpatient (convalescent / rehabilitation, infirmary &amp; psychiatric beds)</td><td>\$100 per day</td></tr> <tr><td>Specialist outpatient (including allied health clinic)</td><td>\$135 for the 1st attendance, \$80 per subsequent attendance, \$15 per drug item</td></tr> <tr><td>General outpatient</td><td>\$50 per attendance</td></tr> <tr><td>Dressing or injection</td><td>\$19 per attendance</td></tr> <tr><td>Psychiatric day hospital</td><td>\$60 per attendance</td></tr> <tr><td>Geriatric day hospital</td><td>\$60 per attendance</td></tr> <tr><td>Rehabilitation day hospital</td><td>\$55 per attendance</td></tr> <tr><td>Day procedure and treatment at Clinical Oncology Clinic or Renal Clinic</td><td>\$96 per attendance</td></tr> <tr><td>Day procedure and treatment in ambulatory facility</td><td>\$195 per attendance</td></tr> <tr><td>Community nursing service (general)</td><td>\$80 per visit</td></tr> <tr><td>Community nursing service (psychiatric)</td><td>Free</td></tr> <tr><td>Community allied health service</td><td>\$80 per visit</td></tr> </table> <p><b>2. Public Charges – Non-eligible Persons</b></p> <table border="1"> <tr><td>Accident &amp; Emergency</td><td>\$1,230 per attendance</td></tr> <tr><td>Inpatient (general hospitals)</td><td>\$5,100 per day</td></tr> <tr><td>Inpatient (psychiatric hospitals)</td><td>\$2,340 per day</td></tr> <tr><td>Intensive care ward/unit</td><td>\$24,400 per day</td></tr> <tr><td>High dependency ward/unit</td><td>\$13,650 per day</td></tr> <tr><td>Nursery</td><td>\$1,340 per day</td></tr> <tr><td>Obstetrics package charge For booked cases, includes • one antenatal checkup; • delivery / delivery care service; and • three days (two nights) hospitalization in a public general ward related to the delivery / delivery care service</td><td>\$39,000</td></tr> <tr><td>Obstetrics package charge For non-booked cases or patients who have not undergone any antenatal checkup provided by HA during the pregnancy concerned, includes • delivery / delivery care service; and • three days (two nights) of hospitalization in a public general ward related to the delivery / delivery care service</td><td>\$90,000</td></tr> <tr><td>Specialist outpatient (including allied health clinic)</td><td>\$1,190 per attendance</td></tr> <tr><td>General outpatient</td><td>\$445 per attendance</td></tr> <tr><td>Dressing or injection</td><td>\$100 per attendance</td></tr> <tr><td>Day procedure and treatment for Haemodialysis at a Renal Clinic/ Centre or other ambulatory facility</td><td>\$3,000 per attendance (Chronic), \$6,000 per attendance (Acute)</td></tr> <tr><td>Day procedure and treatment at Clinical Oncology Clinic</td><td>\$895 per attendance</td></tr> <tr><td>Day procedure and treatment at Ophthalmic Clinic</td><td>\$725 per attendance</td></tr> <tr><td>Day procedure and treatment in ambulatory facility</td><td>\$5,100 per attendance</td></tr> <tr><td>Psychiatric day hospital</td><td>\$1,260 per attendance</td></tr> <tr><td>Geriatric day hospital</td><td>\$1,960 per attendance</td></tr> <tr><td>Rehabilitation day hospital</td><td>\$1,320 per attendance</td></tr> <tr><td>Community nursing service (general)</td><td>\$535 per visit</td></tr> <tr><td>Community nursing service (psychiatric)</td><td>\$1,550 per visit</td></tr> <tr><td>Community allied health service</td><td>\$1,730 per visit</td></tr> </table>	Accident & Emergency	\$180 per attendance	Inpatient (acute general beds)	\$75 admission fee, \$120 per day	Inpatient (convalescent / rehabilitation, infirmary & psychiatric beds)	\$100 per day	Specialist outpatient (including allied health clinic)	\$135 for the 1st attendance, \$80 per subsequent attendance, \$15 per drug item	General outpatient	\$50 per attendance	Dressing or injection	\$19 per attendance	Psychiatric day hospital	\$60 per attendance	Geriatric day hospital	\$60 per attendance	Rehabilitation day hospital	\$55 per attendance	Day procedure and treatment at Clinical Oncology Clinic or Renal Clinic	\$96 per attendance	Day procedure and treatment in ambulatory facility	\$195 per attendance	Community nursing service (general)	\$80 per visit	Community nursing service (psychiatric)	Free	Community allied health service	\$80 per visit	Accident & Emergency	\$1,230 per attendance	Inpatient (general hospitals)	\$5,100 per day	Inpatient (psychiatric hospitals)	\$2,340 per day	Intensive care ward/unit	\$24,400 per day	High dependency ward/unit	\$13,650 per day	Nursery	\$1,340 per day	Obstetrics package charge For booked cases, includes • one antenatal checkup; • delivery / delivery care service; and • three days (two nights) hospitalization in a public general ward related to the delivery / delivery care service	\$39,000	Obstetrics package charge For non-booked cases or patients who have not undergone any antenatal checkup provided by HA during the pregnancy concerned, includes • delivery / delivery care service; and • three days (two nights) of hospitalization in a public general ward related to the delivery / delivery care service	\$90,000	Specialist outpatient (including allied health clinic)	\$1,190 per attendance	General outpatient	\$445 per attendance	Dressing or injection	\$100 per attendance	Day procedure and treatment for Haemodialysis at a Renal Clinic/ Centre or other ambulatory facility	\$3,000 per attendance (Chronic), \$6,000 per attendance (Acute)	Day procedure and treatment at Clinical Oncology Clinic	\$895 per attendance	Day procedure and treatment at Ophthalmic Clinic	\$725 per attendance	Day procedure and treatment in ambulatory facility	\$5,100 per attendance	Psychiatric day hospital	\$1,260 per attendance	Geriatric day hospital	\$1,960 per attendance	Rehabilitation day hospital	\$1,320 per attendance	Community nursing service (general)	\$535 per visit	Community nursing service (psychiatric)	\$1,550 per visit	Community allied health service	\$1,730 per visit	<p><b>Type of Insurance</b> Rashtriya Swasthya Bima Yojana (RSBY)</p> <p><b>Coverage of healthcare expenses</b> All hospitalization charges (except certain specified exclusions) restricted as per package limits</p> <p>Employees State Insurance Scheme (ESIS)</p> <p>Comprehensive coverage includes preventive, primary, secondary and tertiary care, plus Cash Benefits for loss of wages due to Sickness, Maternity, Permanent disablement of self and dependents &amp; rehabilitation</p> <p>Central Government Health Scheme</p> <p>Medical care at all levels and home visits/ care as well as free medicines and diagnostic services</p> <p>Private Health Insurance</p> <p>AB PMJAY</p> <p>Hospital treatment in any public or private hospital contracted under the scheme, worth up to INR 500,000 a year. It covers all pre-existing conditions. In its last revision in 2022, Health benefit package under the scheme includes 1121 packages and 1949 procedures across 27 specialities</p> <p>The MOHFW published a draft national policy for rare diseases in January 2020. The draft does not attempt to establish threshold prevalence rates, which would be impossible given the paucity of data on the incidence of rare diseases. Instead, it classifies rare diseases into three groups on the basis of treatment options and costs, Group 1: diseases for which a one-time curative treatment is available Group 2: diseases requiring long-term or lifelong treatment, where interventions are relatively low-cost and have a documented benefit Group 3: diseases for which treatment is available but at very high cost and over the long term – subdivided into (1) diseases where there is evidence of good long-term treatment outcomes; and (2) diseases for which treatment costs are very high, and for which outcomes data are available in a small number of patients. • The draft says the government will encourage and support efforts by states to screen for and prevent rare diseases and will provide patients with funding of up to Rs1.5 million for the treatment of Group 1 diseases, which will be available in specialist public hospitals for ABPMJAY affiliates [MP India Q3 2020]</p>	<p>Different premium scheme is applied for PBI and Non-PBI, but there is no difference in the medical services received. Insurance premiums differ by class for PBI (Class 3) and Non-PBI (Classes 1, 2, 3). There is no difference in the medical services received, but there is a difference in the budget (benefit value) per head.</p> <p>• From primary medical care to advanced medical care, there is no charge for medical tests, examinations, outpatient treatment, inpatient treatment, or drugs.</p> <p>• Referral by a primary care physician is necessary in order to receive advanced medical care.</p> <p>• Only the level of the hospital room differs from one insured to another, and the insured medical activities are in principal the same. However, this is limited to public hospitals, BPJS-affiliated private hospitals, and health centers run by local governments. (1,710 public or private hospitals, 9,217 health centers)</p> <p>Key Updates in Permenkes no. 3 – 2023 (effective by 23 Jan 2023):</p> <ul style="list-style-type: none"> <li>• In average INA CBG Tariff increased at 6%</li> <li>• Additional coverage on health prevention (screening for COPD, Stunting, anemia, etc)</li> <li>• Some expansion of access to radiotherapy, cath lab, &amp; chemotherapy</li> </ul> <p>Regulates the top-up (co-payment) scheme for both outpatient and inpatient. The extra coverage can be paid by participant, employer, or/and private insurance</p>	<p>• In-kind benefits. There are copayments as follows: End of compulsory education &lt; 70 (30%) Prior to compulsory education (20%) 70 &lt; 75 years (20%; 30% for active income earners) 75+ (10%, 30% for active income earners) High-cost Medical Expense Benefit Scheme: In order to ensure that the patient's copayment is not excessive, patients are reimbursed by the insurer for a portion exceeding the limit of the patient copayment per month after the patient's portion of medical expenses is paid at the counter of medical institutions. Copayment of meal and living expenses during hospitalization • Cash benefits: Injury and illness benefits (employee insurance), lump-sum birth allowance, etc.</p>	<p>• Insurance Benefits and Co-payments</p> <ul style="list-style-type: none"> <li>• Insurance Benefits</li> <li>• Insurance benefits are provided for childbirth, health promotion, rehabilitation as well as prevention and treatment of sickness and injury in daily life.</li> <li>• Two types of insurance benefits: benefit in kind, benefit in cash</li> </ul> <p>1) Benefits in Kind Benefits in kind consist of healthcare benefits and health checkups. Healthcare benefits mean medical services received for diagnoses, tests, provisions of medicines and medical materials, procedures and surgeries, prevention and rehabilitation, hospitalization, nursing, and transportation for diseases and injuries suffered by subscribers and their dependents. Medical services related to diseases that do not interfere with the patient's daily life or work may be excluded from the covered healthcare benefits. These services are specified as non-benefit items in the relevant statutes. Health checkups are provided for the early detection of diseases. Eligible persons receive health checkup sheets and notifications from the NHIS, which also pays for the expenses incurred.</p> <p>2) Benefits in Cash Subscribers and dependents sometimes have no other option but to use medical institutions that are not covered by the NHI. In such cases, the NHI provides cash benefits corresponding to healthcare facilities. Such cases include receiving healthcare services for diseases, injuries, or childbirth, or giving birth to a child at a place other than healthcare facilities. A person with a disability registered under the Act of Welfare of Persons with Disabilities can receive a part of the expenses spent purchasing auxiliary equipment as insurance benefit payment. An amount equivalent to 90% of the lowest amount among the threshold price, specified amount, and actual purchasing price is granted.</p> <table border="1"> <thead> <tr> <th>Insurance Benefits</th> <th>Benefits in kind (97.2%)</th> <th>-Medical Benefits (95.5%) -Physical check-ups costs (2.5%)</th> </tr> </thead> <tbody> <tr> <td></td> <td>Cash Benefits (2.8%)</td> <td>-Medical care costs (7.7%) -Benefits for the appliances of the disabled (5.9%) -Reimbursement in the co-payment ceiling system (75.9%) -Prenatal care costs (10.5%)</td> </tr> </tbody> </table> <p>• Co-payments</p> <ul style="list-style-type: none"> <li>• A patient who receives healthcare treatment should pay co-payments that are part of total healthcare expense. In order to</li> </ul> <table border="1"> <thead> <tr> <th>Category</th> <th>Institution</th> <th>Disease</th> <th>Co-payment rate</th> </tr> </thead> <tbody> <tr> <td rowspan="3">Inpatient</td> <td rowspan="3">-</td> <td>General</td> <td>20%</td> </tr> <tr> <td>Rare diseases</td> <td>10%</td> </tr> <tr> <td>Severe diseases</td> <td>5%</td> </tr> <tr> <td rowspan="5">Outpatient</td> <td>Tertiary hospital</td> <td>-</td> <td>60%</td> </tr> <tr> <td>General hospital</td> <td>-</td> <td>60%</td> </tr> <tr> <td>Hospital</td> <td>-</td> <td>40%</td> </tr> <tr> <td>Clinic</td> <td>-</td> <td>30%</td> </tr> <tr> <td>Pharmacy</td> <td>-</td> <td>30%</td> </tr> </tbody> </table> <p>* Differential application by region • Health insurance benefit coverage to lower the out-of-pocket(OOP) share of patients of serious case (Rare*, Serious diseases**) Rare* 10%; Serious** 5% * Rare disease: hemophilia, chronic renal failure, etc. ** Serious diseases: Cancer, Cardiovascular diseases, Cerebrovascular diseases, Tuberculosis and severe burn injury (Source: 2022 Booklet for the Introduction of NHI System 2024 National Health Insurance &amp; Long-Term Care Insurance System Republic of Korea)</p>	Insurance Benefits	Benefits in kind (97.2%)	-Medical Benefits (95.5%) -Physical check-ups costs (2.5%)		Cash Benefits (2.8%)	-Medical care costs (7.7%) -Benefits for the appliances of the disabled (5.9%) -Reimbursement in the co-payment ceiling system (75.9%) -Prenatal care costs (10.5%)	Category	Institution	Disease	Co-payment rate	Inpatient	-	General	20%	Rare diseases	10%	Severe diseases	5%	Outpatient	Tertiary hospital	-	60%	General hospital	-	60%	Hospital	-	40%	Clinic	-	30%	Pharmacy	-	30%	<p>For healthcare services provided by public sector, it is largely subsidized by government. Public medical institutions: Outpatient treatment (general practitioner): RM1 Outpatient treatment (specialist consultation): RM5 Admission for third class ward: RM500, higher charges for 2<sup>nd</sup> class and 1<sup>st</sup> class wards. For non-Malaysians, the deposit payable admission to 3<sup>rd</sup> class ward is RM600. Private medical institutions: Consultation fees: RM30-RM200 [Source: IQVIA Market Prognosis Report 2019-2023]</p>	<p>PhilHealth provides reimbursements to both government and accredited private facilities. Coverage include: • Inpatient care, including room and board, professional fees, diagnostic, laboratory, and other medical examination services, prescription drugs • Outpatient care, including professional fees, diagnostic, laboratory, and other medical examination services, personal preventive services, prescription drugs.</p>	<p>• 1 (MediSave), 3 (MediShield Life): Allocated to hospitalization, chronic illnesses, ambulatory surgery, high-cost laboratory tests and treatment, and some outpatient treatment ◦ In 3 (MediShield Life), upper limits are imposed depending on the number of days of hospitalization or the surgical procedures, and there are co-pays that depend on the deductible. ◦ No co-pays under 1 (MediSave) and 4 (MediFund). Patients bear the cost of general outpatient treatment and outpatient prescriptions for the common cold, etc., by themselves • 2 (MediSave Care): Patient may withdraw up to \$200 monthly payout (or \$2400/year) from their/spouse's Med iSave to supplement long-term care needs. • 4 (MediFund): Hospitalization, outpatient treatment, nursing care expenses from a MediFund-approved institution • 5 (CareShield Life): Monthly cash benefit starts at \$600 per month in 2020 and increase until age 67. • 6 (ElderShield): A fixed amount is paid to elderly persons with severe physical disabilities. If the patient receives disability certification, payments of \$400 / month are made for a maximum of 72 months. In addition, there is a medical expense reduction system for persons aged 65 or older, as well as a financial support scheme for those not eligible for long-term care insurance.</p> <p>(MOH Healthcare schemes &amp; subsidies: <a href="https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies">https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies</a>)</p>	<p>In general, outpatients must pay a basic outpatient co-payment and a medication co-payment. Outpatient rehabilitation co-payment, if the rehabilitation therapy or traditional Chinese medicine therapy was given and inpatient co-payment if hospitalized. • Basic co-payment: A fixed amount for each hospital category. • Drug co-payment: A fixed amount for each drug price category, and the burden rate is about 20% but upper limit is 200NTD/time. Inpatient co-payment: 5-30% (determined with ward and duration of stay) of the cost of hospitalization and as for the hospital room fees will be required if the room only one or two beds of the difference from actual cost and NHI bed (three or more beds, intensive care beds, and isolation beds). The patient's share of the cost of the hospital room is established as a fixed rate at the time of admission, based on the duration of the hospital stay.</p>	<p>UCS: 3,798 THB/person (2022) • Benefits in kind • Patients select a hospital from among the NHSO designated hospitals within the region under jurisdiction (most are public hospitals) for medical care. • Objects of benefits are expanding beyond acute-phase treatment for AIDS, dialysis, and many cancers, etc. CSMBS: OPD - Fee for service, IPD - DRG • Benefits in kind. No cash benefits. No restrictions on which medical institution can be consulted. • No charge for medical fees at public hospitals. Partial coverage of medical fees at private hospitals SSS: 4,800 THB/person (2022) • Benefits in kind • Patient selects a designated hospital; free up to a certain limit</p>	<p>Coverage: 100% of the medical expenses can be claimed for those who are professional officers and non-commissioned officers and officers and non-commissioned officers specialized in technical areas, and who are serving in the people's security force; children aged less than 6 years old. 100% of the medical expenses can be claimed for cases where the total expense is lower than the level prescribed by the Government and conducted at commune hospitals; 95% of the medical expenses can be claimed for those who are entitled to pension, monthly allowance for reduction in working capacity; receiving monthly social welfare allowance as prescribed by the law; poor household members; ethnic minority people living in areas with difficult or extreme socio-economic conditions. 80% of the medical expenses can be claimed for other individuals. In the event if an individual belongs to more than one category as mentioned above, he/she is eligible for the highest benefit for the insured category. Benefits: Examination and treatment, rehabilitation, antenatal care and birth giving; Level of Insurance Benefit: 100% - 95% - 80% health care expenditure. Services not be covered: Medical costs covered by other sources; Family planning services, infertility treatment; Aesthetic services; Occupational diseases; work related accidents; suicide, self-harm activities, substance abuse, consequences of law violation, etc. Starting from 01 June 2026, individuals undergoing routine health check-ups or free screenings as stipulated by the Law on Disease Prevention are entitled to 100% reimbursement of the cost for their routine health check-up or free screening, based on their eligibility and priority schedule, in accordance with the Health Insurance Fund's balancing capacity.</p>
			Accident & Emergency	\$180 per attendance																																																																																																																		
Inpatient (acute general beds)	\$75 admission fee, \$120 per day																																																																																																																					
Inpatient (convalescent / rehabilitation, infirmary & psychiatric beds)	\$100 per day																																																																																																																					
Specialist outpatient (including allied health clinic)	\$135 for the 1st attendance, \$80 per subsequent attendance, \$15 per drug item																																																																																																																					
General outpatient	\$50 per attendance																																																																																																																					
Dressing or injection	\$19 per attendance																																																																																																																					
Psychiatric day hospital	\$60 per attendance																																																																																																																					
Geriatric day hospital	\$60 per attendance																																																																																																																					
Rehabilitation day hospital	\$55 per attendance																																																																																																																					
Day procedure and treatment at Clinical Oncology Clinic or Renal Clinic	\$96 per attendance																																																																																																																					
Day procedure and treatment in ambulatory facility	\$195 per attendance																																																																																																																					
Community nursing service (general)	\$80 per visit																																																																																																																					
Community nursing service (psychiatric)	Free																																																																																																																					
Community allied health service	\$80 per visit																																																																																																																					
Accident & Emergency	\$1,230 per attendance																																																																																																																					
Inpatient (general hospitals)	\$5,100 per day																																																																																																																					
Inpatient (psychiatric hospitals)	\$2,340 per day																																																																																																																					
Intensive care ward/unit	\$24,400 per day																																																																																																																					
High dependency ward/unit	\$13,650 per day																																																																																																																					
Nursery	\$1,340 per day																																																																																																																					
Obstetrics package charge For booked cases, includes • one antenatal checkup; • delivery / delivery care service; and • three days (two nights) hospitalization in a public general ward related to the delivery / delivery care service	\$39,000																																																																																																																					
Obstetrics package charge For non-booked cases or patients who have not undergone any antenatal checkup provided by HA during the pregnancy concerned, includes • delivery / delivery care service; and • three days (two nights) of hospitalization in a public general ward related to the delivery / delivery care service	\$90,000																																																																																																																					
Specialist outpatient (including allied health clinic)	\$1,190 per attendance																																																																																																																					
General outpatient	\$445 per attendance																																																																																																																					
Dressing or injection	\$100 per attendance																																																																																																																					
Day procedure and treatment for Haemodialysis at a Renal Clinic/ Centre or other ambulatory facility	\$3,000 per attendance (Chronic), \$6,000 per attendance (Acute)																																																																																																																					
Day procedure and treatment at Clinical Oncology Clinic	\$895 per attendance																																																																																																																					
Day procedure and treatment at Ophthalmic Clinic	\$725 per attendance																																																																																																																					
Day procedure and treatment in ambulatory facility	\$5,100 per attendance																																																																																																																					
Psychiatric day hospital	\$1,260 per attendance																																																																																																																					
Geriatric day hospital	\$1,960 per attendance																																																																																																																					
Rehabilitation day hospital	\$1,320 per attendance																																																																																																																					
Community nursing service (general)	\$535 per visit																																																																																																																					
Community nursing service (psychiatric)	\$1,550 per visit																																																																																																																					
Community allied health service	\$1,730 per visit																																																																																																																					
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Category	Item	Types	China 2026	Hong Kong 2026	India 2026	Indonesia 2026	Japan 2026	Korea 2026	Malaysia 2026	Philippines 2026	Singapore 2026	Taiwan 2026	Thailand 2026	Vietnam 2026
			RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PRReMA	PG
Insurance & drug pricing system/ Public healthcare system	Current status of medical insurance system	Healthcare expenditure (% of GDP)	6.7% (2024) Source : China National Health Commission <a href="https://www.nhc.gov.cn/guihuaxxs/c100133/202512/f1c3a3c617484a27a1a26a468afbacee/files/2024%E5%B9%B4%E6%88%91%E5%9B%BD%E5%8D%AB%E7%94%9F%E5%81%A5%E5%BA%B7%E4%BA%8B%E4%B8%9A%E5%8F%91%E5%B1%95%E7%BB%9F%E8%AE%A1%E5%85%AC%E6%8A%A5-20251201161542231.pdf">https://www.nhc.gov.cn/guihuaxxs/c100133/202512/f1c3a3c617484a27a1a26a468afbacee/files/2024%E5%B9%B4%E6%88%91%E5%9B%BD%E5%8D%AB%E7%94%9F%E5%81%A5%E5%BA%B7%E4%BA%8B%E4%B8%9A%E5%8F%91%E5%B1%95%E7%BB%9F%E8%AE%A1%E5%85%AC%E6%8A%A5-20251201161542231.pdf</a>	Current Health Expenditure: 8.3% of GDP (2023/24) Health Bureau - <a href="https://www.hongkong.gov.hk/health-accounts">Hong Kong's Domestic Health Accounts (HKDHA)</a>	<b>Government Health Expenditures (GHE) as percentage of GDP stood at 1.84 per cent.</b>  <b>Source:</b> Economic Survey 2024-25 <a href="https://www.indiabudget.gov.in/economic-survey/doc/eschapt11.pdf">https://www.indiabudget.gov.in/economic-survey/doc/eschapt11.pdf</a>	2.7% (current health expenditure/CHE) 2.9% (total health expenditure/THE) 1. Source: 2024 National Health Accounts (NHA) Dissemination	11.42% (2022) [World Bank]	9.88 % [World Bank Open Data 2023]	4.6% (2023) Source: <a href="https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHAMNHA_HEALTH_EXPENDITUR E_2011-2023_(MNH A_Steering_Mee ting_2024).pdf">https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHAMNHA_HEALTH_EXPENDITUR E_2011-2023_(MNH A_Steering_Mee ting_2024).pdf</a>	5.9% (as of 2024)  Philippine Statistics Authority <a href="https://psa.gov.ph/system/files/sad/2024%20PNHA%20Press%20Release_signed.pdf">https://psa.gov.ph/system/files/sad/2024%20PNHA%20Press%20Release_signed.pdf</a>	4.90% (World Bank, 2022)  <a href="https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=SG">https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=SG</a>	National Health Expenditure(NHE) 7.8%; Current Health Expenditure(CHE) 7.3% (2023) [Source: March 10, 2025, Department of Statistics, Ministry of Health and Welfare]	4.54 [2023 World Bank, Current health expenditure (% of GDP)]	4.6% (2022) [EIU] 4.59% (2021) [World Bank] 4.7% (2021) [Ministry of Health's National Health Account]
		Public Health expenditure (% of GDP)	5.190% (2022) 5.234%(2023) /5.086%(2023) 4.857%(2024) China National Health Commission <a href="https://www.nhc.gov.cn/guihuaxxs/c100133/202512/f1c3a3c617484a27a1a26a468afbacee/files/2024%E5%B9%B4%E6%88%91%E5%9B%BD%E5%8D%AB%E7%94%9F%E5%81%A5%E5%BA%B7%E4%BA%8B%E4%B8%9A%E5%8F%91%E5%B1%95%E7%BB%9F%E8%AE%A1%E5%85%AC%E6%8A%A5-20251201161542231.pdf">https://www.nhc.gov.cn/guihuaxxs/c100133/202512/f1c3a3c617484a27a1a26a468afbacee/files/2024%E5%B9%B4%E6%88%91%E5%9B%BD%E5%8D%AB%E7%94%9F%E5%81%A5%E5%BA%B7%E4%BA%8B%E4%B8%9A%E5%8F%91%E5%B1%95%E7%BB%9F%E8%AE%A1%E5%85%AC%E6%8A%A5-20251201161542231.pdf</a>	Public expenditure on health was 51.8% of total current health expenditure (2023/24) Health Bureau - <a href="https://www.hongkong.gov.hk/health-accounts">Hong Kong's Domestic Health Accounts (HKDHA)</a>	1.28% (2017-2018 BE) [Source: MP India Q3 2020]	58.5% from total healthcare expenditure  Source: 2024 National Health Accounts (NHA) Dissemination	10.4% (2021)	6.12% [Statbase, 2023]	2.4% of GDP (2023) Public Expenditure as a Percentage of Total Expenditure on Health: 52.26% (2022)  Source: <a href="https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHAMNHA_HEALTH_EXPENDITUR E_2011-2023_(MNH A_Steering_Mee ting_2024).pdf">https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHAMNHA_HEALTH_EXPENDITUR E_2011-2023_(MNH A_Steering_Mee ting_2024).pdf</a>	2.17% (44.7% public share of current health expenditure, current health expenditure as a share of total health expenditure 92.2%, total health expenditure as a share of GDP at 5.9%, as of 2024)  <a href="https://psa.gov.ph/system/files/sad/2024%20PNHA%20Press%20Release_signed.pdf">https://psa.gov.ph/system/files/sad/2024%20PNHA%20Press%20Release_signed.pdf</a>	2.5% (2022) <a href="https://data.gov.sg/datasets/d_a40c83a6f36893fc461eda91f84eb6b/view">https://data.gov.sg/datasets/d_a40c83a6f36893fc461eda91f84eb6b/view</a>	4.4019% (60.3% of healthcare expenditure 2023) [Source: Department of Statistics, Ministry of Health and Welfare released on March 10, 2025]	3.53 [2023 World Bank, Domestic general government health expenditure (% of GDP) ]	1.96% (2021) [World Bank] 2.00% (2021) [Ministry of Health's National Health Account]
		Others	N/A	Private expenditure on health was 48.2% of total current health expenditure (2023/24) Health Bureau - <a href="https://www.hongkong.gov.hk/health-accounts">Hong Kong's Domestic Health Accounts (HKDHA)</a>	N/A	BPJS-registered public health centers and private clinics are the gatekeepers in charge of primary care (covered by insurance). Without a referral from these institutions, it is not possible to use insurance at public or private hospitals providing advanced care.	N/A	• Payment of outpatient treatment fee is basically 30% of co-payment. Especially. The patients aged 65 or over is a fixed co-pay of 1,500 KRW up to a total amount under 15,000 Won, and the benefit is 70 percent (co-pay 30 percent) for over 25,000 Won. (Refer to section of "Methods of healthcare subsidy payment")	N/A	16% (Source: MOH's <a href="https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHAMNHA_HEALTH_EXPENDITUR E_2011-2023_(MNH A_Steering_Mee ting_2024).pdf">Malaysia National Health Accounts (MNHA) 2022</a> )	N/A	N/A	N/A	-

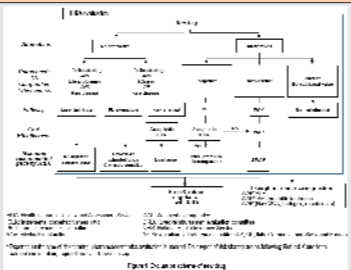
Category	Item	Types	China 2026 RDPAC/PhIRDA	Hong Kong 2026 HKAPI	India 2026 OPPI	Indonesia 2026 IPMG	Japan 2026 JPMA	Korea 2026 KPBMA/KRPIA	Malaysia 2026 PhAMA	Philippines 2026 PHAP	Singapore 2026 SAPI	Taiwan 2026 IRPMA	Thailand 2026 PReMA	Vietnam 2026 PG
Insurance & drug pricing system/ Public healthcare system	Overview of pharmaceutical reimbursement	Overview of pharmaceutical reimbursement	<p>The negotiations on the 2025 National Reimbursement Drug List (NRDL) was carried out and the results was released by the National Healthcare Security Administration on December 7, 2025. In the 2025 NRDL, a total of 114 drugs will be added, while 29 drugs originally included in the list will be removed. The first edition of the Commercial Health Insurance List for Innovative Drugs will include 19 drugs, covering CAR-T cell therapies as well as multiple treatments for rare diseases. The revised NRDL will take effect on January 1, 2026. Following this adjustment, the total number of drugs included in the NRDL will increase to 3,253, comprising 1,857 Western drugs and 1,396 Chinese patent medicines.</p> <p><a href="https://www.nhsa.gov.cn/art/2025/12/7/art_104_18970.html">https://www.nhsa.gov.cn/art/2025/12/7/art_104_18970.html</a></p>	<p>In line with the Government's public healthcare policy to ensure that no one is denied adequate medical treatment due to lack of means, the Hospital Authority provides medical services and drugs or medical items to patients at highly subsidised rates based on their clinical needs and in accordance with the HA's treatment guidelines. Guided by the principles of evidence-based medical practice, targeted subsidy and opportunity cost consideration, the standard fees and charges in public hospitals and clinics do not apply to designated Privately Purchased Medical Items (PPMIs) and SFIs. While patients who need these items/drugs and have the ability to pay for their costs have to purchase at their own expense, financial assistance is provided through the Safety Net to subsidise the medical expenses of patients who have financial difficulties in purchasing PPMIs or specified SFIs listed on the HADF at their own costs.</p>	<p>While pharmaceutical reimbursement in India is facilitated through a range of payers, including public-sector schemes, private health insurers, public-sector undertakings and self-funded programmes, out of pocket expenditure on medicines comprises of a major part of overall healthcare expenditure in India. However, over the years, India has witnessed a steady decline in Out-of-Pocket expenditure as a percentage of Total Health Expenditure in the last 5 years from 48.8% in 2017-18 to 39.4% in 2021-22. According to National Health Accounts estimates for 2021-22, Between FY15 and FY22, the share of out-of-pocket expenditure (OOPE) in THE declined from 62.6 per cent to 39.4 per cent.</p> <p><b>Source:</b> Economic Survey 2024-25 <a href="https://www.indiabudget.gov.in/economic-survey/doc/eschapter/echap11.pdf">https://www.indiabudget.gov.in/economic-survey/doc/eschapter/echap11.pdf</a></p> <p>The primary reason for this decline is attributed to increased government health expenditure, particularly through programs like Ayushman Bharat, which provide subsidized healthcare access to economically weaker section</p> <p>[PPR Country Guide India Q1] <b>Source:</b> MoH data Steps taken by the Government to reduce Out-of-Pocket Health Expenditure <a href="https://mohfw.gov.in/?q=pressrelease-160#:~:text=A%20steady%20decline%20in%20Out.to%2039.4%25%20in%202021%2D22&amp;text=As%20per%20National%20Health%20Accounts,(THE)%20is%2039.4%25">https://mohfw.gov.in/?q=pressrelease-160#:~:text=A%20steady%20decline%20in%20Out.to%2039.4%25%20in%202021%2D22&amp;text=As%20per%20National%20Health%20Accounts,(THE)%20is%2039.4%25</a></p>	<p>No specific reimbursement system for drug cost; it has been included under BPJS-K under the Ina-CBG system since the introduction of UHC in 2014. A new iDRG (Indonesia Diagnoses Related Groups) system said to be more detailed and robust is planned to replace the INA-CBGs. It has been trialed and socialized to all healthcare facilities in the country in October 2025. Certain drugs can only be prescribed by specialists in higher tiers of health facilities (such as regional or vertical hospitals). BPJS-K aims for a 0 payment by patients at discharge, which restricted the medical services and drugs that can be administered to patients. A new coordination of benefit (CoB or KAPJ) scheme has now allowed private insurance companies to collaborate with BPJS-K to finance such gaps, with BPJS-K acting as the primary payer and private insurance as the secondary payer for costs not covered by BPJS-K.</p> <p><b>Source:</b> 1. <a href="https://infopublik.id/kategori/nasional-sosial-budaya/935208/uji-coba-nasional-mulai-1-oktober-sistem-pembayaran-jkn-beralih-ke-idrg">https://infopublik.id/kategori/nasional-sosial-budaya/935208/uji-coba-nasional-mulai-1-oktober-sistem-pembayaran-jkn-beralih-ke-idrg</a></p>	<p>· In-kind benefits. There are copayments as follows: End of compulsory education &lt; 70 (30%) Prior to compulsory education (20%) 70 &lt; 75 years (20%; 30% for active income earners) 75+ (10%, 30% for active income earners) High-cost Medical Expense Benet Scheme *Special or Specified Medical Care System: Basic portion (basic hospitalization fee, etc.) of medical care not covered by health insurance for advanced medical care and clinical trials are covered by health insurance</p>	<p>July 1977: Drug price standards were established along with the introduction of the Work Place Health Insurance System. Introduction of reimbursement system based on actual transaction price in November 1999. Change to listing of all drug items (Negative List System) in July 2000. Change to selective listing (Positive List System) in December 2006. Implement of selective reimbursement system for drugs which is not proven in cost-effectiveness with different co-payment rate (30%,50%,80%)</p>	-	<p>Only drugs listed in the Philippine National Formulary (PNF), with positive recommendation from HTA shall be considered for reimbursement.</p> <p>Currently the DOH has drafted a policy that will transfer the prioritization of topics from HTA to DOH, to be conducted by their proposed National Drug Council (NDC). In addition, a facilitated review process will be established that will allow provisional inclusion in the PNF while undergoing review.</p>	<p>Singapore's pharmaceutical reimbursement system is structured to ensure affordability, accessibility, and sustainability in providing medicines, particularly for chronic diseases, essential treatments, and catastrophic illnesses. The framework involves a combination of <b>government subsidies, insurance schemes, and out-of-pocket payments.</b></p> <p><b>Key Features:</b></p> <ol style="list-style-type: none"> <li><b>Healthcare Financing Framework</b> Singapore's "3M" system forms the foundation of its healthcare financing: <ul style="list-style-type: none"> <li><b>MediShield Life:</b> Covers large hospital bills, including outpatient cancer treatments listed on the <b>Cancer Drug List (CDL).</b></li> <li><b>MediSave:</b> Allows individuals to use personal and family savings for healthcare expenses, including certain drugs and chronic disease management.</li> <li><b>MediFund:</b> Provides financial assistance to low-income individuals who cannot afford out-of-pocket expenses.</li> </ul> </li> <li><b>Drug Subsidies</b> The government provides subsidies for essential and cost-effective medications under the <b>Standard Drug List (SDL)</b> and <b>Medication Assistance Fund (MAF):</b> <ul style="list-style-type: none"> <li><b>Standard Drug List (SDL):</b> Contains subsidized medications for common and chronic conditions, available at public healthcare institutions.</li> <li><b>Medication Assistance Fund (MAF):</b> Offers means-tested subsidies for expensive treatments, including cancer drugs and biologics, for eligible patients.</li> </ul> </li> <li><b>Cancer Drug List (CDL)</b> <ul style="list-style-type: none"> <li>Implemented on <b>September 1, 2022</b>, the CDL is a positive list of outpatient cancer drug treatments that are clinically proven and cost-effective.</li> <li>Only treatments on the CDL are covered under <b>MediShield Life, MediSave, and Integrated Shield Plans (IPs).</b></li> <li>Reimbursement for cancer drugs is determined based on <b>granular claim limits</b>, tailored to the cost of each treatment.</li> </ul> </li> <li><b>Cell, Tissue and Gene Therapy Product (CTGTP) List</b> <ul style="list-style-type: none"> <li>Implemented from 1 August 2024, the CTGTP financing framework supports selected high-cost cell, tissue and gene therapy products used for severe and rare conditions, including certain cancers and genetic disorders.</li> <li>Coverage is provided through a dedicated CTGTP subsidy scheme, separate from the standard drug subsidy and Cancer Drug List (CDL) framework. Eligible Singapore Citizens may receive means-tested subsidies of up to 75%, capped at S\$150,000 per treatment.</li> <li>From October 2025, MediShield Life and MediSave coverage will be extended to listed CTGTPs.</li> </ul> </li> <li><b>Private Health Insurance</b> <ul style="list-style-type: none"> <li><b>Integrated Shield Plans (IPs):</b> Complement MediShield Life coverage, covering additional costs such as private hospital stays and outpatient treatments.</li> <li>As of April 1, 2024, IPs align with the CDL for cancer treatments, ensuring cost containment and clinical appropriateness.</li> </ul> </li> <li><b>Primary Care Networks</b> <ul style="list-style-type: none"> <li>Residents are encouraged to enrol in <b>Healthier SG</b>, which includes subsidies for chronic disease management and selected medications through the Community Health Assist Scheme (CHAS). Medications are priced comparably between public polyclinics and private general practitioners.</li> </ul> </li> <li><b>Patient Contribution:</b> Patients pay the remaining balance not covered by subsidies or insurance.</li> </ol>	<p>Reimbursement will be applied with reimbursement price approved drug by National Health Insurance (NHI) Administration. Although NHI is a universal service, various expending control schemes, e.g., DET, PVA, MEA, etc., are in place: ·Drug Expenditure Target (DET): Set target of the annual drug expense and adjust by the price for the exceeded par. Currently actual adjustment is occurred every year after the implementation. ·Price Volume Agreement (PVA): 5-year contract is needed if the product meets one of the following conditions. 1. Forecast or actual exceed 200M/year for new drug during any year of first 5 years 2. Forecast or actual exceed 100M/year for new drug during any year of first 5 years. Claw back 30-40% of exceeded part of agreed forecast between company and NHIA. Managed Entry Agreement (MEA): A voluntary scheme in principle and is including two scheme PVA (Price Volume Agreement: apart from above PVA) and RSA (Risk Sharing Agreement). PVA is financial base claw back scheme and RSA is outcome base claw back scheme. Health Technology Reassessment. HTR, was introduced in 2022 to review reimbursed drug effectiveness and serving as basis for resource reallocation, however, disputes remained due to lack of legal basis and written regulation for practice. NHIA initiated "drug policy reform" and "MEA regulation amendment" in June 2023 and December 2023 respectively. The revised drug pricing regulations were announced in early 2025 and will take effect in April 2026. Key provisions include: ·Preferential pricing for domestically manufactured drugs introduced within two years of their launch in A10 countries. ·Favorable pricing for innovative medicines containing novel ingredients that received approval abroad within the past five years. ·Alignment of prices for locally produced generics and biosimilars with the original drug's initial pricing level. ·Accelerated access measures, such as parallel review and proactive listing processes, to expedite the availability of breakthrough therapies.</p>	<p>Reimbursement depends upon the type of insurance enrolled in: UCS: benefit in kind. According to NLEM. CSMBS: NLEM and non-NLEM (with conditions) medicines, restrictions on some of high cost anticancer/hematologic drugs. SSS: benefit in kind. According to NLEM.</p>	<p>According to Vietnam Ministry of Finance by June 2025, the percentage of population joining social health insurance is 95.2 %.</p> <p><a href="https://www.qdnd.vn/xa-hoi/tin-tuc/hon-95-dan-so-da-tham-gia-bao-hiem-y-te-836636">https://www.qdnd.vn/xa-hoi/tin-tuc/hon-95-dan-so-da-tham-gia-bao-hiem-y-te-836636</a></p>

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Insurance & drug pricing system/ Public healthcare system	Overview of pharmaceutical reimbursement	Presence/absence of Essential Drug List/ Positive List/ Negative List; EDL/ Positive list/ Negative list	No update, but The National Health Commission issued an announcement to solicit public opinions on the <i>Measures for the Administration of the National Catalogue of Essential Drugs (Revised Draft)</i> . National Health Commission of China <a href="https://www.nhc.gov.cn/wjw/yjzj/202111/6cc228efed34403296cd50716ebd27e0.shtml">https://www.nhc.gov.cn/wjw/yjzj/202111/6cc228efed34403296cd50716ebd27e0.shtml</a>	Only Hospital Authority Safety Net reimbursement list available, but no Essential Drug List	In India, the National List of Essential Medicines (NLEM) was first formulated in 2011 decides the essential medicines. The list is prepared by the Union Ministry of Health and Family Welfare.  The NLEM is a dynamic list and is reviewed every 5 years or so to include or exclude drugs as relevant to the disease burden, newest medical innovations and aligned to the current market competition. The revision is undertaken by the Standing National Committee of Medicines (SNCM) constituted in July 2018 by the Union Ministry of Health and Family Welfare.  The current NLEM was updated and published in 2022, which includes 384 drugs and around 1000 formulations..  <a href="https://nppa.gov.in/nlem2022">https://nppa.gov.in/nlem2022</a>	Drug procurement system of BPJS-K: 1. Regulator (MoH) and LKPP (Govt. Central Procurement Agency) are the two main actors, where: 2. MoH sets the Drug Requirement Plan (bottom-up process), selects the selection team to develop the ForNas (National Formulary), sets up the Tariff Team for HPS (Harga Perkiraan Sendiri - self-assessed prices) as the basis for LKPP to negotiate with the potential suppliers, and creates the Negotiation Team with the LKPP to agree on prices: one winner with the lowest price for one molecule in one province 3. Based on point 2, LKPP issues the E-catalogue and signs an umbrella agreement with the resp. winners of the tender process 4. Users (local health agencies, hospitals, clinics, patients) order based on e-catalogue contracts and paid by BPJS-K based on claim reimbursement 5. The MoH issued the NDEL (National Drug Essential List) with a ministerial decree no. HK.01.07/MENKES/395/2017 listing drugs which have to be available in public health institutions (hospitals and Puskesmas/community health centers) and must be covered by BPJS-Kesehatan. NDEL is reviewed by a ForNas Committee at least every 2 years using several criteria such as efficacy,safety, marketing authorization, risk-benefit ratio and comparative cost effectiveness	The NHI Drug Price Standard specifies the drug items that can be used for insurance-covered medical care.	Essential Drug List is managing by MFDS (Positive Listing) Drug Reimbursement List is updated and managed by HIRA (Positive Listing)	NEML was updated in 2024. The 7 <sup>th</sup> edition released in Q1-2025  Source: <a href="https://pharmacy.moh.gov.my/en/documents/national-essential-medicines-list-neml.html">https://pharmacy.moh.gov.my/en/documents/national-essential-medicines-list-neml.html</a>	The Philippine National Formulary (PNF) serves as the essential drug list of the Philippines.  <a href="https://pharma.doh.gov.ph/the-philippine-national-formulary/">DOH https://pharma.doh.gov.ph/the-philippine-national-formulary/</a>	<b>Standard Drug List (SDL)</b> An SDL has been prepared by Public Healthcare Institutions, Drug Advisory Committee (DAC), and Ministry of Health (MOH) • The Standard Drugs List (SDL) was established in 1979 ◦ It is modelled on the WHO Essential Drug List ◦ It applies to patients who receive assistance for public medical care ◦ Drug access is not linked to listing in the SDL list ◦ Providers of medical services are not limited to drugs listed in the SDL ◦ There are two types of list: SDL1 and SDL2. ▪ SDL1 is for basic drugs. Patients pay S\$1.40/item/week ▪ SDL2 is for high-priced drugs. Patients pay 50%.  <b>Cancer Drug List (CDL)</b> • A positive list of clinically proven and cost-effective outpatient cancer drug treatments was implemented in September 2022. • The <b>list</b> consists of more than 90 percent of cancer treatments approved by the Health Sciences Authority (HSA) – it will continue to expand as the Ministry of Health (MOH) continues to engage drug companies and with the emergence of new clinical evidence. • MediShield Life and MediSave will only cover treatments listed on the CDL from September 2022. ◦ For MediShield Life, more granular claim limits ranging from \$200 to \$9,600 per month for cancer drug treatments on the positive list are allowed, with an additional \$1,200 per year for cancer drug services (cancer screening, diagnostics etc.) ◦ The MediSave withdrawal limits were also adjusted in tandem – up to \$1,200 per month for cancer drug treatments with MediShield Life claim limit above \$5,400, and \$600 per month for other treatments on the positive list, with an additional \$600 per year for cancer drug services and/or other cancer scans (including scans for post-treatment monitoring and radiotherapy). • Integrated Shield Plans (IPs) may also be used to cover treatments on the CDL – however, the CDL will come into effect for IPs from April 1, 2023. Insurers have committed to preserve current IP coverage until August 31, 2024. Treatments beyond the CDL may be covered by IP riders.  <b>Cell, Tissue and Gene Therapy Product (CTGTP) List</b> • Implemented from 1 August 2024, the CTGTP financing framework supports selected high-cost cell, tissue and gene therapy products used for severe and rare conditions, including certain cancers and genetic disorders. • Coverage is provided through a dedicated CTGTP subsidy scheme, separate from the standard drug subsidy and Cancer Drug List (CDL) framework. Eligible Singapore Citizens may receive means-tested subsidies of up to 75%, capped at S\$150,000 per treatment. • From October 2025, MediShield Life and MediSave coverage will be extended to listed CTGTPs.	•Necessary Drugs: Defined by Articles 4, 34, and 35 of <i>National Health Insurance Drug Benefit Items and Payment Criteria</i> . •Essential Drugs List: Based on Article 27-2 of <i>Pharmaceutical Affairs Act</i> , which was established by TFDA.	<b>Thailand National List of Essential Medicines (NLEM)</b> The NLEM constitutes a positive list reimbursable by the three public health insurance systems to encourage rational use of medicines. Exemption for the CSMBs permits reimbursement of unlisted drugs with signatory approval by three attending physicians. For new launches, the application for listing can only be made after a 2-year safety monitoring period (SMP). After inclusion, products will be subjected to price regulation with up to 70% discount. The latest NLEM was announced on October 3, 2024.	Vietnam does have List of Essential Medicines pursuant to Circular 19/2018/TT-BYT dated 30 August 2018. This list is separated from the Reimbursement Drug List which is also developed by the Ministry of Health with the latest list stipulated by Circular 20/2022/TT-BYT dated 31 Dec 2022). Essential Medicine list of Vietnam was first introduced in 1985

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Insurance & drug pricing system/ Public healthcare system	Overview of pharmaceutical reimbursement and/or ratio of medicines	Out of pocket expenses and/or ratio of medicines	NHC announced that average individual out-of-pocket (OOP) medical expenses increased to 27.5% in 2024. National Health Commission <a href="https://www.nhc.gov.cn/guihuaxxs/c100133/202512/f1c3a3c617484a27a1a26a468afbaeee/files/2024%E5%B9%B4%E6%88%91%E5%9B%BD%E5%8D%AB%E7%94%9F%E5%81%A5%E5%BA%B7%E4%BA%8B%E4%B8%9A%E5%8F%91%E5%B1%95%E7%BB%9F%E8%AE%A1%E5%85%AC%E6%8A%A5-20251201161542231.pdf">https://www.nhc.gov.cn/guihuaxxs/c100133/202512/f1c3a3c617484a27a1a26a468afbaeee/files/2024%E5%B9%B4%E6%88%91%E5%9B%BD%E5%8D%AB%E7%94%9F%E5%81%A5%E5%BA%B7%E4%BA%8B%E4%B8%9A%E5%8F%91%E5%B1%95%E7%BB%9F%E8%AE%A1%E5%85%AC%E6%8A%A5-20251201161542231.pdf</a>	N/A	Out of pocket medical expenses are over 70% of all healthcare costs in India [Source: MP India Q3 2020]  <b>Between</b> FY15 and FY22, the share of out-of-pocket expenditure (OOPE) in THE declined from 62.6 per cent to 39.4 per cent.  <b>Source:</b> Economic Survey 2024-25 <a href="https://www.indiabudget.gov.in/economicssurvey/doc/eshapter/echap11.pdf">https://www.indiabudget.gov.in/economicssurvey/doc/eshapter/echap11.pdf</a>	Out-of-pocket (OOP) spending stood at 28.6% – a reduction from 30.6% the previous year, however still relatively high. Source: <a href="https://www.who.int/indonesia/news/detail/24-01-2025-tracking-every-rupiah--indonesia-s-bold-step-towards-universal-health-coverage#:~:text=In%202023%20Indonesia's%20total%20health,year%20C%20however%20still%20relatively%20high.">https://www.who.int/indonesia/news/detail/24-01-2025-tracking-every-rupiah--indonesia-s-bold-step-towards-universal-health-coverage#:~:text=In%202023%20Indonesia's%20total%20health,year%20C%20however%20still%20relatively%20high.</a>	End of compulsory education < 70 (30%) Prior to compulsory education (20%) 70 < 75 years (20%; 30% for active income earners) 75+ (10%, 30% for active income earners) The maximum amount of copayment is set according to the High-cost Medical Expense Benefit Scheme.	Out-of-pocket expenditure in 2023 is 29%. [OECD Health at a Glance 2023]  By category: Private hospitals: 46.4% Private clinics: 18.3% Community pharmacies: 16.5% Traditional & Alternative Medicine: 2.6% Private dental clinics: 4.7% Others: 11.5%  Medicines ratio: 16.5%  At public medical institutions, medical fees are set on the basis of the Fee Act, and if you are a Malaysian citizen, you can be examined for a fee ranging from one to several ringgits. Fees for medical tests, surgery, hospitalization, and drug costs are also set low. These are free of charge for low-income people and civil servants, etc.  Source: <a href="https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHA/MNHA_HEALTH_EXPENDITURE_2011-2023_(MNHA_Steering_Meeting_2024).pdf">https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHA/MNHA_HEALTH_EXPENDITURE_2011-2023_(MNHA_Steering_Meeting_2024).pdf</a>	The %private share of expenses on medicines is at 85%.  WHO-OECD <a href="https://iris.wpro.who.int/bitstream/handle/10665.1/13982/9789290618485-eng.pdf">https://iris.wpro.who.int/bitstream/handle/10665.1/13982/9789290618485-eng.pdf</a>	Patients will be able to draw from MediSave and/or cash to pay the balance of costs after insurance claim limits are reached.	The drug co-payment is a fixed amount established for each drug price category, and the burden rate is about 20% and upper limit is 200NTD/Time. New co-payment which increases drug co-payment to 300NTD/time for non-transferral hospital OPD visit has been announced in 2022, however not put into effect yet as of February 2023.	Depends on what insurance the patient is enrolled in. Under UCS, no co-payment from allowed. There are a wide range of limitations on the medical institutions that can be consulted and the drugs that can be received. The same is true of SSS. If a non-NLEM drug is used, the patient bears the full cost him/herself.	Co-pays are 0–50%, depending of the category of insured.  In general, Vietnam's current out of pocket expenses are relatively high, ~ 40% of healthcare spending (with remaining 60% covered by the Health Insurance Fund and predominantly government budget). For healthcare expenditure covered by the HI Fund, currently 35% is allocated for medicines (including both western and traditional medicines). The co-payment level for each active pharmaceutical ingredient (API) listed in the NRDL is determined by the Minister of Health, ranging from a minimum of 30% to full coverage (100%).	
			Availability of pricing system for reimbursed medicines	On 7 December 2025, the National Healthcare Security Administration and the Ministry of Human Resources and Social Security issued the "National List of Medicines for Basic Medical Insurance, Maternity Insurance, and Work Injury Insurance." Drugs included in the list through negotiated agreements or competitive bidding will, during the validity of the agreements, be subject to a nationally unified reimbursement standard. <a href="https://www.nhsa.gov.cn/art/2025/12/7/art_104_18970.html">https://www.nhsa.gov.cn/art/2025/12/7/art_104_18970.html</a>  On December 2, 2025, the National Drug Price Registration System was officially launched. The system was operated independently from provincial pharmaceutical procurement platforms, this system provides domestic and international pharmaceutical companies with official channel for voluntarily registering and declaring drug prices. <a href="https://www.nhsa.gov.cn/art/2025/12/2/art_14_18930.html">https://www.nhsa.gov.cn/art/2025/12/2/art_14_18930.html</a>	N/A	NA	Refer to the drug procurement system above	The health insurance-covered medical institutions or pharmacies shall make an insurance claim based on the price specified in the drug price standard.	If clinically superior efficacy is proved and cost-effectiveness is demonstrated through Pharmaco-economic Evaluation (PE), a premium price can be evaluated through PE track. In the case of anti-cancer drugs or rare diseases, an ICER threshold twice higher than the PE of general drugs is applied, but Risk Sharing Agreement scheme such as refund or cap are applied with NHIS in RSA track. The PE waiver track is a method to compensate for uncertainty with accepting lowest price among the listing price in worldwide when there is not able to conduct PE due to non-direct comparative clinical trial. Lastly, The WAP(weighted average price) track considers new drug price as comparator price and its market share.	Medicine price displays was enforced in private clinics from 1 May 2025, in accordance with Price Control and Anti-Profitteering (Price Marking for Drug) Order 2025. Full implementation is expected in 2026. GP fees raised from RM10-RM80 in Budget 2026.	PhilHealth will only reimburse cases with medicines that are included in the formulary. However, in the benefit packages (composed of hospitalization, professional fees, and medicines), there is no explicit allocation for how much goes to medicine.	Yes	Yes, PBRS is in place.	There is no reimbursed price of medicines under SSS and UCS as total medical benefit is paid on capitation basis. For the CSMB, reimbursement for OPD script is based on mark-up margin on top of the procurement price. For IPD, coverage is based on diagnosis-related grouping (DRG).

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Insurance & drug pricing system/ Public healthcare system	Overview of pharmaceutical reimbursement	Pricing organization	Most of drugs are market-based pricing in China. National Healthcare Security Administration is only responsible for the pricing of some special drugs, such as toxic and narcotic drugs and for reimbursement price negotiations and adjustments for drugs included in China's National Reimbursement Drug List.	N/A	NPPA is an Organisation under the Department of Pharmaceuticals, Ministry of Chemicals & Fertilizers, Government of India, which was established, <i>inter alia</i> , to fix/ revise the prices of controlled/scheduled formulations and to enforce prices and availability of the medicines in the country, under the Drugs (Prices Control) Order, 2013 (DPCO 2013). DPCO 2013 is an order issued under Section 3 of the Essential Commodities Act, 1955. It came into effect from May 15, 2013. In addition, NPPA also monitors the prices of decontrolled/non-scheduled drugs in order to keep them at reasonable levels. The Organisation is also entrusted with the task of recovering amounts overcharged by manufacturers in respect of all drugs & medical devices from the consumers. <a href="https://nppa.gov.in/">https://nppa.gov.in/</a>	The Government Goods / Services Procurement Policy Agency (abbreviated as LKPP) is a Non-Ministry Government Institution (LPNK) which is under and report to the President of the Republic of Indonesia See also the drug procurement system above	The Minister of Health, Labour and Welfare determines in response to the report from the Central Social Insurance Medical Council ("Chuikyo") . The Chuikyo may seek opinions from the drug pricing Organisation established in the Council if necessary for drug pricing.	NHIS: Payer and negotiate drug price and volume with pharmaceutical companies. HIRA: Set reimbursement guideline and decision making for reimbursement with cost-effectiveness evaluation	There are no specific organizations that monitor the medicines price for now. However, the organization involved in conducting medicines price study is Pharmaceutical Services Programme (PSP), while Ministry of Health is the one who makes the decision. PSP release manual guidelines known as Recommended Retail Prices and Consumer Price Guide as public reference. In Jan 2024, PSP included drug prices into the Price catcher app which is used by the public to compare prices, however it is not updated by pharma companies.	For government procurement: DOH and HTA Unit/ Council  For medicines that meets certain criteria: Pharmaceutical Division and Drug Price Advisory Council may impose maximum retail price  1. Drugs that address health priorities of the general public, especially those for the leading causes of morbidity and mortality  2. Drugs that have high price differentials/ arbitrage compared to international prices  3. Drugs that have limited competition in terms of lack of generic counterparts or lack of market access to these products  4. Drugs where the innovator product is the most expensive yet most prescribed and/or dispensed in the market	Price of medicines in Private sector is subject to market competition. At public hospitals, prices are indirectly controlled by a tender system operated by the ALPS. Since 2015, health technology assessments conducted by the Agency for Care Effectiveness (ACE) for selected innovations have informed cost-effectiveness recommendations, which in turn have guided value-based pricing in the public sector through subsidy and procurement decisions.  ALPS, previously known Group Procurement Office (GPO) is responsible in executing a national-level, end-to-end supply chain blueprint, in partnership with all Public Healthcare Institutions, to ensure access to appropriate and affordable treatments and medications at the public sector.	NHI reimbursement covers both Western and traditional Chinese medicines. The amounts are determined by the NHIA's Expert Committee and PBRS (Pharmaceutical Benefit and Reimbursement Scheme) Joint Committees, which oversees listing, pricing recommendations and coverage restrictions.	The Sub-Committee for the Development of the Median price under the National Drug System Development Committee (NDSDC) establishes a maximum procurement price for both NLEM and non-NLEM.	No update for report period. Will change terminology used: instead of declared/ re-declared price with announced/ re-announced price due to applicable changes in the Price Law 2023 and Pharma Law 2024 There are some updated information - Pharmaceutical Law 44/2024/QH15 and Decree 163/2025/ ND-CP managed by Ministry of Health Submit to DAV: + Announce the Price of prescription Drug, on the website of DAV. + Wholesale price <b>must not be higher</b> than the announced price. + Effective date: 01/07/2025  - Price Law 16/2023/ QH15, managed by Ministry of Finance + Declare the <b>correct actual price</b> that the company sells on the invoice, minus any discounts, if any, and including VAT. + Applied for the List of essential medicines + Declare to Department of Health for each province that where manufacturers/ distributors are located.

Category	Item	Types	China 2026	Hong Kong 2026	India 2026	Indonesia 2026	Japan 2026	Korea 2026	Malaysia 2026	Philippines 2026	Singapore 2026	Taiwan 2026	Thailand 2026	Vietnam 2026		
			RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PRReMA	PG		
Insurance & drug pricing system/ Public healthcare system	Overview of pharmaceutical reimbursement	Pricing process	<p>For Public Hospitals, there are mainly two approaches:</p> <p>1. Centralized Drug Procurement Program. Competitive bids shall be used to purchase medications and be carried out by local governmental authorities on a province-by-province basis under the central coordination of NHC. The "zero-mark-up" policy has been implemented since 2017 (the drug price that a hospital charges the patient should be the same as it pays to the drug suppliers).</p> <p>2. Volume-Based Procurement. The NHSA directly negotiates with pharmaceutical companies about drug supply for public hospitals and strive to get favorable terms by insisting on bulk purchasing. The participant with the lowest tender price will be the bid winner. By securing the purchase price at the terminal end, the cost at each distribution phase upwards will be reduced, which ultimately leads to an end lower price.</p> <p><a href="http://www.nhsa.gov.cn/art/2020/7/31/art_37_3387.html">http://www.nhsa.gov.cn/art/2020/7/31/art_37_3387.html</a></p> <p><a href="http://www.nhc.gov.cn/tigs/s3581/201704/0563e06eff4441ffa9772dc30b487848.shtml">http://www.nhc.gov.cn/tigs/s3581/201704/0563e06eff4441ffa9772dc30b487848.shtml</a></p>	N/A	<p>Drugs/formulations which are included in the NLEM are <i>ipso facto</i> included under Schedule I of DPCO 2013 and NPPA has to fix the ceiling prices of such drugs/formulations.</p> <p>Under the current DPCO 2013, there are three categories of formulations:</p> <ul style="list-style-type: none"> <li>- Scheduled formulations which are listed under Schedule I of the DPCO and for which ceiling prices are fixed by the NPPA based on average Price-to-Retailer (PTR) of all brands with a market share of at least 1% plus a 16% retailer margin. MRP of such drugs can only be revised, once every year in the month of April based on Wholesale Price Index (WPI). Such formulations can only be discontinued from the market with prior approval from NPPA.</li> <li>- Non-scheduled formulations are all other drugs not included in the Schedule I of the DPCO and for which ceiling prices/ retail prices are not fixed by the NPPA, but such formulations are monitored by the NPPA and are allowed to avail an annual price increase upto 10% of MRP in the preceding 12 months.</li> <li>- New drugs are formulations launched by an 'existing manufacturer' of Schedule I drug by combining the drug with another scheduled or non-scheduled drug or a scheduled formulation launched by changing the strength or dosages or both as listed in Schedule I. Retail prices of such drugs are fixed by NPPA, however, they continue to be regulated as non-scheduled formulations thereafter and are allowed to avail 10% annual price increase. Further, the DPCO 2013 has a number of price reporting and compliance requirements for all formulations.</li> </ul>	See above drug procurement system	<ul style="list-style-type: none"> <li>- Regarding new drugs, after the regulatory approval, upon receiving the application for listing in the NHI price list by business operators, an Organisation calculating drug prices shall formulate a draft of the calculation and report it to the Chuikyo. Upon receiving the report from the Chuikyo, the Minister of Health, Labour and Welfare shall, in principle, register the drug in the NHI price list within 60 days after the regulatory approval.</li> <li>- For existing listed drugs, their actual sales price to medical institutions and pharmacies shall be investigated and their list prices shall be repriced periodically based on the results.</li> </ul>	<p>*The MOHW's draft of pricing reform plan was announced at the end of November 2025. It has not been finalized yet</p> <p>(1) Generic &amp; Off-patent Pricing (since 2nd half of 2026)</p> <p>From 2026, the Government announced a plan to recalibrate generic drug pricing toward approximately 40% of the originator price, replacing the previous differentiated generic pricing structure. Additional step-down mechanisms are planned for markets with a large number of concurrently listed generics, with the objective of strengthening expenditure efficiency and addressing excessive price clustering in off-patent markets.</p> <p>(2) Reimbursement &amp; Access for Innovative Medicines (since 2026)</p> <p>To improve access to medicines for patients with high unmet medical needs, the Government indicated plans to introduce accelerated reimbursement pathways for rare and severe diseases, with simplified review procedures and shorter timelines for selected products.</p> <p>(3) Flexible Pricing Contract / List-Net Price Structure (since Q1 of 2026)</p> <p>Policy discussions continued on the introduction of a flexible pricing contract model, under which list prices may be maintained at internationally comparable levels while transaction prices are managed through confidential arrangements, aiming to balance international reference pricing risks with domestic fiscal sustainability.</p> <p>(4) Cost-effectiveness &amp; Post-listing Evaluation (since 2027)</p> <p>The authorities signaled a more flexible application of ICER thresholds, taking into account disease severity, patient population size, and budget impact.</p> <p>In the medium term, the Government plans to strengthen post-listing evaluation using real-world data (RWD), with the objective of aligning reimbursement levels more closely with actual clinical outcomes and utilization patterns.</p> <p>(5) Post-listing Price Adjustment Predictability (since 2028)</p> <p>Ongoing policy dialogue addresses challenges arising from multiple, overlapping post-listing price adjustment mechanisms. The Government has acknowledged the need to improve predictability and coherence by reviewing the timing, scope, and interaction of price-volume agreements, indication expansion adjustments, and reassessment-related price cuts.</p>	PSP's Medicines Pricing Branch keeps a medicine price database based on information obtained from every level in the medicine distribution chain, as reference in the negotiation process and monitoring of medicine prices.	HTA is the process used by the government to determine products that will enter the PNF and consequently be procured and reimbursed by government.	In certain situations, the Maximum Retail Price (MRP) is imposed for medicines that meet the above-mentioned criteria.	Drugs seeking public funding are assessed by the Agency for Care Effectiveness (ACE) through health technology assessment (HTA), during which value-based price negotiations are conducted with companies to inform Ministry of Health (MOH) subsidy and financing decisions. These products are subsequently procured centrally via ALPS for public healthcare institutions, with tender prices generally aligned to the price negotiated with ACE as part of the public funding assessment, and are paid for through a combination of government subsidies, MediShield Life insurance and MediSave, depending on eligibility and scheme rules.	In contrast, drugs not seeking public subsidy are not subject to mandatory HTA, are priced freely by companies based on commercial considerations, procured directly by hospitals or distributors, and are generally paid for out-of-pocket by patients, with limited insurance or MediSave coverage.	For NDA-approved drugs, reimbursement submissions will be accepted, evaluated by CDE (Center for Drug Evaluation) for HTA (Health Technology Assessment), and reviewed by Expert Committee. Finally, a PBRS meeting will be held every 2 months to reach a resolution on NHI drug listing and pricing. A new office was founded and effective from January 2024, Named Center for Health Policy and Technology Assessment, CHPTA. The reimbursement processes before PBRS meeting are under charge of CDE, including review of submission of items eligible for parallel review and ordinary items, HTA and the expert meeting. NHIA indicates the objective of the new measure aiming to speed up reimbursement approval process by 6 months and 4 months for parallel review case and ordinary review case respectively.	Medicines are categorized as "price-controlled products" under the Ministry of Commerce (Price and Service Act) although the agency permits operation of market mechanism (no enforcement of fixed pricing system). Free pricing for the new drugs launched is permitted. Threat is from median price setting for public procurement which has potential impact on the industry from the gap between "median price for public hospitals" and "market price for private hospitals".	Importers, manufacturers shall announce intended wholesale price, intended retail price of a drug (where there is a need to declare the retail price) prior to placing the first lot of the drug it imported on Vietnam market. After market approval, if drug is eligible for reimbursement by national health insurance, it will follow the relevant tender/procurement process.

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Insurance & drug pricing system/ Public healthcare system	Overview of pharmaceutical reimbursement	Pricing rules/methods	For exclusive drugs, the pricing method is NRDL negotiation. For non-exclusive drugs under the government procurement, the price is set according to the procurement regulation. For other non-exclusive drugs, the price is set by bidding (volume-based procurement, VBP). For habit-forming drugs and spirit drugs, the price is set by government. <a href="http://www.nhsa.gov.cn/art/2020/7/31/art_37_3387.html">http://www.nhsa.gov.cn/art/2020/7/31/art_37_3387.html</a>	Pricing rules are not applicable. Tendering system.	Under DPCO 2013 there are three pricing pathways for formulations: • Market Based Price I Para 4: Ceiling Prices of most scheduled formulations are taking the Simple average PTR of all the brands of the drug having more than 1% market share and adding a 16% retailer margin to the same.  Monopoly situation/lack of competition or when there is no decrease in average PTR I Para 6: Ceiling prices of such formulation are fixed by taking the average PTR of the drug and subtracting a Monopoly Condition component and adding a 16% retailer margin to the same.  • Plenary Powers I Para 19: The provision is used by NPPA in case of emergency or public interest situations to fix prices of scheduled or non-scheduled formulations. NPPA has resorted to price fixation of many scheduled as well as non-scheduled drugs under its plenary powers with differing formula and different reasoning For eg. Price fixation of 108 cardiovascular and anti-diabetic non-scheduled drugs in 2014, Trade Margin Rationalization of 42 oncology drugs in 2019 and price fixation of 5 scheduled drugs using institutional data in 2020.	Same as above Note: the setting of HPS is non-transparent resulting in prices in some cases so low that no providers are willing to offer. The government realized this and will amend the situation in the coming tender process in 2020.	• The price of new drugs shall, in principle, be calculated by the comparable pricing method. (Among drugs already listed in the NHI drug price list, a most similar to a new drug in terms of indications, pharmacological action, composition/ chemical structural formula, dosage form, formulation category, and formulation/dose regimen, is selected as a comparator drug and calculated by comparing the daily drug price. Furthermore, based on clinical data, premiums are added based on its level of innovation, usefulness, marketability, etc. If there are already 3 or more similar drugs, it is deemed as a new drug with limited novelty, and the drug price is calculated at a low level based on the rules. Drugs already marketed overseas are further adjusted according to the foreign average price adjustment rule.) *For already-listed drugs, the actual sales price to medical institutions and pharmacies is investigated, and a new price is calculated by adding consumption tax and a certain percentage of the current drug price to the weighted average of transaction price by brand.	  New medicines can select the listing pathway according to characteristics such as the clinical usefulness, comparator, severity, type of diseases etc. (Figure 1. Evaluation scheme of new drug) For the generics pricing system, MoHW announced new system to improve drug quality. Generic price will be set upon how many criteria they have satisfied among. i) Independent BE (Bioequivalence) test instead of BE test done by consortium of many pharmaceutical companies, ii) In-house manufacturing, iii) DMF listing. If satisfied all criteria, generic price will be 53.55% of original, two items met – 43.3%, one item met – 33.3%, none of criteria met – 30%. Until reassessment of generic price, 2 years of preparation period will be provided. The President of HIRA reports the assessment result to the Ministry of Health and Welfare. Then, the Minister determines whether the medicines are covered or uncovered along with the upper limit amount, and makes the results public, after review by the NHI policy deliberative committee.	Pricing follow market forces; no specific rules	Cost-effectiveness is used as the primary method for HTA.  External Reference Pricing from a basket of countries, with the lowest price plus adjustments is used for MRP.	See above.	"National Health Insurance drug payment program and payment standard" The NHIA regulates drug pricing and reimbursement in Taiwan. When setting reimbursement prices, it references the prices of a basket of ten benchmark countries (A10), including Australia, Belgium, Canada, France, Germany, Japan, Sweden, Switzerland, the UK and the US. The reference prices for these A10 benchmark countries are based on information published by their respective national health authorities, and typically include any combination of the manufacturers' cost, wholesale price, pharmacy mark-up, VAT, and the prescription price. Category 1 drugs are priced at the median of the ten reference countries, while the drug prices for Category 2 are determined by any one of five major methods. Under both drug categories, additional reimbursements may be granted for drugs if certain R&D-related conditions are met. *Category 1 (breakthrough innovative product, with a substantial improvement of therapeutic value over comparators), Category 2A (new drug demonstrating moderate improvement over best comparator), or 2B (new drug similar to best comparator).	Free pricing during launch with threats of median price setting as mentioned. NDSDC approved five criteria for median price setting including: cost-plus, profit ceiling, comparative pricing, price negotiation and pharmaco-economic evaluation. Currently, comparative pricing and price negotiations are adopted but with unclear, inconsistent, and less meaningful negotiation process focusing on "cost-containment".	The review of drug prices as announced, re-announced by pharmaceutical business establishments shall be performed following the principles of: a) Not higher than the selling price of the drug in Asean countries, or countries with equivalent conditions; b) The accuracy of factors forming the product's selling price that are declared by the importer, the manufacturer or the establishment placing contract manufacturing orders of the drug; c) The appropriateness of the price in relation to the movement of price forming factors of the product such as raw materials, fuel, exchange rate, labor cost and other relevant costs in the case of price upward adjustment. With the Pharmaceutical Law 44/2024/QH, Decree 163/2025/ND-CP regulations regarding price declaration are becoming clearer.

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Insurance & drug pricing system/ Public healthcare system	Overview of pharmaceutical reimbursement	HTA introduction	China National Health Development Research Centre under the National Health Commission issued the Notice on the <i>Guidelines for Quality Control of Clinical Comprehensive Evaluation of Drugs (2024 Trial Version)</i> on December 31, 2024. <a href="http://www.nhei.cn/nhei/zntfb/202412/d33db3fcd94daeabe49cfa95fa24f9.shtml">http://www.nhei.cn/nhei/zntfb/202412/d33db3fcd94daeabe49cfa95fa24f9.shtml</a>	No HTA in place	The main purpose of HTA is to inform policy decisions in health care, and thus improve the uptake of cost-effective innovative technologies, and to inform the formulation of safe, effective, health policies that are patient-focused and seek to achieve the best value or the most optimal outcome. HTA program has been supporting the Central and the State Health Systems for evidence-based decision-making on the implementation of new health technologies, revision of health benefit packages, designing of new screening programs, pricing, and procurement. As per National Health Policy (NHP) 2017, HTA is required to ensure that technology choice is participatory and is guided by considerations of scientific evidence, safety, consideration on cost effectiveness and social values. Working under the aegis of Department of Health Research, HTA is entrusted with the responsibility to analyse health technologies viz. medicines, medical devices and health programmes for its cost-effectiveness, clinical-effectiveness, and equity issues by means of HTA, and in turn help in decision making for an efficient use of the limited health budget and provide people access to the quality health care reducing their OOPE on health. It is an attached office of the Department of Health Research, It's goal is to evaluate and assess health technologies, such as medical devices, drugs, procedures, and public health programs, to inform evidence-based healthcare decisions and policies. National Health Authority (NHA) the implementing body for AB-PMJY has constituted the Health Financing and Technology Assessment unit (HeFTA) for conducting HTA studies for inclusion of drugs and medical devices as part of the Health Benefit Packages (HBPs). Recently NHA has renewed its MoU with the Department of Health Research (DHR) and the Indian Council of Medical Research (ICMR). The renewed collaboration aims to further strengthen technical cooperation for evidence-based decision-making to optimize healthcare resource allocation and enhance quality across India's flagship health schemes. So far 98 studies have been completed by the HTA Secretariat in India  <a href="https://link.springer.com/content/pdf/10.1007%2F-s41669-017-0037-0.pdf">https://link.springer.com/content/pdf/10.1007%2F-s41669-017-0037-0.pdf</a>	Recent development in 2024, Ministry of Health has formed the new Health Technology Assessment Committee led by Professor Auliya Suwantika from University of Padjajaran. With the newly established committee, Ministry of Health started to focus on building HTA ecosystem to enable more evidence-based decision or policy. It is currently being piloted with only one innovative medicine. At the end of 2024, the HTA committee launched a new business process called "One Stop, One Standard" which will synchronize the HTA and national formulary listing process in a form of one door mechanism. Now, all drugs that want to be listed in the national formulary need to be assessed through HTA. Furthermore, the new HTA committee developed a new HTA scheme named Stakeholder-Led-Submission (SLS). The new scheme will allow the involvement of industry in conducting the HTA study to be submitted for review by the HTA committee. The intention is to speed up the process of HTA study for listing recommendation and as the solution to clear the bottleneck issue in the HTA. The technical guidance for SLS is currently at the public hearing & consultation stage and is expected to be formalized in early 2026.	The cost- effectiveness analysis system started in April 2019. Drugs and medical devices with large market sizes or extremely high unit prices are evaluated, and the evaluation results are not used to judge whether or not insurance can be reimbursed, but are once listed in insurance and then used for price adjustment. However, rare diseases for which there are not enough treatment methods for designated intractable diseases and drugs and medical devices used only for children are excluded. Hereafter, the evaluation system will be enhanced, cases will be collected, and the ideal system and utilization method will be examined.	HIRA disclosed final reports on the contracted research for HTA guideline renewal by Jan 22nd, 2021. Upon this, pre-notification is under progress and main changes are, 1) Time horizon, 2) Consistent analysis on target population (especially for the subgroup), 3) Model structure appropriateness (AdviSHE), 4) Uncertainty analysis, 5) Diagnostics to be included if necessary, 6) Adjustment of cross-over impact, 7) Discount rate 5% -> 4.5%	Increasing awareness and interest driven by PhAMA's White Paper on HTA for evaluation of innovator pharmaceutical products released in 2025. PSP plans to strengthen their HTA section to enhance public access to innovative drugs.	The guidelines for HTA were released in 2020. Under the law, only those with positive recommendation after HTA shall be procured or reimbursed by government.  Health Technology Assessment Council <a href="https://hta.dost.gov.ph">https://hta.dost.gov.ph</a>	<ul style="list-style-type: none"> <li>In August 2015, Agency for Care Effectiveness (ACE) was established within MoH, with the aim to support national clinical policy decision-making through evidence-based assessment and produce national guidance on appropriate care.</li> <li>ACE evaluates the clinical efficacy and safety of the drug concerned in comparison to its main comparators, which are defined as either the treatment that is most likely to be replaced by the new drug or, in case of add-on treatments, the current treatment without the add-on product. The agency published its <i>Drug Evaluation Methods and Process Guide</i> in February 2018, which is intended to provide the industry with an overview of its methodology and increase the transparency of its processes and decision-making.</li> <li>For drugs deemed to offer equivalent, non-inferior clinical benefits relative to comparators, a cost minimization analysis (CMA) is conducted. If the drug is deemed to offer clinically superior efficacy over comparators, a cost-effectiveness analysis (CEA) is conducted.</li> <li>From 1 January 2021, under a new company-led process, pharmaceutical companies can request for their oncology drugs to be evaluated for funding consideration. The pilot process under ACE enables parallel regulatory and funding submissions to allow cancer drugs to be evaluated closer to the anticipated date of regulatory approval and expedite funding considerations to improve patient access to clinically necessary treatments.</li> <li>ACE was also responsible for establishing the Cancer Drug List that took effect in September 2022.</li> <li>In 2021, the Consumer Engagement and Education (CEE) team was set up to help patients, caregivers and the public become involved in ACE's work. CEE has started to invite patient and volunteer organizations to provide inputs into ACE's HTA evaluations to ensure that future policy recommendations are relevant to patients.</li> </ul> <p>[ACE official website: <a href="http://www.ace-hta.gov.sg/our-process-and-methods.html">http://www.ace-hta.gov.sg/our-process-and-methods.html</a>]</p>	The current reimbursement review process includes a comprehensive evaluation of the therapeutic and pharma-economic aspects of a new drug by CDE using the HTA. This evaluates the efficacy and/or effectiveness as well as the comparative safety of a new drug. Other aspects of the assessment include budgetary impact, as well as related ethical, social and political issues. The HTA process involves several government agencies to collect evidence and finalize the assessment report. The categorisation of the drug is also determined during this stage. The HTA assessment report is completed and submitted to the NHIA within 42 days, and it provides the basis for the listing and pricing recommendations during the drug benefit expert meeting. The Center for Health Policy and Technology Assessment (CHPTA) was established on December 27, 2023 to conduct Horizon Scanning (HS), Health Technology Assessment (HTA) and Health Technology Re-assessment (HTR).	A health technology assessment agency under the MoPH, the Health Intervention Technology Assessment Program (HITAP), is primarily responsible for conducting economic evaluation of some drugs, especially high-cost products. Its major mission is to assess and appraise health interventions and technologies efficiently and transparently. It does its assessment in several steps. For instance, every year HITAP asks various stakeholders – health-care providers, academics, hospital purchasers, payers, and patient advocacy groups – across the country for potential drugs that should be evaluated. The NLEM committee can also ask HITAP to assess certain products to help with its decisions. HITAP has its own experts to conduct pharmacoeconomic evaluations. It has developed not only national guidelines for economic evaluation but has also incorporated the World Health Organization guideline that average GNI per capita be considered as a cost-effective threshold. Recently, this threshold based on GNI per capita is set at Baht 160,000 per Quality Adjusted Life Year (QALY). HITAP assessments have sometimes been used to successfully negotiate drug prices with manufacturers before the drugs are listed on the NLEM.	HTA will be used as a primary tool to better shape the reimbursement list in the future

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Insurance & drug pricing system/ Public healthcare system	Overview of pharmaceutical reimbursement	Others	N/A	-	Different healthcare providers/ Hospitals have their own methods for procurement of Medicines	-	N/A	N/A	-	The guidelines for HTA are currently being reviewed for updating.  <a href="http://bit.ly/AOMGPGSHEPubCon">http://bit.ly/AOMGPGSHEPubCon</a>	N/A	NHIA's Horizon Scanning Implementation began on Sept. 26, 2020, requiring manufacturers to register their planned products and expected prices for the next 2 years, which should be considered in NHIA's budgeting process. A cancer drug fund exempt from the NHI global budget will be established from January 2025 to reimburse cancer drugs with clinical or financial uncertainty. The budget for the first year is 5 billion NTD and will be increased to 10 billion NTD in 2027.	-	-
					State governments					Independent Medical Corporations are entrusted with procurement and distribution of Drugs and Medicines, to the Government Medical Institutions, through competitive bidding process. These corporations finalize the list of drugs every year based the requirements from the Government Medical Institutions eg: Tamilnadu State Medical Services corporation (TNMSC)				
Other	Procurement of medicines (Tendering/ bidding)	On October 28, 2025, the eleventh round of the National Centralized Drug Procurement was announced. This procurement included 55 drugs, covering areas including anti-infectives, anti-allergy, anti-tumor, hypoglycemic, anti-hypertensive, lipid-lowering, and anti-inflammatory analgesics.  <a href="https://www.gov.cn/lianbo/bumen/202509/content_7041559.htm">https://www.gov.cn/lianbo/bumen/202509/content_7041559.htm</a>	Process for adopting new drugs has been established at public hospitals, etc., based on Hospital Authority Drug Formulary scheme. Review criteria consist of superiority in treatment, evidence, adverse reactions, whether or not mentioned in international guidelines, and cost-effectiveness analysis It is tendering system. For patent drugs, using close tender and generics, using open tender. Strategic Procurement Office developed in 2023 responsible to procure medicine for Chronic Disease Co-Care Pilot Scheme for primary healthcare, ride on the system of Hospital Authority.	The drug procurement process for the central government and state government procurement are not uniform. There are several central government procurement entities. The common feature of these procurements is that they follow tender process. Further, Government e Marketplace (GeM) is a Government owned & national public procurement portal, which allows onboarding of private drugs manufacturer for procurement of generic medicines. As per Rule 147 and Rule 149 of the General Financial Rules (GFRs), central government procurement of goods and services will be mandatory for goods and services available on GeM. State government procurements are through independent Medical Corporations/ procurement agencies. See also the above drug procurement process.	Government procurement of medicines are regulated in the Minister of Health Regulation No.17 of 2024, Presidential Decree No.16 of 2018, and Presidential Decree No.46 of 2025, along with relevant Govt. Central Procurement Agency (LKPP) regulations (e.g. LKPP Regulation No.2 of 2025 and medicine catalog changes)	Differs from each medical institution.	In the Korean drug distribution market, medicines are traded between wholesalers or pharmaceutical companies, medical institutions and pharmacies on a per item basis, and transaction conditions are also generally set by item. In addition, in the case of OTC or national hospital bidding, it can be found the total price transaction, which is a contract for negotiating the total price of various produce.	Industry faced serious setbacks with the public tender system in 2025. Key challenges include: - Delays in call for tenders - Opaque award system - Lack of transparency on tender pricing of bidders Industry has been bringing these challenges to Members of Parliament to try resolve these setbacks.	Similar to reimbursement, only medicines included in the formulary may be procured by government hospitals. DOH hospitals are able to benefit from centralized procurement, getting volume discounts. However, implementation of pooled procurement, multi-year contracting, and capacity building on forecasting and supply chain management is still necessary to improve affordability.	• ALPS was established on 1 July 2018 to replace the former Group Procurement Office, as a new supply chain agency in support of the three healthcare clusters to achieve system-wide gains and support care transformation through greater economies of scale, new capabilities and innovations in procurement and supply chain management. • Products that demonstrate good quality standard and supported by data are preferred at the tendering evaluation.  ALPS is responsible for the implementation of a new CHAS subsidy framework for chronic diseases drugs that is slated to be rolled out in 2023. ALPS will be the central procurement agency for a whitelist of chronic diseases drugs that will be offered at subsidized prices in the primary care network of private General Practitioners (GPs). [ <a href="https://www.singhealth.com.sg/about-singhealth/procurement">https://www.singhealth.com.sg/about-singhealth/procurement</a> ]	Differs from each hospital. Bidding by individual hospitals (1 or 2-year contract is common)	Prior to procurement, drug listing in both public and private hospital formularies are mandatory. Under the Procurement Act, three main procurement methods must be used, in accordance with the conditions stipulated: 1. <b>General invitation method:</b> A government agency may invite general entities that have the qualifications specified by the government agency to submit a proposal. 2. <b>Selection method:</b> A government agency may invite at least three particular entities that have the qualifications specified by the government agency to submit a proposal, unless there are fewer than three entities that meet the qualifications. This method can be used if there are special circumstances or conditions – for example, an article being procured that has special characteristics or is especially complex, or must be manufactured, sold, constructed, or serviced by a highly skilled person, or which, by the nature of its use, or technical specifications, must be of a brand name. 3. <b>Specific method:</b> A government agency may invite one specific entity that has the qualifications specified by the government agency, to submit a proposal, or to directly negotiate a price matter that has a small budget. This method can be used if there are special circumstances or conditions – for example, if there is only one qualified entity, or an article is to be purchased due to a disaster or epidemic, and the other two methods would lead to a delay and severe damage. Challenges are from the low median price set for both single-source and multi-source medicines. In addition, there are public procurement privileges for GPO produced medicines and generics listed in the Thai Innovation List limiting free and fair market competition.	There are two ways of conducting drug procurement (utilizing public funds) in Vietnam: (i) tenders by individual state-owned hospitals level and (ii) centralized tenders (national level). Tender packages: • Innovative / Originator drugs can be both procured via a separate tender package (hospital level) and price negotiation (if listed as eligible for price negotiation on a national level). • Generics 1: EU-GMP or equivalent principles and standards accredited by regulators on the SRA list • Generics 2: EU-GMP; or PIC/s GMP in ICH members • Generics 3: assessed by Vietnam authority as conforming with GMP principles and standards & proven bioequivalence • Generics 4: locally manufactured (WHO-GMP) • Generics 5: remaining (meeting WHO-GMP) Validity of tendering time: • Drugs subject to tendering by individual hospital: max 12 months • Drugs subject to centralized tender: max 36 months	

Category	Item	Types	China 2026	Hong Kong 2026	India 2026	Indonesia 2026	Japan 2026	Korea 2026	Malaysia 2026	Philippines 2026	Singapore 2026	Taiwan 2026	Thailand 2026	Vietnam 2026
			RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PReMA	PG
Intellectual property rights/IP	Overview of Intellectual property right system	Patent law (Governing ministries)	<p><i>The Patent Law</i> comes into force in June 2021 with the following new contents.</p> <p>1. Introduction of "Drug Patent-term Compensation System" and "Patent Disputes Early Resolution Mechanism"</p> <p>2. Increase the scope of infringement damages compensation</p> <p><i>The Patent Law</i> <a href="https://www.cnip.gov.cn/ar t/2020/11/23/ar t_97_155167.htm">https://www.cnip.gov.cn/ar t/2020/11/23/ar t_97_155167.htm</a></p> <p>On November 10, 2025, the China National Intellectual Property Administration issued the "Patent Examination Guidelines (Draft for Deliberation)," which will come into force on January 1, 2026. <a href="https://www.cnip.gov.cn/ar t/2025/11/13/ar t_66_202561.htm">https://www.cnip.gov.cn/ar t/2025/11/13/ar t_66_202561.htm</a></p>	<p>There are two types of patents in Hong Kong:-</p> <p>1. Standard patent</p> <p>Standard patent includes a standard patent (R) and standard patent (O). A standard patent (R) is a patent granted by re-registration of a designated patent office, i.e. the European Patent Office, in respect of patents granted under the European Patent Convention designating the United Kingdom, the State Intellectual Property Administration, and the United Kingdom Patent Office.</p> <p>A standard patent (O) is a standard patent by original grant, where a substantive examination of the patentability of the application will be carried out. The applicant for a standard patent (O) makes a direct application to the Hong Kong Intellectual Property Office for the examination and grant of the standard patent (O).</p> <p>Both standard patent (R) and standard patent (O) are valid for 20 years from deemed date of filing of the application (for standard patent (R)) or from the date of filing of the application (for standard patent (O)).</p> <p>2. Short term patent</p> <p>The applicant for a short term patent makes a direct application to the Hong Kong Intellectual Property Office. The Patents Registry will examine the formalities of the application. There is no substantive examination.</p> <p>A short term patent is valid for 8 years from the date of filing of the application.</p>	<p>The additional patentability criterion under the Patents Act, 1970 remains which is further restricted by way of judicial precedent, requiring bio-pharmaceutical patents to prove "enhanced therapeutic efficacy" before it can be patented. Given that this is applicable to only one technology area, it conflicts with the non-discrimination principles provided by TRIPS Article 27 and WTO rules. This, coupled with Indiscriminate and mechanical use of Section 3(d) in patent applications by the IPOs, along with inconsistent interpretations of the terms 'efficacy', 'enhanced therapeutic efficacy' and 'property' across the IPOs, have made patenting bio-pharmaceutical products extremely difficult in India.</p> <p>However, there have been few amendments brought about to the implementing Patent Rules 2003 particularly in relevant provisions pertaining to pre-grant oppositions (PGO), working requirements of the patent and filing of the statements in respect thereof and requirement for the patent applicant to disclose information in respect of corresponding foreign applications.</p> <p>While the amendments brought about positive changes in the PGO process such as clarity in the procedure for hearing, change in the timelines for filing statement and evidence, etc., there remains significant bottlenecks as all have not yet been defined.</p> <p>Further, amendments simplified Form 27 and now requires the patentees to file Form 27 (Statement regarding the Working of Patented Invention/s on a Commercial Scale in India) once every 3 years but the new inclusions of a new Entries 4 &amp; 5 re. licensing in Form 27 is a cause of concern from CL point of view.</p>	<p>2016 amendments to the Patent Law preclude patents on new uses (indications) and establish an additional patentability criterion of "increased meaningful benefit" for certain forms of innovation, such as new salts or new dosage forms. These restrictions are overly broad and will undermine support for important innovations and appear to conflict with existing international obligations by imposing additional or heightened patentability criteria that discriminate against particular classes of technology. The Patent Office has been implementing technical guidelines that remove this impermissible restriction, but the underlying provisions in the 2016 Patent Law remain unchanged. In addition, the 2016 Patent Law still imposes new patent disclosure requirements regarding the source and origin of genetic resources. Such requirements introduce uncertainties into the patent system that inhibit innovation in relevant technologies and undermine the potential of benefit-sharing.</p> <p>Source: Pharma NTE Report 2023</p> <p>In the recent update, the government has revised the 2016 Patent Law in the Q4 2024. With the revision, the 2016 Patent Law superseded with "Undang-undang (UU) Nomor 65 Tahun 2024" / Law Number 65 of 2024 concerning the Third Amendment to Law Number 13 of 2016 on Patents.</p>	<p>Patent Act (Law No. 121, 1959)</p> <p>Final revision: Law No. 51, 2023 (Promulgated on June 14, 2023)</p> <p>Effective date: January 1, 2024</p> <p>Term of patent rights and initial date: 20 years from the filing date of the patent application, up to 5 years extension (Article 67 of the Patent Act)</p>	<p>[KRPIA Note]</p> <ul style="list-style-type: none"> <li>Links to the Patent Act and its Enforcement Decree remain unchanged.</li> <li>Patent Term Extension (PTE) – Amendment and Implementation</li> <li>Amendments to Korea's Patent Term Extension (PTE) system were passed by the National Assembly in December 2024, promulgated thereafter, and entered into force on July 22, 2025, following the statutory grace period. <ul style="list-style-type: none"> <li>Under the amended Patent Act:</li> <li>The total effective patent term, including any extension, may not exceed 14 years from the date of marketing approval.</li> <li>Only one patent per marketing approval is eligible for patent term extension, requiring applicants to strategically select a single patent where multiple patents relate to the same approved product.</li> <li>Applications filed in violation of this one-patent-per-approval rule are deemed invalid ab initio, and any improperly granted extension is treated as if it never existed.</li> <li>The amendment also clarifies the method of calculating the extension period, including the treatment of delays in patent registration, to enhance transparency and consistency in administration.</li> </ul> </li> </ul> <p>Ongoing Legislative Developments – Invalidation Decision Pre-Notification System</p> <ul style="list-style-type: none"> <li>Separately, a bill introducing an Invalidation Decision Pre-Notification System (무효심결예고제) has been proposed and is currently under review by the relevant subcommittee of the National Assembly. The proposed system would allow the patent authority to pre-notify its preliminary view on patent invalidation prior to issuing a final decision, with the aim of enhancing procedural fairness and allowing patentees an opportunity to respond or amend claims.</li> <li>In principle, research-based pharmaceutical companies have expressed support for the introduction of a pre-notification mechanism. However, concerns have been raised regarding the specific design of the proposed amendment, particularly a discretionary proviso that would allow the patent authority not to apply the pre-notification step in cases related to the patent-regulatory approval linkage system.</li> <li>Industry stakeholders have noted that excluding linkage-related invalidation proceedings from the pre-notification process could undermine legal predictability for patent holders and weaken the effectiveness of patent enforcement during the regulatory approval process, potentially tilting the balance of the linkage system against patentees.</li> <li>Research-based industry associations are therefore actively engaging with policymakers to seek clarification or revision of the proposed carve-out, emphasizing the importance of maintaining consistent procedural safeguards in linkage-related disputes.</li> </ul>	<p>The Intellectual Property Corporation of Malaysia (MyIPO) is the office responsible for handling patents. The MyIPO is party to several international treaties, such as Patent Cooperation Treaty (PCT), Paris Treaty, Budapest Treaty, Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)</p> <p>Key takeaways of the Patent (Amendment) Bill 2021:</p> <ol style="list-style-type: none"> <li>The Patent (Amendment) Bill 2021 contains 69 amended clauses that have included Malaysia's commitments in the TRIPS Agreement on public health, the Regional Comprehensive Economic Partnership Agreement (RCEP) and the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP).</li> </ol> <p>The formal recognition of patents as an asset class which can be the subject of a security interest in the same way as a movable property. This legal recognition can be found at Section 39 of the amended Patent Act.</p>	<p>The Intellectual Property Office (IPO) is the office responsible for handling patents. IPO employs the first-to-file principle, wherein the date of application is the date on which it was received by the IPO. If satisfactory, the term of patent right is 20 years from the date of application. Currently, there is no system for extension of the patent term.</p> <p>The Philippines is party to several international treaties, such as Patent Cooperation Treaty (PCT), Paris Treaty, Budapest Treaty, Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).</p>	<p><b>The Patents (Amendment) Rules 2024</b> came into operation on <b>August 16, 2024</b>.</p> <p>A notable amendment includes:</p> <ul style="list-style-type: none"> <li><b>Simplified Requests for Examination Reports:</b> <ul style="list-style-type: none"> <li>Applicants relying on final search results established by the Intellectual Property Office of Singapore (IPOS) under the Patent Cooperation Treaty (PCT) are no longer required to file copies of certain documents previously mandated.</li> </ul> </li> </ul> <p><a href="https://www.ipos.gov.sg/docs/default-source/resources-library/patent-s/circulars/circular-no-3-2024.pdf?stfrsn=b960e987_1">https://www.ipos.gov.sg/docs/default-source/resources-library/patent-s/circulars/circular-no-3-2024.pdf?stfrsn=b960e987_1</a></p> <p><b>Supplemental Guidance for AI-Related Patent Applications</b></p> <p>On <b>October 11, 2024</b>, IPOS released supplemental guidance for the examination of artificial intelligence (AI)-related patent applications.</p> <p>This guidance serves as a quick reference for applicants seeking to protect AI-related inventions, ensuring clarity in patentability assessments.</p> <p><a href="https://www.ipos.gov.sg/docs/default-source/resources-library/patent-s/guidelines-and-useful-information/supplemental-guidance-for-the-examination-of-ai-related-patent-applications.pdf">https://www.ipos.gov.sg/docs/default-source/resources-library/patent-s/guidelines-and-useful-information/supplemental-guidance-for-the-examination-of-ai-related-patent-applications.pdf</a></p>	<p>Taiwan has 3 kinds of intellectual property rights: patents, utility models, and designs.</p> <p><i>Taiwan Pharmaceutical Affairs Act</i> has incorporated a new chapter of "Patent Linkage of Western Pharmaceuticals" since the end of 2017 and this amendment was promulgated by presidential order on Jan 31, 2018 and implemented from Aug 20, 2019. Under the patent linkage system, a new drug marketing approval holder may complete listing and reporting of the patent information with respect to the pharmaceutical patent. On the other hand, a generic drug approval applicant who seeks grant of drug approval for the generic drug shall make relevant certification or declaration in regard to the patent listed by the new drug approval holder with the competent authority, and the competent authority will stay issuance of drug approval for a period of 12 months to clear relevant patent disputes. The first applicant of generic drug approval to successfully challenge patent validity or make non-infringement declaration against the new drug and to have produced complete in full the materials required of the application for approval of the generic drug will be granted an exclusive marketing term of 12 months. Regulations regarding drug patents are defined and set forth in Article 40-2, 40-3, 100-1 and 48-3 to 48-22 of <i>Pharmaceutical Affairs Act</i>.</p>	<p>The 1979 Patent Act was amended by the 1999 Patent Act No. 3 (effective September 27, 1999)</p> <p>Duration and base date of patent rights: 20 years from date of application (Patent Act, Article 35)</p> <p>Ministry of Commerce /Department of Intellectual Property (DIP) [Patent Office "Overview of information on industrial property right offices or agencies and industrial property right systems in each country or region", updated on 2016.8.31]</p> <p>Decree 65/2023/ND-CP Elaboration On Several Articles and Implementation Measures of the Law on Intellectual Property Regarding Industrial Property Rights, Protection Of Industrial Property Rights, Rights to Plant Varieties, and State Management Of Intellectual Property Circular 23/2023/TT-BKHON regulating in details some provisions of the Law on Intellectual Property and implementation measures of Decree 65/2023/ND-CP</p> <p>Governing bodies: Ministry of Science Technology, National Office of Intellectual Property Ministry of Health registered drugs containing active ingredients still within the period of IP protection can be protected by patent.</p>	<p>Patents are regulated by: Law XX/2025/QH15 Amending, Supplementing a number of articles of Law on Intellectual Property (Law number is not yet available as of hitherto)</p> <p>Law 07/2022/QH15 Amending, Supplementing a number of articles of Law on Intellectual Property 50/2005/QH11 Law 36/2009/QH-22 Amending, Supplementing a number of articles of Law on Intellectual Property Decree 65/2023/ND-CP</p>

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Intellectual property rights/IP	Overview of Intellectual property right system	Trademark law	<p>The amendment on the <i>Trademark Law of the People's Republic of China</i> was adopted on the 10th Session of the Standing Committee of the Thirteenth National People's Congress on 23 April 2019, the date of entry into force of the amendment is November 1<sup>st</sup>, 2019.</p> <p>Trademark Law: <a href="https://www.gov.cn/guoguo/2020-12/24/content_5572941.htm">https://www.gov.cn/guoguo/2020-12/24/content_5572941.htm</a></p> <p>English Reference: <a href="http://ipr.mofcom.gov.cn/zhuanti/kblh/jplaws/trademark/sbf2.pdf">http://ipr.mofcom.gov.cn/zhuanti/kblh/jplaws/trademark/sbf2.pdf</a></p> <p>On July 7, 2025, the China National Intellectual Property Administration (CNIPA) issued the <i>Measures for the Fast-Track Examination of Trademark Registration Applications</i>. The Measures provide for expedited examination of trademark applications involving national interests, public interests, or major regional development strategies, with eligible applications to be completed within twenty working days. Fast-track examination applies to circumstances such as strategic emerging industries and future industries, major national projects and key events, provincially prioritized industrial chains, responses to public emergencies, and other matters of significant practical importance.</p> <p><a href="https://www.gov.cn/gongbao/2025/issue_12266/202509/content_7039591.html">https://www.gov.cn/gongbao/2025/issue_12266/202509/content_7039591.html</a></p>	<p>A trade mark, once registered, is valid for 10 years from the date of registration. Renewal for further periods of 10 years each is possible.</p>	<p>The Trademarks Act [Trademark Act, effective September 15, 2003; Patent Office website] [Trademark Rules, effective September 15, 2003; Patent Office website]</p> <p>On November 19, 2015, the Indian Department of Industrial Policy &amp; Promotion (DIPP), now Department for Promotion of Industry and Internal Trade (DPIIT), publicly announced amendment of the trademark rules on its website, and public comment began. The amendment incorporated improved execution of expedited examination, including early processing of objections, increase of the fee, definition of well-known trademarks, application procedures for sound trademarks, and changes in the various forms, etc. [JETRO New Delhi, 201512]</p> <p>On September 9, 2025, the Office of the Controller General of Patents, Designs and Trademarks (CGPDTM) issued a public notice seeking stakeholders' comments for drafting new Trademarks Guidelines aimed at improving trademark registration and opposition procedures.</p>	<p>Trademark Law: first-to-file principle Term: 10 years from application (renewal possible) An affidavit of use must be submitted for renewal procedures</p>	<p>Trademark Act (Law No. 127, 1959) Final revision: Law No. 51, 2023 (Promulgated on June 14, 2023) Effective date: January 1, 2024 Term of trademark rights: 10 years from the date of registration. It can be further updated every 10 years (Article 19 of the Trademark Act). Patent Office</p>	<p>[KRPIA Note] - Links to the Patent Act and Enforcement Decree remains the same - Added key changes on the Patent Act below:  (1) Amendment effective May 1, 2024 (proclaimed Oct 31, 2023) • Coexistence Consent System: Allows registration of identical or similar marks where the owner of a prior mark (or prior applicant) provides consent, subject to safeguards to prevent consumer confusion (e.g., not permitted for identical mark and identical goods/services). • Acquired Distinctiveness through Use: Expands recognition of distinctiveness acquired through continuous use, broadening the scope of marks potentially registrable based on use. • Clarification on Rights Where No Heirs Exist: Clarifies treatment of trademark rights upon the owner's death without heirs. (2) Amendment promulgated Jan 21, 2025 and effective July 22, 2025 • Shortened Opposition Period: The statutory opposition period was reduced to 30 days, accelerating the post-publication phase of registration procedures. • Enhanced Remedies for Willful Infringement: The cap on punitive damages for intentional trademark infringement was increased (up to five times the actual damages), strengthening deterrence against bad-faith infringement</p>	<p>Trademarks Bill 2019 (Bill) which was passed on 2 July 2019 will facilitate Malaysia's accession to the Madrid Protocol Under Ministry of Domestic Trade and Consumer Affairs. Trademark Law/ principle of (compromised) prior use Duration: 10 years from application (renewable)</p> <p>MyIPO had issued the guidelines of trademarks (as updated on January 6 2020) to facilitate the transitions of trade mark applications filed under Trade Marks Act 1976 to the new Act. [Conventus Law]</p> <p>The principal legislation governing Trademark Law in Malaysia remains unchanged. However, there have been slight changes to the regulatory guidelines governing Trademarks in Malaysia. This is due to the issuance of the Trademarks Act 2019 Practice Direction 1/2021 on the 3<sup>rd</sup> of November 2021. These guidelines have been issued pursuant to the power conferred on the Registrar of Trademarks through Sections 160 and 183 of the Trademarks Act. Source : <a href="#">Intellectual Property Corporation of Malaysia</a></p>	<p>Similar to patents, IPO employs first to file principle for trademarks. Term granted is ten years, but there is no limit on the renewal (may be renewed continuously). Trademarks may require checking with the FDA to ensure compliance with existing brand names and labeling rules.</p>	<p>• Term: 10 years from application filing • Renewal possible every 10 years, starting from 6 months before expiry, through the filing of Form TM19</p> <p><a href="https://www.ipos.gov.sg/about-ip/trade-marks/managing-trade-marks#renew-or-restore-your-trade-mark">https://www.ipos.gov.sg/about-ip/trade-marks/managing-trade-marks#renew-or-restore-your-trade-mark</a></p>	<p>Taiwanese trademark law (new <a href="#">Trademark Act</a>): amended November 30, 2016</p>	<p>Enforced July 28, 2016 (1991 Trademark Law amended by 2016 Law No.3) General principle of rights conferral: first-to-file principle Duration and base date of trademark rights: 10 years from date of application (Registered trademark is considered to be that registered on the date of application). In addition, it can be renewed every 10 years (Trademark Act, Article 53; Trademark Law, Article 42) [Patent Office "Overview of information on industrial property right offices or agencies and industrial property right systems in each country or region", updated on 2016.8.31] The most recent version of the Trademark Act is from amendments that were enacted in 2016. The 2016 amendments include provisions to file multi-class applications, to file sound marks, and shorten the time period in responding to office actions and oppositions. The 2016 amendments also codified Thailand's obligations under the Madrid Protocol.</p>	<p>Trademarks are regulated by: Law 07/2022/QH15 Amending, Supplementing a number of articles of Law on Intellectual Property Law on Intellectual Property 50/2005/QH11 Law 36/2009/QH-22 Amending, Supplementing a number of articles of Law on Intellectual Property Decree 65/2023/ND-CP Elaboration On Several Articles and Implementation Measures of the Law on Intellectual Property Regarding Industrial Property Rights, Protection Of Industrial Property Rights Circular 23/2023/TT-BKHHCN regulating in details some provisions of the Law on Intellectual Property and implementation measures of Decree 65/2023/ND-CP</p> <p>Term: 10 years after the registration Legal protection: Starts from date of registration</p>

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Intellectual property rights/IP	Overview of Intellectual property right system	Patent linkage	<p>In July 2021, China National Intellectual Property Administration, National Medical Products Administration and Supreme People's Court successively issued the "Implementing the Measures for Patent Disputes Early Resolution Mechanism", "Implementing the Measures for Administrative Adjudication System of Patent Disputes Early Resolution Mechanism", "Provisions on Several Issues Concerning the Application of Law in the Trial of Civil Cases of Patent Disputes Related to Drugs Applied for Registration", marking the formal establishment of China's drug patent-term compensation system. In December 2021, the Beijing Intellectual Property Court issued the "Guidelines on Filing Civil Cases on Drug Registration Related Patent Disputes".</p> <p>As of April 2022, China National Intellectual Property Administration have received 59 administrative adjudication requests on drug patent disputes filed by patentee or MAH, and formally registered 39 requests that meet the acceptance conditions. <a href="https://www.cnipa.gov.cn/art/2022/4/25/art_53_175126.html">https://www.cnipa.gov.cn/art/2022/4/25/art_53_175126.html</a></p> <p>As of 14 November 2025, the China National Intellectual Property Administration has publicly issued a total of 183 administrative decisions on pharmaceutical patents, among which, more than half (98 cases) were voluntarily withdrawn by the requesters. Of the cases that received substantive rulings, 37 were found to fall within the scope of patent protection, accounting for approximately 20.2%; 34 were determined not to fall within the scope of patent protection, accounting for approximately 18.6%; and 14 were dismissed for failing to meet statutory requirements, accounting for approximately 7.7%. <a href="https://mp.weixin.qq.com/s/sA7q8WKMtKHZa-KfX9nEiA">https://mp.weixin.qq.com/s/sA7q8WKMtKHZa-KfX9nEiA</a></p> <p><i>Implementing the Measures for Patent Disputes Early Resolution Mechanism</i> <a href="https://www.gov.cn/zhengce/zhengceku/2021-07/04/content_5622330.htm">https://www.gov.cn/zhengce/zhengceku/2021-07/04/content_5622330.htm</a></p> <p><i>Implementing the Measures for Administrative Adjudication System of Patent Disputes Early Resolution Mechanism</i> <a href="https://www.cnipa.gov.cn/art/2021/7/5/art_74_160566.html">https://www.cnipa.gov.cn/art/2021/7/5/art_74_160566.html</a></p> <p><i>Guidelines on Filing Civil Cases on Drug Registration Related Patent Disputes (Trial)</i> <a href="https://bjzcfy.bjcourt.gov.cn/article/detail/2022/01/id/6468073.shtml">https://bjzcfy.bjcourt.gov.cn/article/detail/2022/01/id/6468073.shtml</a></p> <p>The Measures for Administrative Adjudication and Mediation of Patent Disputes issued by the China National Intellectual Property Administration came into force on February 1, 2025. The Measures aim to regulate procedures for handling patent disputes, enhance the efficiency of administrative adjudication and mediation, and protect the lawful rights and interests of patent holders and the public. <a href="https://www.gov.cn/gongbao/2025/issue_11826/202501/content_7001286.html">https://www.gov.cn/gongbao/2025/issue_11826/202501/content_7001286.html</a></p>	There is no patent linkage in Hong Kong.	India does not provide for patent Linkage and considers it as a TRIPS plus requirement.	None Only the holder of patent rights can submit an application for a drug including active ingredients that are patent protected, and the applicant must submit a patent certificate at the time of application.	PMDA shall not approve generic drugs if the active ingredient cannot be manufactured due to the existing patent for the active ingredient of the original drug. Note: In essence, only product and use patents are applicable (PFSB/ELD Notification No. 0605014 dated June 5, 2009) MHLW announced conducting a trial for expert committee system on Nov.14, 2025.	As of December 2025, there have been no material enacted legislative changes to Korea's patent-regulatory approval linkage system since its full implementation in March 2015. The system continues to operate with its four primary features: (1) Patent Listing on the "Green List"; (2) Generic Notification to the patentee; (3) a Sales Stay mechanism triggered by timely litigation or scope confirmation actions; and (4) Generic Exclusivity for qualifying first challengers. While the linkage framework remains stable, policy and legislative discussions continue around possible refinements to Green List listing standards and first-generic related mechanisms (e.g., proposals concerning clarification of listing criteria and restrictions related to listing/de-listing in connection with first-generic approval). In addition, a separate Patent Act amendment initiative to introduce an "Invalidation Decision Pre-Notification" procedure (무효심결예고제)—which would provide patentees an additional opportunity to amend claims before a final invalidation decision—has been proposed and is under legislative/industry review. Stakeholders have raised concerns that, depending on its final design, the pre-notification step could affect the timing and predictability of linkage-related invalidation proceedings and, by extension, the linkage system's operation (including the nine-month track and first-generic incentives). In this context, discussions have included a possible carve-out/proviso to allow linkage-related invalidation cases to proceed without the pre-notification step so that the linkage timetable is not undermined.	NPRA is currently working on Patent Linkage, with implementation projected in May 2027. Current status: 2 <sup>nd</sup> engagement with industry stakeholders in March 2026.	There is no patent linkage in the Philippines. We believe the Philippines should reinstate patent linkage as a mechanism to allow patent holders to resolve patent disputes prior to the marketing of follow-on pharmaceutical products. An agreement must be made between the Intellectual Property Office of the Philippines (IPOP) and the FDA recognizing that a certificate of product registration for a generic medicine will not be issued by FDA unless the applicant can present a certification from IPOP confirming the patent covering a particular product has expired. Such coordinating mechanism existed in 2005 but has since been removed. Note, however, that local pharmaceutical companies are opposing patent linkage because it is being viewed as "anti-access".	<p><b>Amendments to the Patent Linkage System</b> Effective August 1, 2024, the <b>Health Products (Therapeutic Products) Regulations 2016</b> were amended to clarify the types of patents that must be declared during the registration of therapeutic products. Key changes include:</p> <ul style="list-style-type: none"> <li>• <b>Specified Patent Types for Declaration:</b> <ul style="list-style-type: none"> <li>◦ Patents containing claims for an active ingredient of the therapeutic product.</li> <li>◦ Patents containing claims for a formulation or composition of the therapeutic product.</li> <li>◦ Patents containing a claim for the use of an active ingredient in the manufacture of the therapeutic product for a specific therapeutic, preventive, palliative, or diagnostic use.</li> </ul> </li> <li>• <b>Exclusions from Declaration:</b> <ul style="list-style-type: none"> <li>◦ Patents that are in force in respect of the therapeutic product but do not fall under the abovementioned categories are not subject to the requirements under regulation 23. A non-exhaustive list of patents to which regulation 23 does not apply can be found under regulation 23(11) of the Regulations.</li> </ul> </li> </ul> <p><a href="https://www.hsa.gov.sg/announcements/regulatory-updates/regulatory-updates-for-therapeutic-product-registration-(effective-1-aug-2024)">https://www.hsa.gov.sg/announcements/regulatory-updates/regulatory-updates-for-therapeutic-product-registration-(effective-1-aug-2024)</a></p>	Patent Linkage was legislated in Pharmaceutical Affairs Act on Dec 2017. Patent Linkage implementation regulation which including both Chemical as well as Biologics has been announced on Jul 1, 2019 and took effect on Aug 20, 2019. If lawsuit filed, TFDA approval for generic application is stayed for 12 months. 12-month period of marketing exclusivity for the first generic applicant for market approval by successfully invalidating the relevant drug patent.	There is currently no patent linkage between the Thai FDA and the Department of Intellectual Property. There was a starting collaborative action among public and private sectors on patent linkage.	The new IP Law 07/2022/QH15 revised: • Article 128: the regulator shall carry out protection of clinical trial data during the drug registration process on the request of the registrant, not disclosing such data for unfair competition purposes, except when public health is harmed. Article 131a: compensate patent holders for the delay in granting marketing authorizations, except when the delay is self-inflicted or due to force majeure events beyond the regulator's control.

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Intellectual property rights/IP	Overview of Intellectual property right system	Regulatory data protection	<p>In May 2022, "Regulations for the Implementation of the Drug Administration Law of the People's Republic of China (Draft for Comments)" proposed to implement regulatory data protection. <a href="https://www.nmpa.gov.cn/xxgk/zhqyj/zhqyjy/p/20220509222233134.html">https://www.nmpa.gov.cn/xxgk/zhqyj/zhqyjy/p/20220509222233134.html</a></p> <p>On September 30, 2024, The State Council issued the <i>Regulations on the Administration of Cyber Data Security</i> officially came into force on 1 January 2025. <a href="https://www.gov.cn/yao wen/liebiao/202409/content_6977785.htm">https://www.gov.cn/yao wen/liebiao/202409/content_6977785.htm</a></p> <p>In March 2025, National Medical Products Administration (NMPA) issued the <i>Measures for the Implementation of Regulatory Data Protection (Trial, Draft for Comment)</i> and <i>Procedures for the Regulatory Data Protection (Draft for Comments)</i> and publicly solicited comments. <a href="https://www.nmpa.gov.cn/xxgk/zhqyj/zhqyjy/p/20250319181537196.html?type=pc&amp;m=">https://www.nmpa.gov.cn/xxgk/zhqyj/zhqyjy/p/20250319181537196.html?type=pc&amp;m=</a> <a href="https://www.nmpa.gov.cn/xxgk/zhqyj/zhqyjy/p/20250319181537196.html?type=pc&amp;m=">https://www.nmpa.gov.cn/xxgk/zhqyj/zhqyjy/p/20250319181537196.html?type=pc&amp;m=</a></p>	8 years (from 2012 onward). Generics proven to infringing patent rights could be delisted the drug registration by the application of patent owner.	<p>India does not provide for RDP and considers it as a TRIPS plus requirement.</p> <p>CDSKO has issued Public Notice dated October 8, 2025 inviting comments to help formulate a balanced policy on ensuring a level playing field in new drug approvals in India as far as 1st applicant who obtains approval of a new drug based on CT and BE study data and the subsequent applicants who obtain approval of the same new drug based on BE study data for whom the cost of regulatory compliance is much lesser as they are not required to conduct the CT.</p> <p>DPIIT has issued Meeting Notice dated November 10, 2025 on consultations to be held by Hon'ble Minister of Commerce &amp; Industry on RDP with Indian industry associations and Indian pharma companies</p>	N/A	<p>As applications for generic drugs cannot be filed during the reexamination period (a post market surveillance period to confirm the efficacy and safety after marketing), the reexamination period substantially functions as a data protection period. New active ingredient: 8 years Additional indication: 4 years Rare Disease: 10 years Rare diseases and pediatric indications may extend the original reexamination period up to 10 years. (Article 14-4 of the PMD Act; PFSB Notification No. 0401001 dated April 1, 2007)</p>	<p>Korea has traditionally not provided explicit "data exclusivity," with practical data protection historically implemented through the drug re-examination (post-marketing surveillance) system. Under the amended Pharmaceutical Affairs Act, promulgated on February 20, 2024, the re-examination system was abolished and integrated into a unified Risk Management System (RMS) for post-market drug safety, with the amendment taking effect on February 21, 2025. The new legal framework introduces a statutory Data Protection System, under which clinical trial data submitted for marketing authorization are protected from regulatory reliance for a defined period—six years for new drugs and ten years for orphan drugs. During the protection period, follow-on applicants are prohibited from relying on the protected data to obtain marketing approval, unless independent data are submitted, consent is obtained from the original marketing authorization holder, or an exception applies for public health reasons. While the system strengthens regulatory data protection, it does not constitute an automatic market exclusivity, as approval of follow-on products remains possible where legally permissible alternative data are provided. The restructured framework replaces the prior dual operation of re-examination and risk management processes, aiming to reduce administrative burden and enable more efficient lifecycle safety management. As the data protection system entered into force in 2025, implementation details—particularly regarding its interaction with biosimilars, improved drugs, and regulatory practice—continue to evolve, and further clarification through subordinate regulations and enforcement guidance is expected.</p>	<p>By virtue of the Directive on Data Exclusivity, which was issued by the Director of Pharmaceutical Services and came into force on 1 March 2011, undisclosed, unpublished and non-public domain pharmaceutical test data of the following is protected under the data exclusivity regime:</p> <ul style="list-style-type: none"> <li>- New drug products containing a new chemical entity.</li> <li>- Second indication of a registered drug product.</li> <li>- The period of data exclusivity cannot be more than: <ul style="list-style-type: none"> <li>o Five years for a new drug product containing a new chemical entity.</li> <li>o Three years for data concerning the second indication of a registered product.</li> </ul> </li> </ul> <p>The data exclusivity period runs from the date the new drug product, or the second indication is first registered/granted marketing authorization/ first approved and granted data exclusivity/ test data protection in the country of origin or any country recognized by the Director of Pharmaceutical Services. Data exclusivity protection does not extend to situations where compulsory licenses have been issued and does not prevent the government from taking any necessary action:</p> <ul style="list-style-type: none"> <li>- To safeguard public health or national security.</li> <li>- For the purposes of non-commercial public use.</li> <li>- During a national emergency or public health crisis.</li> <li>- During any other urgent circumstances as may be declared by the government.</li> </ul> <p>Source: Thomson Reuters Practical Law DE Directive Feb 2011</p>	<p>Similar to patent linkages, there is no data exclusivity in the Philippines.</p>	<p>• From the date on which marketing approval for a new drug, etc., is granted, it is not permitted to sell the same product or a similar product to another party for at least 5 years, based on the following:</p> <ul style="list-style-type: none"> <li>i ) Safety, efficacy information submitted to obtain marketing approval,</li> <li>ii ) facts that are proved in marketing approval.</li> </ul> <p>[Patent 2013, Vol. 66, No.10, 78-88] [JETRO website material, "JETRO Global Trade Investment Report" 2016 edition]</p>	<p>•NDA: A 5-year data protection period was additionally established by the <i>Pharmaceutical Affairs Act</i>. However, this is limited to cases where NDA application is filed with TFDA within 3 years of the international birth date (pharmaceutical approval) of the drug.</p> <p>•New Indications: 3 years of data protection; if conducting clinical trials in Taiwan, 5 years of data protection. These are limited to cases where application is filed with TFDA within 2 years of the international birth date (pharmaceutical approval) of the drug.</p>	<p>In order to receive "data protection" under the Trade Secrets Act (amended in 2015), a trade secrets recordal application and the required supporting documents must be submitted to the Thai FDA along with an application for marketing approval. After the Thai FDA has been notified by the applicant that the data submitted with the marketing approval application is to be treated as a trade secret, the Thai FDA will keep the submitted data confidential for five years from the date of notification.</p>	<p>Under the current regulations specified in Circular 05/2010/TT-BYT guiding data protection of clinical data in drug registration, in order to qualify for data protection in Vietnam, it is required that the request for data protection must be submitted within 12 months from the date a Marketing Authorization (MA) was first granted in any country in the world. This is not always feasible as this would require companies to immediately apply for MA in Vietnam as soon as a product is approved for circulation in any country in the world. Today, large number of innovative pharmaceutical companies have not managed to obtain the approval letter for RDP in Vietnam. The reasons quoted include the lengthy process, unclear guidelines about the right, data protection time being too short compared to registration time and the inability to meet the requirements. Vietnam should provide Automatic Regulatory Data Protection consistent with international standards, in particular putting in place a procedure that automatically grants RDP upon Marketing Authorization approval, without additional requirements.</p>

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Intellectual property rights/IP	Overview of Intellectual property right system	Patent eligibility for secondary use, salt, polymorph, formulation, etc.	On December 22, 2023, <i>The Guideline for Patent (2023)</i> was issued by the China National Intellectual Property Administration, which stipulates the patentability requirements for secondary use, salt, polymorph, formulation, etc. In China, drug use inventions can be protected through Swiss-style claims. <a href="https://www.cnipa.gov.cn/module/download/download.jsp?classid=0&amp;showname=%e4%b8%93%e5%88%a9%e5%ae%a1%e6%9f%a5%e6%8c%87%e5%8d%97.pdf&amp;filename=8d8282d3c26b4900b82dbadfbdc7aa9.pdf">https://www.cnipa.gov.cn/module/download/download.jsp?classid=0&amp;showname=%e4%b8%93%e5%88%a9%e5%ae%a1%e6%9f%a5%e6%8c%87%e5%8d%97.pdf&amp;filename=8d8282d3c26b4900b82dbadfbdc7aa9.pdf</a>	It is possible to make direct purpose-limited product claims relating to second or further medical uses of a known substance or composition in the following form: "Substance X or composition comprising X for use in the treatment of Y." Further, a Swiss-style claim is also possible, subject to any evolution of any local case authority. Therefore, it is possible to draft a claim in the following Swiss-style form: "The use of substance X or composition comprising X in the manufacture of a medicament for the treatment of Y."	Section 3(d) of the Indian Patents Act adds an additional hurdle, beyond the requirement of novelty, non-obviousness and industrial application by adding a fourth substantive criteria of "enhanced efficacy". Under this provision, salts, esters, ethers, polymorphs, and other derivatives of known substances are presumed to be the same substance as the original chemical and thus not patentable, unless it can be shown that they differ significantly in properties with regard to efficacy.	See above on issues of the revised Patent Law	Patents for secondary use, salt, polymorph, formulation, etc. are patentable subject matter. However, therapeutic methods for the treatment shall not apply to patented inventions.	Korea recognizes patent protection for secondary uses, salts, polymorphs, and formulations. However, patentability standards for salt and polymorph inventions are somewhat stricter in Korea than in other major jurisdictions.	N/A	Under Republic Act No. 9502, salts, esters, ethers, polymorphs, metabolites, pure form, particle size, isomers, mixtures of isomers, complexes, combinations and other derivatives of a known substance shall be considered the same substance, unless they differ significantly in properties with regard to efficacy.	N/A	Yes, according to TIPO (Taiwan Intellectual Property Office) regulation.	There is a restrictive eligibility for secondary use (i.e., "new use" patents) for pharmaceuticals and several decisions have been issued by patent authorities that have disallowed such patents.	N/A
		Patent term extension	In June 2021, the <i>Patent Law</i> officially came into force, in which Article 42 stipulated the drug patent-term compensation system <i>The Rules for Implementation of the Patent Law (revised in 2023)</i> issued by the State Council and <i>The Guideline for Patent (2023)</i> issued by the China National Intellectual Property Administration, further stipulated the patent-term compensation system for drugs on the basis of the Article 42 of the <i>Patent Law</i> . <i>The Rules for Implementation of the Patent Law</i> <a href="https://www.cnipa.gov.cn/art/2023/12/21/art_98_189197.html">https://www.cnipa.gov.cn/art/2023/12/21/art_98_189197.html</a> <i>The Guideline for Patent (2023)</i> <a href="https://img.chinacourt.org/mup/uploadfile/2023/12/22/15/8234b7c35ab4a0acd51c010d8274c826.pdf">https://img.chinacourt.org/mup/uploadfile/2023/12/22/15/8234b7c35ab4a0acd51c010d8274c826.pdf</a>	Patent term extension is not available in Hong Kong.	India does not provide for patent term extension or patent term restoration.	N/A	It can be extended up to 5 years. Multiple patents may be extended multiple times in accordance with additional indication, dosage form, etc. (Article 67 of the Patent Act)	Enable to extend up to 5 years if clinical trial was conducted in Korea	As of 2021, there is no provision for the extension of a patent term in Malaysia. However, new drug products containing a new chemical entity and second indication of a registered drug product are eligible for data exclusivity. Source: Thomson Reuters Practical Law	N/A	Up to 5 years <a href="https://www.ipos.gov.sg/docs/default-source/resources-library/patents/guidelines-and-useful-information/patents-formalities-manual.pdf?sfvrsn=5e2b7859_18">https://www.ipos.gov.sg/docs/default-source/resources-library/patents/guidelines-and-useful-information/patents-formalities-manual.pdf?sfvrsn=5e2b7859_18</a>	At most 5 years	There is no form of patent term extension or patent term restoration.	N/A

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Intellectual property rights/IP	Overview of Intellectual property right system	Compulsory license	<p><a href="https://www.cnipa.gov.cn/art/2020/11/23/art_97_155167.html">The Patent Law https://www.cnipa.gov.cn/art/2020/11/23/art_97_155167.html</a> (See article 53-63)</p>	<p>A compulsory license under a standard patent may be granted by the court under any of the circumstances below:-</p> <ol style="list-style-type: none"> <li>1. If a standard patent is not being worked at all or to the fullest extent that is reasonably practicable;</li> <li>2. Where the patented invention is a product, a demand for the product in Hong Kong is not being met on reasonable terms;</li> <li>3. Where the patented invention is capable of being commercially worked in Hong Kong by manufacture but it is being prevented or hindered by the importation of the product (in the case that the patented invention is a product) or by the importation of a product obtained directly by means of the process (in the case that the patented invention is a process);</li> <li>4. Where the patent owner refuses to grant a licence or licence on reasonable terms, with the result that the working of any other patented invention that relies upon the patent under compulsory licence is prevented or hindered or that the establishment or development of commercial or industrial activities in Hong Kong is unfairly prejudiced;</li> <li>5. That the conditions imposed by the patent owner has unfairly prejudiced the manufacture, use or disposal of materials not protected by the patent or the establishment or development of commercial or industrial activities in Hong Kong.</li> </ol> <p>The court will not make an order for a compulsory licence unless the applicant for the compulsory licence has made reasonable efforts to obtain authorization from the patentee on reasonable commercial terms and conditions and that such efforts have not been successful within a reasonable period of time.</p> <p>The court shall exercise the power with a view to securing the following purposes:-</p> <ol style="list-style-type: none"> <li>1. That inventions which can be worked on a commercial scale in Hong Kong and which should in the public interest be so worked shall be worked there without undue delay and to the fullest extent that is reasonably practicable;</li> <li>2. That the inventor or person beneficially entitled to a patent shall receive reasonable remuneration having regard to the nature of the invention;</li> <li>3. That the interests of any person for the time being working or developing an invention in Hong Kong under the protection of a patent shall not be unfairly prejudiced.</li> </ol> <p>The Patents Ordinance also provides for a situation where import compulsory licence for patented pharmaceutical products may be granted.</p> <p>During a period of extreme urgency declared by the Chief Executive in Council, and where the Director of Health considers that the pharmaceutical industry in Hong Kong has no or insufficient capacity to manufacture a patented pharmaceutical product to meet the needs for the product in Hong Kong, the Director of Health may grant an import compulsory licence under the patent concerned, subject to such terms and conditions as he may impose, to a public officer or any other person to do in Hong Kong in relation to the product all or any of the following which is necessary or expedient:-</p> <ol style="list-style-type: none"> <li>1. Importing, putting on the market, stocking or using the product;</li> <li>2. Any other act which would amount to an infringement of the patent concerned.</li> </ol> <p>At any time after the grant of a standard patent or a short term patent in respect of a patented pharmaceutical product, any person may apply to the Director of Health for the grant of an export compulsory licence.</p>	<p>The CL regime established by the 1970 Patents Act remains largely intact.</p> <p>The CL chapter as it stands, severely undercuts, if not eliminates, the anticipated benefits that are meant to accrue from the exclusive rights granted under a patent. It goes beyond the realm of Public Health exigencies and extends sweeping CL provisions across the board and not just to "national emergency" situations and "public health crises" as clarified by the Doha Declaration on TRIPS and Public Health, 2001. Predominantly, there are two distinct CL provisions under the Indian Patent Law, namely, those under Section 84 and those under Section 92. A third provision, Section 92A of the Patents Act provides for CLs for exports. Further, Section 66 of the Patents Act, 1970 provides for revocation of patents in public interest. It empowers the Central Government to revoke a patent in Public Interest on the grounds of the patent being "mischievous to the state and generally prejudicial to the public."</p>	<p>In 2021, Indonesia issued CLs for antiviral COVID-19 therapeutics. Moreover, Indonesia issued a CL for one of these antiviral therapeutics despite entering into a voluntary licensing agreement with the right holder. Also, in 2020, Indonesia issued Presidential Regulation No. 77/2020 on government use of CLs. The regulation was published in final form without consulting stakeholders. The regulation broadly enables government agencies to request CLs for pharmaceutical products to address emergency needs in the public interest. If a CL is granted and the government is unable to implement the patent, it may appoint a third party to do so. Despite efforts in 2019 to address and revise existing CL regulations to more appropriately align with global norms and best practices, this new regulation and the process by which it was developed and issued, along with the CLs for the antiviral COVID-19 therapeutics, send a troubling signal to innovators.</p> <p>Source: PhRMA NTE Report 2023</p>	<p>In the case of non-working, dependent patent or the public interest, a non-exclusive license may be requested (Articles 83, 92, and 93 of the Patent Act). However, no case has been granted yet.</p>	<p>Korea's Patent Act provides for compulsory licensing in limited circumstances, including national emergencies, extreme urgency, or non-commercial use in the public interest. In 2025, a Patent Act amendment bill was introduced by Representative Kwon Chil-seung (Bill No. 2207968) seeking to expand and clarify the government's authority to grant non-commercial compulsory licenses in urgent public health situations, particularly where rapid response is required to prevent the spread of Class I infectious diseases. The proposal was motivated by concerns raised during the COVID-19 pandemic that patent holders of vaccines or treatments—could effectively monopolize supply or refuse distribution in order to maintain high prices, thereby constraining timely access during public health crises. Under the proposed amendment, where the government determines that non-commercial use of a patented invention is necessary to protect public safety and health, it may itself implement the invention or authorize a third party to do so. According to the proceedings of the National Assembly's Industry, Trade, Small and Medium Enterprises and Startups Committee, the bill has been formally referred to the standing committee and remains under review, together with other Patent Act amendment proposals. As of late 2025, the bill has not been adopted or entered into force, and its final scope and impact remain subject to further legislative deliberation.</p>	<p>The Patent (Amendment) Bill 2021 introduces a few important amendments to the rules on compulsory licensing in Malaysia. The summary of the key amendments are as follows:</p> <ol style="list-style-type: none"> <li>1. The amendments under Part X of the Patent act seek to empower the Registrar to grant a compulsory license.</li> <li>2. Amending parts of the Patent Act to comply with the obligation under Article 31bis of the Agreement on Trade-Related Aspects of Intellectual Property Rights ("TRIPS Agreement"). The objective here is to allow the grant of a compulsory license to produce a pharmaceutical product in Malaysia and to export that pharmaceutical product to an eligible importing country to address its public health problems.</li> <li>3. Allowing anyone to apply to the Registrar of Patents for a compulsory license where the products produced in Malaysia under the patent for sale in the domestic market are sold at unreasonably high prices without any legitimate reason. Giving the Registrar authority to grant a compulsory license notwithstanding an exclusive license contract between the licensor and a licensee. The amendments will also protect the licensor from any action for breach of contract by the licensee resulting from the granting of the compulsory license by the Registrar.</li> </ol>	<p>Under Republic Act No. 9502, IPO may grant compulsory licensing for patented drug products under the following cases:</p> <ul style="list-style-type: none"> <li>• National emergency or other circumstances of extreme urgency;</li> <li>• Where the public interest, in particular, national security, nutrition, health or the development of other vital sectors of the national economy as determined by the appropriate agency of the Government, so requires; or</li> <li>• Where a judicial or administrative body has determined that the manner of exploitation by the owner of the patent or his licensee is anticompetitive; or</li> <li>• In case of public non-commercial use of the patent by the patentee, without satisfactory reason;</li> <li>• If the patented invention is not being worked in the Philippines on a commercial scale, although capable of being worked, without satisfactory reason: Provided, that the importation of the patented article shall constitute working or using the patent; and</li> <li>• Where the demand for patented drugs and medicines is not being met to an adequate extent and on reasonable terms, as determined by the Secretary of the Department of Health.</li> </ul>	<p>Patent (Compulsory Licensing) Bill, 1968</p> <ul style="list-style-type: none"> <li>• At any time after the expiration of three years from the date of the sealing of any patent in the United Kingdom belonging to a class of inventions specified in the Schedule to this Act and where such patent has been registered in Singapore and remains in force, any person interested may apply to the Registrar upon any one or more of the grounds set out in subsection (2) of this section for a license under the patent.</li> <li>• Where a license has been granted under section 3 or 5 of this Act and the patentee and the licensee are unable to agree within a reasonable time on the amount of royalty or compensation to be reserved to the patentee under the license, the Registrar shall determine the royalty or compensation payable, but in no case shall the Registrar fix a royalty or compensation payable to the patentee under the license exceeding ten per cent of the net ex-factory sale price in bulk of the patented article, to be determined in such manner as may be prescribed.</li> </ul> <p><a href="https://sso.agc.gov.sg/Bills-Supp/15-1968/Public/19680513?DocDate=19680513">https://sso.agc.gov.sg/Bills-Supp/15-1968/Public/19680513?DocDate=19680513</a></p>	<p>Exists. Compulsory licenses are provided for by the Patent Act (amended January 18, 2017), and although it has been invoked for drugs and DVDs, there are no manufactured embodiments. In order to cope with national emergencies and other grave emergencies, the Patent Office must approve compulsory utilization of the necessary patent rights and swiftly notify the patent owners in accordance with an urgent decree or notification by the Central Administrative Office. When it becomes necessary to approve compulsory utilization in one of the following cases, the Patent Office can approve compulsory utilization upon application.</p> <ol style="list-style-type: none"> <li>1. For non-profit purposes to promote public benefit</li> <li>2. When execution of an invention or utility model will unavoidably violate a previous invention or utility model and represents an important technological improvement with economic significance compared to the previous invention or utility model</li> <li>3. When the patent owner has conditions that limit competition or result in unfair competition and has been penalized by a court decision or Fair Trade Committee</li> </ol>	<p>Compulsory Licensing and Government Use of patents are allowed under the Patent Act. The pending amendments to the Patent Act will reform the method by which compulsory licenses are granted according to the WTO Doha Agreement. There have been no compulsory licenses issued on pharmaceuticals since 2008.</p>	<p>Ministry of Health planned to draft Circular on Compulsory License, latest draft dated 2015; however, this regulation has been put on shelf indefinitely. The Intellectual Property Law was amended in 2025 which states that "The licensee must pay the patent holder adequate compensation depending on the economic value of the license in each specific case as stipulated by the Government, except in cases where the license is transferred under a mandatory import order for pharmaceuticals under an international treaty to which the Socialist Republic of Vietnam is a party, and the compensation for the use of the patent under the mandatory import order has already been paid in the exporting country."</p>

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Intellectual property rights/IP	Overview of Intellectual property right system	Anti-counterfeit efforts	N/A	Introduction of two-dimensional barcodes, etc. An anti-counterfeit task force was inaugurated in 2007 and made by the joint effort of Custom & Excise Department, Department of Health, The Hong Kong Association of the Pharmaceutical Industry (HKAPI) and its members, and Consumer Council in 3 key directions: Public awareness information exposing counterfeit drugs is made public in the bulletin "Choice" magazine published by Consumer Council with printed version of 100,000 circulation, also electronic version which could be accessed by China Enforcement Joint raid of industry, Custom and Excise Department and Department of Health Deterrence Revoke license and court sentence  Court enforcement Rights of an IP owner may also bring enforcement action in court. Interim measures, such as interim injunction, may be granted by the court pending trial and resolution of the dispute between the right owner and the third party. An interim injunction may be obtained relatively quickly.	Vide GSR 823 (E) dated November 17, 2022, MoH has issued the Drugs (Eighth Amendment) Rules, 2022 mandating QR code/ barcode for top 300 brands. The notification will come into force from August 1, 2023. The GSR amended labelling requirements (Rule 96 of the Drugs Rules 1945) requiring the manufacturers of drug formulation products as specified in Schedule H2 to print or affix Bar Code or Quick Response Code on its primary packing label or, in case of inadequate space in primary package level, on the secondary package level that store data or information legible with software application to facilitate authentication. Vide GSR 757(E) dated October 16, 2025, the Health Ministry has notified draft Drugs (Amendment) Rules 2025 proposing to add Table 2 containing – 1) All Vaccines; 2) All Antimicrobials; 3) All Narcotic and Psychotropic drugs listed under the Narcotic and Psychotropic drugs Act, 1985; and 4) All Anticancer drugs in the existing Schedule H2 of the Drugs Rules, 1945  As regards exports, the Directorate General of Foreign Trade (DGFT), vide public notice dated January 31, 2025, decided to withdraw the provisions related to the Track and Trace System for pharmaceutical exports under the Foreign Trade Policy (FTP). The Track and Trace System, introduced via Public Notice dated 10th January 2011, mandated barcoding at various packaging levels. While tertiary and secondary packaging requirements were successfully implemented in 2011 and 2013, primary-level barcoding and parent-child data uploading faced operational challenges and were repeatedly deferred, with the last extension valid until February 1, 2025. According to DGFT, the step has been taken to streamline export regulations by aligning with the evolving regulatory framework of the MoH. The decision to withdraw these provisions was based on the following key considerations:  • MoH has already implemented barcode/QR code requirements for 300 drug brands under the Drugs Rules, 1945, effective August 1, 2023, with plans for further expansion. • Most export destinations have their own serialization requirements, ensuring product traceability without additional domestic regulations. • MoH as the primary regulatory authority, provides a unified framework through the Central Drugs Standard Control Organization (CDSCO), ensuring consistency and eliminating duplication. The stated aim was to enhancing ease of doing business for pharmaceutical exporters while ensuring regulatory coherence. Accordingly, the provisions under Para 2.76 of the Handbook of Procedures (HBP) 2023 were also withdrawn.	•BPOM/NADFC established a 4th Deputy Enforcement to counter illegal products equipped with execution authority •NADFC has issued 230 revocation of selling & distributing counterfeit items in first quarter 2018 to combat counterfeit practices •NADFC bill containing the law enforcement authority to be immediately passed as a regulation Raising consumers' awareness that there are counterfeit drugs on the market, and that they should purchase drugs at reputable stores. IPMG consistently combats any suspicious practice of selling counterfeit drugs and raise consumers' awareness through its website <a href="http://www.stopobatpa.lsu.com/">http://www.stopobatpa.lsu.com/</a>	The Japanese Ministry of Health, Labor and Welfare has established the "Suspicious Drugs Reporting Network [ <a href="https://www.yakubutsu.mhlw.go.jp/">https://www.yakubutsu.mhlw.go.jp/</a> ]," a website for notifying the general public on counterfeit medicines (provided in Japanese only). The Ministry has also announced that the government and enterprises will collectively address counterfeit measures for counterfeit medicines. [ <a href="https://www.jpma.or.jp/globalhealth/fake_measures/index.html">https://www.jpma.or.jp/globalhealth/fake_measures/index.html</a> ]	In Korea, it is prohibited to sell, store or display counterfeit drugs (Article 61, Pharmaceutical Affairs Act (PAA)). Violation of this prohibition can lead to the imposition of: Administrative sanctions: suspension of business and cancellation of approval (Article 76, PAA). Criminal sanctions: imprisonment for up to 5 years or a fine not exceeding KRW 50 million (Article 93, PAA).  Additionally, under Article 3 of the Act on Special Measures for the Control of Public Health Crimes, a person who manufactures or sells counterfeit drugs can be punished as follows: If the [counterfeit] drug is seriously harmful to the human body: imprisonment from 5 years to life. If the value of the [counterfeit] drug, based on its retail price, is equal to or exceeds KRW 10 million per annum: imprisonment from 3 years to life. If the counterfeit drug results in death or injury to persons: death penalty or imprisonment from 5 years to life.  The Ministry of Food and Drug Safety (MFDS) and the Prosecutors' Office have regulatory powers to prohibit counterfeit drugs. Additionally, the Korean Customs Office and Korean Intellectual Property Office can regulate the import and export of products infringing intellectual property rights, including counterfeit drugs.  In the meantime, as of January 1, 2019, a Pharmaceutical Serialization System has been implemented. The system enables the tracking of the passage of drugs from production, import, distribution and consumption by identifying a unique serial number on each drug package, and thus should help prevent counterfeit/illegal drugs from entering the supply chain.	MOH has launched a nationwide campaign known as TOBaTS (Tolak Ubat Tidak Berdaftar- Decline Unregistered Medicines) to tackle counterfeit and/or unregistered medicines sold online in 2024. PhAMA has been invited to support the campaign in 2025 and beyond. In Q1-2025, a MOU was signed with Lazada and Shopee, the two most popular e-commerce sites in Malaysia, to support TOBaTS. Promotional efforts through roadshows and events were heightened in 2025.	In 2014, various stakeholders convened to establish the Coalition for Safe Medicines (CSM) as a response to the call "to collaborate and cooperate with the FDA in advocating activities to raise the level of consciousness of the public about the dangerous effects to health of using counterfeit medicines". The FDA celebrates the "National Consciousness Week against Counterfeiting" on an annual basis where the various stakeholders are invited to participate in the week-long activities. CSM serves as a platform for initiatives and programs to counteract the proliferation of substandard and falsified medical products. IPO is part of CSM and focuses on intellectual property matters.	• Penal provisions have been established to punish the importer when a counterfeit drug is discovered at the time of custom clearance. • If a counterfeit drug is found by HSA, it is announced in an HSA news release to call attention to it and make it known widely. • HSA also cooperates with INTERPOL on its global anti-counterfeit efforts, such as online surveillance of local e-commerce platforms for illegal medical products.  <a href="https://www.hsa.gov.sg/illegal-health-products-found-in-singapore">https://www.hsa.gov.sg/illegal-health-products-found-in-singapore</a> <a href="https://www.hsa.gov.sg/announcements/press-release/hsa_opspangea2022">https://www.hsa.gov.sg/announcements/press-release/hsa_opspangea2022</a>	The competent regulatory authorities (Ministry of Health and Welfare) and the Intellectual Property Protection Police Corps, as well as the related agencies including Customs, Taiwan Police, Coast Guard, and Ministry of Justice Investigation Bureau set up special groups, e.g., Allied Control Group (聯合緝查小組) and Expert Group of Illicit Drugs Control (打擊不法藥物專案會報), to make efforts to control counterfeit drugs.	The Department of Intellectual Property is the secretariat for the National IP Center for Enforcement (NICE) which is an inter-agency group for addressing enforcement of anti-counterfeits. There has not been any involvement with the pharmaceutical industry in this group or its subcommittee, but there is potential that it can be an effective structure to address the issue of counterfeit medicine.	• Crime of Infringement is enforced for manufacture and sale of counterfeit goods [Penal Code Article 157] • Viet Nam Association for Trademark Protection opened a new office in Ho Chi Minh City as a counterfeiting countermeasure (2013.5). • Survey activity by Market Controller Office. • National Institute of Drug Quality Control of Vietnam (INDQC); tightening of surveillance by testing agency under government. • Border measures through cooperation with Customs (tightening of control) – Checking of quality through sampling of corporations with past violations

Category	Item	Types	China 2026	Hong Kong 2026	India 2026	Indonesia 2026	Japan 2026	Korea 2026	Malaysia 2026	Philippines 2026	Singapore 2026	Taiwan 2026	Thailand 2026	Vietnam 2026
			RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PreMA	PG
Intellectual property rights	Overview of Intellectual property right system	Others	<p><i>The revised Anti-Unfair Competition Law of the People's Republic of China</i> was adopted at the 16th Meeting of the Standing Committee of the 14th National People's Congress on June 27, 2025, and came into force on October 15, 2025.  <a href="https://www.samr.gov.cn/zw/zfx/xgk/fdzdgknr/fgs/art/2023/art_3737890d856a4e44a8ea07c50c90c116.html">https://www.samr.gov.cn/zw/zfx/xgk/fdzdgknr/fgs/art/2023/art_3737890d856a4e44a8ea07c50c90c116.html</a></p> <p>On January 23, 2025, the Anti-Monopoly and Anti-Unfair Competition Committee of the State Council issued the <i>Guidelines on Anti-Monopoly in the Pharmaceutical Sector</i>, aimed at effectively preventing and curbing monopolistic practices in the pharmaceutical field, safeguarding fair market competition, and protecting the interests of consumers and the public.  <a href="https://www.samr.gov.cn/zw/zfx/xgk/fdzdgknr/fldzfy/art/2025/art_4f615267290d443f9b4e571774ed3d2a.html">https://www.samr.gov.cn/zw/zfx/xgk/fdzdgknr/fldzfy/art/2025/art_4f615267290d443f9b4e571774ed3d2a.html</a></p> <p>On February 28, 2025, the State Administration for Market Regulation (SAMR) issued the <i>Implementation Measures for the Fair Competition Review Regulations</i>, which came into force on 20 April 2025.  <a href="https://www.samr.gov.cn/zw/zfxxgk/fdzdgknr/fgs/art/2025/art_2084c3ba225943c2a670d27e85fb00be.html">https://www.samr.gov.cn/zw/zfxxgk/fdzdgknr/fgs/art/2025/art_2084c3ba225943c2a670d27e85fb00be.html</a></p>	-	Requirement to file annual statements on working of patents under FORM 27 The Patent Act, 1970 requires all patent holders to file an annual statement summarizing the extent to which the patented invention has been commercially worked in India. Form 27 has been recently amended & simplified. Pre-grant opposition: Section 25(1) of the Indian Patents Act, 1970 provides a provision for filing a pre-grant opposition against a patent application. Under this provision any person, any third party or the Government may challenge the application of grant of patent and inform to the controller of Patents of the opposition, in writing against the grant of a patent after the application for a patent has been published and before the grant of the patent. Such law does not exist globally and is unique to India. Also, since there is no defined timeframe, generic companies have misused this law in order to delay in the grant of patent. This coupled with no Patent term extension clause available in India is detrimental for innovators to launch their products in the country.	-	N/A	N/A	There have been two other new bills so far which have been passed in late December 2021 by the Dewan Negara (Upper House of Malaysia's Parliament). These bills and their objectives are as follows: <b>- The Copyright (Amendments) Bill 2021</b> The copyright law amendments serve to provide efficient and effective protection of intellectual property in line with current demands and to fulfil, the needs of the business community and stakeholders. The amendment is also to prepare Malaysia to join the Marrakesh Treaty to Facilitate Access To Published Works For Persons Who Are Blind, Visually Impaired Or Otherwise Print Disabled (Marrakesh Treaty) <b>- Geographical Indications Bill 2021</b> This bill was enacted in line with the need to protect registered or unregistered geographical indications in Malaysia, in line with the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement which were effective on 1 <sup>st</sup> January 1995. <b>1. Malaysia Intellectual Property Strategy 2021 – 2025</b> The Kick-off Consultation Session for the Malaysia Intellectual Property Strategy 2021 - 2025 was held jointly by MyIPO & WIPO on 29 January 2021. This policy is to support the Shared Prosperity Vision 2030 to change Malaysia's economic model to be more progressive, knowledge-based and high-valued, and to attract more R&D investments, the Malaysian IP ecosystem needs to be effective in safeguarding the R&D outputs	While the FDA defines that intellectual property rights are not covered by the product registration application and approval, the marketing authorization holder is responsible to protect their rights through the local court.	N/A	-	Based on the new Drug Act of 2019, the number of patent or petty patent applications which went through the publication process according to the patent law must be disclosed in the application for marketing registration of a drug formula.	-

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Healthcare and Pharmaceutical industry policy	Investment restriction	<p>On July 7, 2025, the National Development and Reform Commission, together with six other Ministries, jointly issued the "Notice on Implementing Several Measures to Encourage Domestic Reinvestment by Foreign-Invested Enterprises." This document represents an important step in deepening the reform of the foreign investment promotion system and mechanism, aiming to attract and utilize foreign investment more effectively.</p> <p><a href="https://www.gov.cn/zhengce/zhengceku/202507/content_7032625.htm">https://www.gov.cn/zhengce/zhengceku/202507/content_7032625.htm</a></p> <p>On February 17, 2025, the State Council of China approved the "2025 Action Plan for Stabilizing Foreign Investment" at its executive meeting. It aims to stabilize and expand foreign investment by orderly broadening autonomous openness, enhancing investment promotion, optimizing the effectiveness of open platforms, and strengthening service guarantees.</p> <p><a href="https://www.gov.cn/zhengce/content/202502/content_7004409.htm">https://www.gov.cn/zhengce/content/202502/content_7004409.htm</a></p> <p>Chinese and English version: <a href="https://swj.huabei.gov.cn/wzwm/57878864.html">https://swj.huabei.gov.cn/wzwm/57878864.html</a></p>	<p>• There are no provisions limiting investment in the pharmaceutical industry.</p> <p>• running pharmaceutical import/export, manufacturing, pharmacies, distribution need relevant licenses from Department of health</p>	<p>In Pharmaceuticals, 100 % FDI is allowed in greenfield projects under automatic rule. For brownfield projects, it is automatic route upto 74% and beyond that is through Government route.</p> <p><b>Source:</b> Consolidated FDI Policy 2020</p> <p><b>OTHER CONDITIONS</b></p> <p>(i) 'Non-compete' clause would not be allowed in automatic or government approval route except in special circumstances with the approval of the Government.</p> <p>(ii) (The prospective investor and the prospective investee are required to provide a certificate along with the application for foreign investment</p> <p>(iii) Government may incorporate appropriate conditions for FDI in brownfield cases, at the time of granting approval.</p> <p>(iv) FDI in brownfield pharmaceuticals, under both automatic and government approval routes, is further subject to compliance of following conditions:</p> <p>(a) The production level of National List of Essential Medicines (NLEM) drugs and/or consumables and their supply to the domestic market at the time of induction of FDI, being maintained over the next five years at an absolute quantitative level. The benchmark for this level would be decided with reference to the level of production of NLEM drugs and/or consumables in the three financial years, immediately preceding the year of induction of FDI. Of these, the highest level of production in any of these three years would be taken as the level.</p> <p>(b) R&amp;D expenses being maintained in value terms for 5 years at an absolute quantitative level at the time of induction of FDI. The benchmark for this level would be decided with reference to the highest level of R&amp;D expenses which has been incurred in any of the three financial years immediately preceding the year of induction of FDI.</p> <p>(c) The administrative Ministry will be provided complete information pertaining to the transfer of technology, if any, along with induction of foreign investment into the investee company. Consolidated FDI Policy 2020 Department for Promotion of Industry and Internal Trade</p> <p>(d) The administrative Ministry (s) i.e. Ministry of Health and Family Welfare, Department of Pharmaceuticals or any other regulatory Agency/Development as notified by Central Government from time to time, will monitor the compliance of conditionalities</p> <p>FDI up to 100%, under the automatic route is permitted for manufacturing of medical devices. The above mentioned conditions will, therefore, not be applicable to greenfield as well as brownfield projects of this industry</p> <p><b>Incentivization of Local API Production</b></p> <p>• Supply chain disruptions during the initial phase of the COVID-19 crisis underlined the local industry's heavy dependence on API imports from China. In a bid to minimize country's dependence on imports and to give fillip to indigenous manufacturing. In order to make the country self-reliant in APIs and drug intermediates, the Department of Pharmaceuticals has launched various Production Linked Incentives (PLI) schemes.</p> <p>One PLI such scheme is the Production Linked Incentive (PLI) scheme for promotion of domestic manufacturing of critical Key Starting Materials (KSMs)/ Drug Intermediates (DIs) and Active Pharmaceutical Ingredients (APIs) in India</p> <p>The tenure of the scheme is from FY 2020-2021 to 2029-30 with total financial outlay of ₹6,940 crores. Till date 32 companies/pharmaceutical entities have been selected for greenfield production through 48 projects involving 33 APIs/DIs/KSMs .</p> <p>Key outcomes, as of June 2025 include the following:</p> <ol style="list-style-type: none"> <li>1. Out of the 6-year production tenure of the scheme, till June 2025, 3¼ years of implementation stand completed.</li> <li>2. Already, against committed investment of ₹3,938.5 crore, cumulative investment for the projects approved under the scheme has substantially exceeded the target, reaching ₹4,709 crore.</li> <li>3. Cumulative sales of ₹1,962 crore have been reported over the period from FY2022-23 onwards, including exports of ₹479 crore, thereby avoiding imports worth ₹1,483 crore.</li> </ol> <p><b>Source:</b> Rajya Sabha Q/A dated August 19, 2025.</p>	<p>No change. Additional: The decline in realized foreign investment is a major concern, given that foreign investors contribute to the bulk of the capital invested in this sector</p> <p>10 years after the policy was put into effect, 90% of raw medicine materials still reliant on imports, which leads to costly and uncompetitive local generics production.</p> <p>Presidential Instruction (Inpres) 90% of API is still imported hence increase trade deficit and weaken rupiah. Presidential Instruction (Inpres) 6/2016 targeted a reduction in API imports and the development of the domestic pharmaceutical industry but not much has changed since the regulation was issued</p> <p><b>Source:</b> INDEF Policy Brief Vol 1. No. 1/ II/2020- Fostering Foreign Direct Investment in the Pharmaceutical Sector, February 2020</p>	<p>Basically, there are no restrictions limiting investment.</p>	<p>In 2026, Korea's healthcare policy environment is expected to further emphasize patient access to innovation while maintaining fiscal sustainability of the National Health Insurance (NHI) system. Building on the New Drug Innovation Value Reward System introduced in 2024, the government is strengthening policy instruments that link clinical value, real-world outcomes, and reimbursement flexibility.</p> <p>Key policy directions include:</p> <p>Expanded use of flexible ICER application and PE waiver pathways for innovative medicines targeting severe, rare, or life-threatening diseases, reinforcing earlier access under conditions of managed uncertainty.</p> <p>Broader application of Risk-Sharing Agreements (RSAs), including performance-based and outcome-linked models supported by real-world data (RWD), to balance early patient access with budget predictability.</p> <p>Increased policy attention to RWD and post-listing evidence generation, positioning Korea as a test-bed for adaptive reimbursement models rather than purely ex-ante cost-containment mechanisms.</p> <p>While these measures improve Korea's attractiveness for innovative drug launches, investment uncertainty remains due to the parallel expansion of post-listing price controls, including re-pricing mechanisms based on international reference pricing (IRP) and actual transaction prices (ATP). As a result, multinational pharmaceutical companies are expected to take a more selective approach to pipeline prioritization, favoring products aligned with high unmet medical need and policy-favored therapeutic areas.</p>	<p>There is no restriction in particular for pharmaceuticals.</p> <ul style="list-style-type: none"> <li>• Foreign capitalization of pharmacies (traditional herbs, Chinese herbal medicine) is now allowed.</li> <li>• Land ownership is depending upon law of each state. When a foreigner establishes a 100% foreign-capital hospital, it is necessary to obtain a Malaysian doctor's license.</li> </ul>	<p>There are no provisions limiting investment in the pharmaceutical industry.</p>	<ul style="list-style-type: none"> <li>• There are no provisions limiting investment in the pharmaceutical industry.</li> <li>• Under the Health Product (Licensing of Retail Pharmacies) Regulations 2016, Investment in pharmacies is possible with a license granted by the Health Science Authority</li> </ul> <p>[HSA website] <a href="https://www.hsa.gov.sg/therapeutic-products/retail-pharmacy-licence/overview">https://www.hsa.gov.sg/therapeutic-products/retail-pharmacy-licence/overview</a></p>	<p>Permission based on the "Statute for Investment by Foreign Nationals" is necessary in order for foreigners to invest in Taiwan.</p> <p>While investment by overseas Chinese and foreigners is in principle unrestricted, those investments falling within the "Negative List for Investment by Overseas Chinese and Foreign Nationals" are prohibited or limited as an exception. Moreover, investment by Chinese corporations requires permission based on "Investment permission for continental Chinese decree", and only the types of businesses listed in "Investment by continental Chinese, by industry" are allowed. Industries related to pharmaceuticals are not included in the "Negative List".</p> <p>[JETRO: Restrictions on Foreign Investment]</p>	<p>In almost all industries, the provisions of the Foreign Business Act make it impossible to start an enterprise with solely foreign capital or a majority of foreign capital, unless a foreign business license is obtained through the Ministry of Commerce.</p> <p>Another exception, under the Investment Promotion Act, it is possible for foreign-capital companies to establish a wholly owned company if approval is obtained from the Thailand Board of Investment.</p>	<p>There is no restriction of stock ratio, 100% foreign capital affiliated is available.</p>

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Healthcare and Pharmaceutical industry policy	Import, international distribution regulation	<p>On September 30, 2025, the National Medical Products Administration (NMPA) issued the "Announcement of the NMPA on Matters Related to the Import of Commercial-Scale Batch Products of Overseas Approved Drugs Before Approval in China," allowing the import and sale of commercial-scale batches of overseas-approved drugs produced prior to their approval in China.</p> <p><a href="https://www.nmpa.gov.cn/xgk/gtg/ypggtg/ypqtggtg/20250930090453177.html?type=pc&amp;m=">https://www.nmpa.gov.cn/xgk/gtg/ypggtg/ypqtggtg/20250930090453177.html?type=pc&amp;m=</a></p>	<p>An import/export license is required for pharmaceuticals (including Chinese medicines and Chinese herbal medicines), regardless of the trading partner. *</p> <p>In order to import pharmaceuticals, it is necessary to apply for and obtain a pharmaceutical import license each time,** and obtaining a Wholesaler Poisons License and product registration certificate (or similar document) before applying for the import license is mandatory. Even if a company is authorized as a Hong Kong corporation and exports items classified as locally produced in Hong Kong, a series of restrictions on pharmaceutical imports are applied.</p>	<p>Drugs: CDSCO (Central Drug Standard Control Organisation) provides Registration Certificate and issuing License for import of drugs into India. Both manufacturing site and product need to be registered. An application shall be made to the Licensing Authority in Form 40, either by the manufacturer himself, having a valid wholesale License, for sale or distribution of drugs or by his authorized agent in India either having a valid License to manufacture for sale of a drug or having a valid wholesale License for sale or distribution of drugs</p> <p>Medical Devices: The Central Licensing Authority is the authoritative body that oversees the importation of all classes of medical devices; the manufacture of Class C and D medical devices; the clinical evaluation and approval of investigational medical devices; and the clinical evaluation and approval of new IVDs. The responsibility of overseeing the manufacture of Class A and B medical devices and the sale, stocking, exhibiting, and distribution of all classes of medical devices is delegated to state licensing authorities.</p>	<p>It is mandatory that the marketed pharmaceutical products be produced in Indonesia within 5 years after registration. Marketing authorization for a product is however granted only to pharmaceutical manufacturing companies in Indonesia. Some exceptions from this localization requirement can be granted, e.g. small number of products requiring technology not available in Indonesia, government need, products under patent.</p>	<p>"Law Concerning Quality, Effectiveness, and Safety of Pharmaceuticals and Medical Devices" applies.</p>	<p>None in particular</p>	<p>There is no description of direct restrictions on import of drugs by foreign-affiliated companies.</p>	<p>In order to import drug products, the following must be satisfied:</p> <ul style="list-style-type: none"> <li>The establishment involved in the importation must secure a License to Operate from the Food and Drug Administration</li> <li>The product to be imported must be registered with the Food and Drug Administration from 2012</li> </ul>	<ul style="list-style-type: none"> <li>An importer's license for therapeutic products (TPIL) and a wholesaler's license for therapeutic products (TPWL) are required to import and wholesale therapeutic products respectively. Companies must comply with the GDP standard.</li> <li>For the import and wholesale of an unregistered therapeutic product for patient's use, apart from the TPIL and TPWL, a consignment approval from HSA's Therapeutic Products Branch will also be required prior to the import.</li> <li>Companies which are only importing therapeutic products solely for supply to ships/aircraft leaving Singapore, export or non-clinical use require an importer's license for therapeutic product (TPIL). An importer's license for restricted activity only may be applied for.</li> </ul> <p>[HSA website]  <a href="https://www.hsa.gov.sg/therapeutic-products/dealers-licence/overview">https://www.hsa.gov.sg/therapeutic-products/dealers-licence/overview</a></p>	<p>Approval is required for importing pharmaceuticals.</p>	<p>For medicines and pharmaceutical products, it is necessary to obtain an import license in accordance with the Import and Export of Commodity Act (B.E. 2522 (1979)). The new Drug Act (No. 6) B.E. 2562 published in the Government Gazette on April 16, 2019. The key changes are:</p> <ul style="list-style-type: none"> <li>New Drug Registration has to provide "Documents that show the number of patent or petty patent application which went through the publication process according to patent law" (Section 9).</li> <li>Marketing authorization shall be valid for seven years from the date it was issued and need renewal. (Section 11).</li> <li>The new section added on procedure, regulations, and conditions of drug research (Section 8) and the penalty fee (Section 12).</li> <li>All fees in the Drug Act 1967 have been replaced (Section 14).</li> </ul> <p>The Japanese-Thai Economic Partnership Agreement affords preferential treatment with exemption from tariffs (Type No. 30: medical supplies and pharmaceuticals) Bilateral agreement with PMDA, Japan and with TGA, Australia.</p>	<p>Historically, most multinational pharmaceutical companies have done business in Vietnam via representative office (RO) model in Vietnam. With Pharmaceutical Law 105/2016 and Decree No. 54/2017/ND-CP, foreign pharmaceutical companies can establish pharma business establishment for importation (FIE Importer). Wholesale/Distribution is reserved for domestic companies. It has been clear that Vietnam does not intend for foreign companies to engage in the distribution sector for pharmaceuticals. Vietnam's WTO Schedule of Commitments on Services has intentionally excluded pharmaceuticals from the sectors for which market access is open to distribution by foreign investors. At the end of 2024, the Pharmaceutical Law No. 44/2024, amending Pharmaceutical Law no. 105/2016. All regulations related to FIE Importers are now instituted in Article 53a Rights and Responsibilities of Foreign-Invested Enterprises, which moves FIE regulations from current Decree to Law level, with some amendments. Effective 1 July 2025. FIE Importers are not allowed to conduct wholesale, retail activities except for what are permitted in Article 53a.3, while FIE Manufacturers rights are made clearer in the Law revision. While Vietnam continues to reserve distribution rights for domestic companies, certain activities have been enabled to address practical challenges and promote sector development.</p>

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Healthcare and Pharmaceutical industry policy	Industry development policy	<p>On January 3, 2025, the State Council issued the <i>Opinions on Comprehensively Deepening the Reform of Drug and Medical Device Regulation to Promote the High-Quality Development of the Pharmaceutical Industry</i>, which introduced 24 specific measures across five key areas, aiming to promote high-quality industry development while ensuring a high level of safety for drugs and medical devices. <a href="https://www.gov.cn/zhengce/content/202501/content_6996115.htm">https://www.gov.cn/zhengce/content/202501/content_6996115.htm</a></p> <p>On July 1, 2025, the National Healthcare Security Administration and the National Health Commission jointly issued the <i>Several Measures to Support the High-Quality Development of Innovative Drugs</i>, aiming to systematically advance the research and development, market access, reimbursement, and clinical application of innovative drugs through full-chain policy support. The Measures seek to establish a multi-tiered healthcare security system in which the Commercial Health Insurance Innovative Drug List complements the National Basic Medical Insurance Drug List. <a href="https://www.nhsa.gov.cn/art/2025/7/1/art_104_17058.html">https://www.nhsa.gov.cn/art/2025/7/1/art_104_17058.html</a></p> <p>On April 24, 2025, the Ministry of Industry and Information Technology, the Ministry of Commerce, the National Health Commission, the National Healthcare Security Administration, the National Data Bureau, the National Administration of Traditional Chinese Medicine, and the National Medical Products Administration, jointly issued the <i>Implementation Plan for the Digital and Intelligent Transformation of the Pharmaceutical Industry (2025–2030)</i>. The Plan aims to foster new quality productive forces and promote the high-quality development of the pharmaceutical industry by advancing the integration of next-generation information technologies across the entire pharmaceutical industry value chain. <a href="https://www.mit.gov.cn/zw/gk/zcwj/wjfb/tz/art/2025/art_13998d1c720e41438c5d25a943101f76.html?isFromHistoryPage=1">https://www.mit.gov.cn/zw/gk/zcwj/wjfb/tz/art/2025/art_13998d1c720e41438c5d25a943101f76.html?isFromHistoryPage=1</a></p>	<p>Deepen healthcare system reform – enhancing sustainability, strengthening primary healthcare and increasing healthcare manpower</p> <p>The HA will set up the <b>Office for Introducing Innovative Drugs and Medical Devices</b> in the first half of 2026 to <b>actively identify needs and benefits of innovative drug treatments</b> for local patients <b>through big data analytics</b>, and contact innovative drug and medical device manufacturers to make good use of the "1+" registration mechanism to proactively introduce into Hong Kong innovative drugs and medical devices that are cost-effective and beneficial to patients. (HHB) [64]</p> <p>Attract clinical trials investments - fostering collaboration with GBA, enhance patient referral efficiency, etc. Enhance regulatory framework, e.g., piloting priority evaluation for severe or rare diseases</p> <p>Set up Hong Kong Centre for Medical Products Regulation (CMPR) and submit legislative proposal on regulating medical devices in 2026 <a href="https://www.policyaddress.gov.hk/2025/en/policy.html">https://www.policyaddress.gov.hk/2025/en/policy.html</a> <a href="https://www.policyaddress.gov.hk/2025/en/supplement.html">https://www.policyaddress.gov.hk/2025/en/supplement.html</a></p>	<p>The Department of Pharmaceuticals is implementing the following central sector schemes with the objective to increase efficiency and competitiveness of domestic pharmaceutical and medical devices industry so as to enable them to play a lead role in the global market and to ensure accessibility, availability and affordability of quality pharmaceuticals and medical devices for mass consumption.</p> <p>1-Production Linked Incentive (PLI) Schemes</p> <ul style="list-style-type: none"> <li>• PLI Scheme for promotion of domestic manufacturing of critical Key Starting Materials (KSMs)/Drug Intermediates (Dis)/ Active Pharmaceutical Ingredients (APIs) in India</li> <li>• PLI Scheme for Promoting Domestic Manufacturing of Medical Devices c)</li> <li>• PLI Scheme for Pharmaceuticals DoP also implements Scheme for Promotion of Bulk Drug Parks; and Scheme for Promotion of Medical Device Parks.</li> </ul> <p>1- National Policy on Research and Development and Innovation in Pharma-MedTech Sector in India - The Department of Pharmaceuticals has brought out the National Policy on Research and Development and Innovation in Pharma-MedTech Sector in India, with the objective of achieving Atmanirbharata in the Pharma-MedTech sector through measures to accelerate research and development (R&amp;D) and innovation in the sector.</p> <p>2- The Scheme for Promotion of Research and Innovation in Pharma MedTech sector launched by the DoP provides for the setting up of a Centre of Excellence in each of the seven National Institute for Pharmaceuticals Education and Research (NIPERs), with industry-academia collaboration. In addition, established Pharma-MedTech companies undertaking research in six identified priority areas in collaboration with academia are eligible for financial assistance under the scheme.</p> <p>3. PM launched ₹1 Lakh Crore Research, Development and Innovation Scheme</p> <p>On November 3, 2025, Prime Minister Narendra Modi launched the INR 1 Lakh Crore Research, Development and Innovation (RDI) Scheme. The scheme aims to promote a private sector-driven R&amp;D ecosystem in the country. Recognizing the critical role of the private sector in driving innovation and commercializing research, the RDI Scheme provides long-term financing or refinancing support with extended tenors at low or nil interest rates. The scheme also addresses existing challenges in funding private research by offering growth and risk capital. It focuses on facilitating innovation, promoting technology adoption, and improving competitiveness across emerging areas.</p> <p>The key objectives of the RDI Scheme are as follows:</p> <ul style="list-style-type: none"> <li>- Encourage private sector participation: To scale up research, development, and innovation in sunrise domains and other sectors vital for economic security, strategic purpose, and self-reliance.</li> <li>- Finance transformative projects: To support projects at higher levels of technology readiness for faster translation from concept to market.</li> <li>- Support acquisition of critical technologies: To enable access to technologies of high strategic importance.</li> <li>- Facilitate Deep-Tech Fund of Funds: To strengthen the financing ecosystem for deep technology start-ups and innovation-driven enterprises.</li> </ul>	<p>Some tax incentives (tax holiday and tax allowance) might be granted for 'pioneer industries' such as API manufacturing, R&amp;D activities locally etc. Please refer to the decree of MoFinance no. 35/2018</p>	<p>In 2024, Japanese government began pro-innovation policies including "2024 Pricing Reform", regulatory innovation and "Gate Opening Summit for Innovative Drug Discovery" in July.</p>	<p>The government's healthcare policy in 2026 continues to be shaped by the Second National Health Insurance (NHI) Master Plan, with implementation moving from policy design to operational execution. The fast-track reimbursement system for life-threatening diseases—shortening the listing timeline from approximately 330 days to 150 days—is expected to be institutionalized and gradually expanded in scope. From a healthcare policy standpoint, notable developments include: Normalization of expedited reimbursement pathways as a standard policy tool for oncology, rare diseases, and selected high-impact therapies, rather than as exceptional measures. Stronger alignment between industrial policy and health policy, with reimbursement incentives increasingly linked to domestic clinical development, early Korean patient access, and contribution to health outcomes. Greater reliance on post-market management tools, such as conditional coverage, RWD-based reassessment, and outcome-based RSAs, to mitigate uncertainty while preserving access. At the same time, healthcare cost-containment remains a dominant policy objective due to rapid population aging and structural pressure on NHI finances. This creates a dual policy signal: Pro-access and pro-innovation at entry, Stricter price discipline and reassessment after listing. Balancing these two objectives—early access versus long-term sustainability—will remain a central policy challenge in 2026, with direct implications for industry investment decisions and launch sequencing strategies.</p>	<p>The government's industry development policies can be broken down into the following categories.</p> <p><b>1. Pro-business policies</b></p> <p>These policies revolve around the Government's intention to increase the ease of setting up a business in Malaysia. These include making sure the cost of setting up a business is low. Based on Section 562 of the Companies Regulations 2017, the fee for the registration of a foreign company with a share capital of not more than RM1,000,000.00 is RM 5000.00. Pro-business policies also include policies that improve access to basic utilities and immigration policies that are conducive for investment.</p> <p><b>2. Attractive tax and other incentives</b></p> <p>The Malaysian government has maintained and improved upon its tax and incentive policies to remain an attractive destination for foreign investment.</p> <p>The following is a list of tax rates applicable to the pharmaceutical industry in Malaysia - <b>Corporate tax rates</b></p> <ul style="list-style-type: none"> <li>(i) Resident and non-resident companies- 24 percent</li> <li>(ii) Resident companies with paid-up capital of RM2.5 million and less at the beginning of the first RM500,000 (USD162,337.67) chargeable income- 17 percent</li> <li>(iii) On subsequent chargeable income-24 percent</li> </ul> <p>- <b>Personal Income tax rates</b> 0%-30%</p> <p>The following is a list of all the incentives that can be applicable to the pharmaceutical industry</p> <p>- <b>Incentives for Manufacturing Companies</b></p> <ul style="list-style-type: none"> <li>(i) Pioneer Status with income tax exemption of 70% of statutory income for 5 years, or</li> <li>(ii) Investment Tax Allowance (ITA) of 60% of qualifying capital expenditure incurred within a period of 5 years (to be offset against 70% of statutory income for each assessment year.)</li> </ul> <p>- <b>Incentives for High Technology Companies</b></p> <ul style="list-style-type: none"> <li>(i) Pioneer Status with full income tax exemption of statutory income for 5 years, or</li> <li>(ii) ITA of 60% on qualifying capital expenditure incurred within a period of 5 years (to be offset against 100% of statutory income for each assessment year.)</li> </ul> <p>- <b>Incentives for Strategic Projects</b></p> <p>Incentives for Strategic Projects are dependent on:</p> <ul style="list-style-type: none"> <li>i) Level of investment</li> <li>ii) High technology/technology transfer</li> <li>iii) Linkages with local ecosystem/vendor development</li> <li>iv) High income employment/technical skills</li> <li>v) Level of R&amp;D undertaken locally</li> </ul> <ul style="list-style-type: none"> <li>(a) Pioneer Status with full income tax exemption of statutory income for 10 years, or</li> <li>(b) ITA of 100% of qualifying capital expenditure incurred within a period of 5 years (to be offset against 100% of statutory income for each assessment year.)</li> </ul> <p>- <b>Incentives for Research &amp; Development (R&amp;D)</b></p> <ul style="list-style-type: none"> <li>(i) Contract R&amp;D company</li> <li>(a) Pioneer Status with 100% income tax exemption of statutory income for 5 years, or</li> <li>(b) ITA of 100% of qualifying capital expenditure incurred within 10 years (to be offset against 70% of the statutory income in each year of assessment.)</li> <li>(ii) R&amp;D Company</li> <li>ITA of 100% of qualifying capital expenditure within 10 years and to be offset against 70% of the statutory income for each year of</li> </ul>	<p>The Board of Investments led the crafting of the Pharmaceutical Roadmap. This is to be published in the BOI Website soon.</p>	<p>The Singapore government actively supports the growth and development of the biopharmaceutical industry through various investments. Singapore has over 60 manufacturing facilities across a wide range of products, including bulk active pharmaceutical ingredients, bulk biologics, drug products and nutritional supplements</p> <p>A new 10-year plan was announced in Jan 2021 to grow Singapore's manufacturing sector by 50 percent and maintain its share of about 20 per cent of gross domestic product (GDP) - the Manufacturing 2030 plan. The biomedical cluster is central to Singapore's vision and to achieve its target, the government is committed to:</p> <ul style="list-style-type: none"> <li>• Step up efforts to attract the best global and local companies in niche areas such as innovative technologies that will help Singapore remain a critical node in global value chains.</li> <li>• Offer tailored support to grow the size and capabilities of employees advanced manufacturing. These investments in Singapore's capabilities aim to equip Singapore for end-to-end production of many biomedical products, including vaccines.</li> </ul> <p>The government will continue efforts to attract frontier investments in the biopharmaceutical industry, and build strong partnerships between public and private sectors, as well as between companies and academia to upskill talent in the sector. The government will continue to build strong capabilities within the biopharma sector, in areas of medical technologies such as gene therapy, stem cells treatment, cancer immunotherapy and personalised/precision medical treatments.</p> <p>Examples include the Biologics Pharma Innovation Programme Singapore (BioPIPS), a consortium initiated by the Agency for Science, Technology and Research (A*STAR), with support from the Economic Development Board (EDB), announced on December 6, 2022. The consortium fosters partnerships between pharmaceutical industry players GSK, Sanofi and Takeda with research communities from the A*STAR, the National University of Singapore (NUS), Nanyang Technological University (NTU) and the Singapore Institute of Technology (SIT) to boost Singapore's biologics manufacturing capabilities.</p> <p>Singapore continues to enhance the working environment in biopharma and biomedical parks for businesses to ensure infrastructure will support expansion of the industry.</p> <ul style="list-style-type: none"> <li>• While the MoH is keen to foster innovation in areas such as gene therapy, biologics and biosimilars, it remains wary of driving up demand</li> </ul>	<p>Act for The Development Of Biotech And New Pharmaceuticals Industry is established to promote the development of local biotech and new pharmaceuticals industry (Jan 2017; Ministry of Economic Affairs)</p>	<p>There are several national initiatives to develop Thai industries in the medical, biopharmaceutical and health service sectors. Thailand 4.0 is an initiative that aims to elevate several technology sectors to "value creation" through regulatory reform, tax incentives and attracting FDI with the goal of technology transfer. One of the targeted sectors in Thailand 4.0 is the biopharmaceutical industry. The Board of Investment, in alignment with the national initiatives, is also targeting FDI from medical device and biopharmaceutical industry with tax and other pull incentives. The National Legal Reform Committee, in alignment with the national initiatives, is reviewing all laws and licenses for relevance and seeking to cut unnecessary laws and licenses for ease of doing business. The Ministry of Public Health is reforming the Clinical Research environment in an effort to make Thailand more competitive in attracting clinical trials. Thai FDA is one of target government agencies to improve their licensing service to digital platforms so that the index of Thailand Ease of Doing Business can be more competitive to other economies. Services that they are reforming include one stop service, shortening health products reviewing process especially pharmaceutical products, etc.</p>	<p>The Pharmaceutical Law No. 44/2024, amending Pharmaceutical Law no. 105/2016 brought about minor revisions (pre-dominantly focusing on enablers with no competitive incentives). Furthermore, with consistent advocacy from the industry, the perception of the regulator is now moving more towards "faster access, better procurement and more efficient reimbursement will drive investments". This shift with the activities by the National Steering Committee for the Pharma Sector Development implementing Decision 376 and 1165 will create exciting policy advocacy opportunities moving forward and bring about long-awaited change in regulations enhancing the pharma operating and investment environment. A number of incentives of the industry's interest are:</p> <ul style="list-style-type: none"> <li><b>a. Clinical trials</b> <ul style="list-style-type: none"> <li>▪ Prioritize MA registration and importation procedures for drugs undergone clinical trials in Vietnam</li> <li>▪ Eligible for incentives/support from national technology and science funds</li> <li>▪ Medicines for clinical trials can be imported without SIQ, based on approved research protocol published on MOH website</li> <li>▪ Enable importation of drugs without MAs used in clinical trial without SIQ based on research protocol approved by MOH.</li> </ul> </li> <li><b>b. Local manufacturing</b> <ul style="list-style-type: none"> <li>▪ Prioritize MA registration procedures for drugs locally manufactured</li> <li>▪ Incentives in procurement of tech transferred originators in Vietnam</li> <li>▪ Eligible for incentives/support from national technology and science funds</li> </ul> </li> <li><b>c. General</b> <ul style="list-style-type: none"> <li>▪ Special incentives per Investment Law for establishment or expansion of projects of at least 3,000 billion VND with disbursement of at least 1,000 billion VND within 3 years of project approval/license from authority.</li> <li>▪ Other incentives/support per laws related to investment</li> </ul> </li> </ul>

							<p>assessment (iii) In-house Research Investment Tax Allowance of 50% of qualifying capital expenditure incurred within 10 years and to be offset against 70% of statutory income for each year of assessment</p> <p>- <u>Guidelines for Incentive for Manufacturers of Pharmaceutical Products Including Vaccines Under the 2021 Budget</u> The incentive is for both new and existing companies: (i) Income tax rate of 0% to 10% for a period of 10 years (ii) Income tax rate of 10% for the subsequent period of 10 years</p> <p><b>3. Intellectual property protection (IP Protections)</b> Malaysia has strong IP protections in place and is committed to safeguarding IP on inventions. To ensure IP protection in Malaysia is in line with international standards and provides protection for both local and foreign investors, Malaysia is a party to the following treaties: - World Intellectual Property Organization (WIPO), 1967; - Paris Convention for the Protection of Industrial Property 1883; - Berne Convention for the Protection of Literary and Artistic Works (1886); - Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement; - Patent Cooperation Treaty (PCT) 1970</p> <p><b>4. Educated workforce</b> Malaysia remains a highly attractive country for foreign direct investment as it commands a highly educated workforce. A breakdown of the key attributes of Malaysia's educated workforce are below: - A talented, young, educated and productive workforce - A multilingual workforce speaking two or three languages, including English - A comprehensive system of vocational and industrial training, including advanced skills training. - Harmonious industrial relations with very infrequent trade disputes.</p> <p><b>5. Well developed infrastructure</b> Malaysia retains a strong reputation for having decent infrastructure, which is a prerequisite in attracting foreign investment especially from the pharmaceutical sector. The Malaysian government will continue its policy of supporting the development of world-class airports, seaports and sophisticated telecommunications networks. Malaysia will also continue its focus on its efforts to increase the availability of industrial parks, specialized parks as well as Clinical Trials and Bioequivalence Centres.</p>	<p>for expensive new drugs too sharply. • Pharmaceutical companies will continue to be frustrated by lengthy delays in formulary listing, as well as the cumbersome process for eligible patients to access MAF subsidies, which hinders the uptake of new therapies in the public sector. • The pharmaceutical industry will continue to work with the Singapore government through the Consortium for Clinical Research &amp; Innovation Singapore and the Singapore Clinical Research Institute and the public healthcare institutions to overcome challenges and grow its clinical trial landscape toward maintaining Singapore's status as a biomedical research hub.</p>	
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		RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PReMA	PG
Healthcare and Pharmaceutical industry policy	Medicine Price Controls	-	-	-	-	-	-	While drug prices are left to market forces, there is continuous threats of price regulations. Hence the industry remains vigilant and take proactive steps to gain trust to mitigate any potential risk of price capping.	The government is able to introduce price controls through maximum retail price (MRP). Under RA 9502, while the State recognizes it effective as the primary instrument to ensure access to quality affordable medicines, it also recognizes it as a reserve instrument for the regulation of prices of drugs and medicines.  Section 23 of the law provides the list of drugs that may be subject to price regulation.  Further to implement this, an operational guideline was issued by the DOH.  <a href="https://www.officialgazette.gov.ph/2008/06/06/republic-act-no-9502/">https://www.officialgazette.gov.ph/2008/06/06/republic-act-no-9502/</a> <a href="https://dmas.doh.gov.ph:8083/Rest/GetFile?id=656913">https://dmas.doh.gov.ph:8083/Rest/GetFile?id=656913</a>	-	-	-	As reported in pricing section
	Procurement of Medicines	-	-	-	-	-	-	In 2024, MOH initiated a dual-tender policy where two suppliers share the tender. Ratio will be based on price and clinical recommendations from HCPs. The objective of the new policy is for drug security to ensure availability of critical medicines and avoid potential drug shortage as happened with insulin shortage in Malaysia in 2024.  A Generic-First Policy for public health facilities was established in 2007 as a cost-containment measure. With increased pressure to reduce medical inflation, there were calls to shift to generic drugs in 2024 in the National Heart Center (partial private).  In Q1-2025, insurance companies sent out circulars to private panel hospitals to shift to generic medicines as one of the ways to reduce medical bills. There is pushback from the private hospitals and PhAMA is collaborating with the Association of Private Hospitals to mitigate the situation.  Another recommendation from insurance players is the use of Diagnosis-Related Groups (DRG) in hospitals, where pricing will be grouped into specific buckets of cost according to therapeutic areas. The MOH plans to implement DRG in private hospitals in 2025.	Under the law, only those with positive recommendation after HTA shall be procured or reimbursed by government.  Currently, government procurement may be done centrally for "population-based" interventions, or individually through local government units. PhilHealth may also procure through reimbursement for "individual-based interventions"  Health Technology Assessment Council <a href="https://hta.dost.gov.ph">https://hta.dost.gov.ph</a>	-	-	-	As reported in pricing section
	Government counterpart	N/A	Health Bureau Commerce and Economic development Bureau	Drug Controller General of India	<ul style="list-style-type: none"> <li>Ministry Of Health Republic Indonesia [<a href="https://kemkes.go.id/id/home">https://kemkes.go.id/id/home</a>] as policy maker</li> <li>The National Agency of Drug and Food Control (NA-DFC) or BPOM as controlling body [<a href="https://www.pom.go.id/">https://www.pom.go.id/</a>]. Until 2000, NA-DFC was under the Ministry of Health, but it became a semi independent Organisation reporting to the President under the purview of the MOH in 2001. The parliament is however deliberating a BPOM Bill under the initiative of BPOM, which will make this agency in its existence sanctioned by a law, not only by a Presidential Decree, more powerful</li> </ul>	Ministry of Health, Labour and Welfare (MHLW) Pharmaceuticals and Medical Devices Agency (PMDA)	Division of health Industry Promotion, Bureau of Health Industry, Ministry of Health and Welfare	Ministry of Health ( <a href="http://www.moh.gov.my/english.php">http://www.moh.gov.my/english.php</a> ) Malaysian Industry Development Authority (MIDA) ( <a href="http://www.moh.gov.my/english.php">http://www.moh.gov.my/english.php</a> )	The Department of Trade and Industry and the Board of Investments <a href="https://boi.gov.ph/tag/dti/">https://boi.gov.ph/tag/dti/</a>	N/A	<ol style="list-style-type: none"> <li>1. Organization of the head office of ROC Ministry of Health and Welfare</li> <li>1) Department of Planning</li> <li>2) Department of Social Insurance</li> <li>3) Department of Social Assistance and Social Work</li> <li>4) Department of Protective Service</li> <li>5) Department of Nursing and Health Care</li> <li>6) Department of Medical Affairs</li> <li>7) Department of Mental and Oral Health</li> <li>8) Department of Chinese Medicine and Pharmacy</li> <li>9) Office of International Cooperation</li> <li>10) Secretariat</li> <li>11) Hospital and Social Welfare Organizations Administration</li> <li>2. Auxiliary organs of Ministry of Health and Welfare</li> <li>1) Food and Drug Administration</li> <li>2) Center for Disease Control</li> <li>3) National Health Insurance Administration</li> <li>3. Taiwan Food and Drug Administration Cooperation Units</li> <li>1) Center for Drug Evaluation</li> <li>2) Taiwan Drug Relief Foundation</li> </ol>	<ul style="list-style-type: none"> <li>• Ministry of Public Health (MoPH); Thai FDA</li> <li>• Ministry of Higher Education, Science, Research and Innovation; National Science Technology and Innovation Policy Office, Thailand Center of Excellence for Life Science (TCELS)</li> <li>• Medical Science Faculty, Pharmaceutical Science Faculty</li> <li>• Medical Council, Pharmacy Council</li> <li>• National Economic and Social Development Board, The Prime Minister's Office, Ministry of Commerce</li> </ul>	<ul style="list-style-type: none"> <li>• Crime of Infringement is enforced for manufacture and sale of counterfeit goods [Penal Code Article 157]</li> <li>• Viet Nam Association for Trademark Protection opened a new office in Ho Chi Minh City as a counterfeiting countermeasure (2013.5).</li> <li>• Survey activity by Market Controller Office.</li> <li>• National Institute of Drug Quality Control of Vietnam (INDQC); tightening of surveillance by testing agency under government.</li> <li>• Border measures through cooperation with Customs (tightening of control) – Checking of quality through sampling of corporations with past violations</li> </ul>

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Healthcare and Pharmaceutical industry policy	Supporting Associations and/or organizations	N/A	N/A	•Central Drug Standard Control Organisation Central Licensing Authority	Indonesia Investment Coordinating Board [http://www.bkpm-jpn.com/] IDI (Indonesian Medical Association), PERSI (Hospital Association)	Japan Agency for Medical Research and Development (AMED) Japan Science and Technology Agency (JST) National Institute of Biomedical Innovation, Health and Nutrition New Energy and Industrial Technology Development Organisation (NEDO) Organisation for Small & Medium Enterprises and Regional Innovation. Innovation Network Corporation of Japan Regional Economy Vitalization Corporation of Japan	KHIDI (Korea Health Industry Development Institute): <a href="http://www.khidi.or.kr/">http://www.khidi.or.kr/</a> KPS KOTRA (Korea Trade-Investment Promotion Agency): <a href="https://www.kotra.or.kr/index.do">https://www.kotra.or.kr/index.do</a>	NA	Various pharmaceutical associations are in place.  The government has established various consultative groups: • For Health, there is an Advisory Council • For Trade, the Pharma Technical Working Group For FDA, Pharma Industry Working Group	• Economic Development Board (EDB) <a href="https://www.edb.gov.sg/en/our-industries/pharmaceuticals-and-biotechnology.html">https://www.edb.gov.sg/en/our-industries/pharmaceuticals-and-biotechnology.html</a> • Enterprise Singapore (ESG) <a href="https://www.enterprisesg.gov.sg/industries/healthcare-and-biomedical">https://www.enterprisesg.gov.sg/industries/healthcare-and-biomedical</a>	N/A	Board of Trade, Federation of Thai Industries Thailand Center of Excellence Life Office of The Thailand Research Fund	Pharma Group Vietnam
	Contract research organization	According to Frost & Sullivan's forecast, the Chinese Contract Research Organization (CRO) market expanded from 38.8 billion RMB in 2018 to 84.8 billion RMB in 2023, and the compound annual growth rate (CAGR) is 16.9%. It is expected that China's CRO market will reach 112.7 billion RMB by 2026, with a CAGR of 9.9% for the period from 2023 to 2026.  <a href="https://img.frostchina.com/attachmen/17182944/aGBP_TPLRkP5KHrTrk7Kspm.pdf">https://img.frostchina.com/attachmen/17182944/aGBP_TPLRkP5KHrTrk7Kspm.pdf</a>	N/A	Vide GSR 581(E) dated September 19, 2024, the MoH notified the New Drugs and Clinical Trials (Amendment) Rules, 2024 (NDCT) on Clinical Research Organisation (CROs).  The amended NDCT has provisions on CROs registration with the Central Licensing Authority, Inspection of CRO registered etc.	Quintiles (IQVIA), Prodia the CRO, Pacific Bridge Medical, Equilib International, Hayya Life Science, PAREXEL, Syneos Health etc	The domestic CRO market scale is estimated as 209.6 billion yen(2023) by Japan CRO association.	N/A	Updated list: <a href="https://ichgcp.net/cro-list/country/malaysia">https://ichgcp.net/cro-list/country/malaysia</a> • Syneos Health • SGS • Labcorp Drug Development • ICON • Clinipace • ClinActis • Across Global • Info Kinetics Sdn Bhd • Novotech • PAREXEL • IQVIA • PPD	Several Contract Research Organisations are present in the country, such as IQVIA, PPD, ICON, PAREXEL, etc. These CROs have been attracted to the growth of the Philippines as a clinical research hub.	IQVIA, CMIC, EPS, ICON, PAREXEL International, Novotech, Intellim and more	N/A	Non-exhaustive list of active CRO's in Thailand IQVIA Parexel Acires Covance PPD Asia Global Research	Hospitals
	Contract manufacturing organization	According to the "2025-2030 In-depth Analysis and Development Outlook Forecast Report on China's Biopharmaceutical Outsourcing (CRO/CMO/CDMO) Industry" released by the Zhongshang Industrial Research Institute, the market size of China's CRO sector is projected to reach 162.9 billion RMB in 2025 and further expand to 174.7 billion RMB in 2026.  <a href="https://www.seccw.com/Document/detail/39193.html">https://www.seccw.com/Document/detail/39193.html</a>	N/A	N/A	Combiphar, Dexa Medica, Bernofarm, Sanbe Farma, Kalbe Farma, and other local pharmaceutical companies Additional: Biofarma (for vaccines)	N/A	N/A	In 2020, a total of 265 facilities were licensed by the Drug Control Authority (DCA), Ministry of Health Malaysia. (NPRA annual report 2020) This cover facilities that produce pharmaceuticals, health supplements, traditional medicine, and veterinary products, including contract manufacturing organizations.  A List of all Licensed Manufacturers in the QUEST System is available on <a href="https://www.npra.gov.my/index.php/en/informationen/quest-list-of-manufacturers-wholesalers-importers/quest-list-of-manufacturers.html">https://www.npra.gov.my/index.php/en/informationen/quest-list-of-manufacturers-wholesalers-importers/quest-list-of-manufacturers.html</a>	Existing legislations allow contract manufacturing in the Philippines. These provide alternatives for companies to just contract manufacture products locally instead of establishing their own manufacturing plants.	Beacons, A-Bio Pharma, CCM and more	N/A	OLIC (Made a subsidiary of Fuji Chemicals Industrial on August 3, 2012) Inter Thai Pharmaceuticals ( <a href="http://www.interthaipharma.com">http://www.interthaipharma.com</a> )	Local: DGH, Traphaco, Domesco, IMEXPHARM, OPC, Cuu Long, Pharmedic etc.

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		RDPAC/PhIRDA	HKAPI	OPPI	IPMG	JPMA	KPBMA/KRPIA	PhAMA	PHAP	SAPI	IRPMA	PReMA	PG
Pharmaceutical industry groups	Name of main organization (Please insert weblink if available)	N/A	The Hong Kong Association of the Pharmaceutical Industry (HKAPI) <a href="http://www.hkapi.hk">www.hkapi.hk</a>	<ul style="list-style-type: none"> <li>Indian Drug Manufacturers' Association (IDMA) was formed in 1961: Membership of over 1000 wholly-Indian large, medium and small companies.</li> <li>Confederation of Indian Pharmaceutical Industry</li> <li>Organisation of Pharmaceutical Producers of India (OPPI) - Established in 1965, OPPI represents the research-based pharmaceutical companies in India.</li> <li>Indian Pharmaceutical Alliance was founded in 1999. Represents 23 national India based pharma companies</li> </ul>	<p>[1] International Pharmaceutical Manufacturers Group (IPMG): a group in which major foreign-affiliated companies participate <a href="http://www.ipmg-online.com/?&amp;lang=eng">http://www.ipmg-online.com/?&amp;lang=eng</a></p> <p>[2] GP Farmasi (GPF): an organisation of local generic companies <a href="http://www.gpfarmasi.or.id">www.gpfarmasi.or.id</a></p>	<p>Federation of Pharmaceutical Manufacturers' Associations of Japan (FPMAJ)</p> <p>Japan Pharmaceutical Manufacturers Association (JPMA)</p> <p>Japan Generic Medicines Association</p> <p>Japan Self-Medication Industry Association</p> <p>Japan Association of Proprietary Medicine Manufacturers</p> <p>Japan Ophthalmic Pharmaceutical Manufacturer's Association</p> <p>Japan Kampo Medicine Manufacturers Association (JKMA)</p> <p>Home Medicine Association of Japan</p> <p>Topical Formulation Council</p> <p>Japan Association of Vaccine Industries (JAVI)</p> <p>Intravenous Solutions Society</p> <p>Japan Blood Products Association</p> <p>Nationwide Household Delivery Drug Association</p> <p>Japan Association of Clinical Reagents Industries</p> <p>Pharmaceutical Contract Manufacturers Association</p> <p>Forum for Innovative Regenerative Medicine</p>	<p>KRPIA (Korea Research-based Pharmaceutical Industry Association): <a href="http://www.krpia.or.kr/">http://www.krpia.or.kr/</a></p> <p>KPBMA (Korea Pharmaceutical and Bio-pharma Manufacturers Association): <a href="https://www.kpbma.or.kr/">https://www.kpbma.or.kr/</a></p> <p>KoBIA (Korea Bio medicine Industry Association): <a href="http://www.kobia.kr/">http://www.kobia.kr/</a></p> <p>KoreaBIO: <a href="https://www.koreabio.org/">https://www.koreabio.org/</a></p>	<p>Pharmaceutical Association of Malaysia (PhAMA): Innovative R&amp;D-based pharmaceutical companies. (<a href="http://www.phama.org.my/">http://www.phama.org.my/</a>)</p> <p>Malaysian Organisation of Pharmaceutical Industries (MOPI): local manufacturers of generic drugs. (<a href="http://www.mopi.org.my/">http://www.mopi.org.my/</a>)</p> <p>Malaysian Association of Pharmaceutical Suppliers (MAPS): importers of generic drugs (<a href="http://www.i-maps.my/1.asp">http://www.i-maps.my/1.asp</a>)</p>	<p>Pharmaceutical and Healthcare Association of the Philippines (PHAP) <a href="http://www.phap.org.ph">http://www.phap.org.ph</a></p> <p>Philippine Chamber of Pharmaceutical Industry (PCPI)</p> <p>Philippine Pharmaceutical Manufacturers Association (PPMA)</p>	<p>Singapore Association of Pharmaceutical Industries (SAPI) <a href="http://www.sapi.org.sg">www.sapi.org.sg</a></p>	<ol style="list-style-type: none"> <li>Taiwan Pharmaceutical Manufacturer's Association (TPMA) <a href="http://www.tpma.org.tw/">http://www.tpma.org.tw/</a></li> <li>Taipei Pharmaceutical Agents and Distributors Association (TPADA) <a href="http://www.tpada.org.tw">http://www.tpada.org.tw</a></li> <li>International Research-based Pharmaceutical Manufacturers Association (IRPMA) <a href="http://www.irpma.org.tw/">http://www.irpma.org.tw/</a></li> <li>Taiwan Pharmaceutical Marketing &amp; Management Association (TPMMA) <a href="http://www.tpmma.org.tw">http://www.tpmma.org.tw</a></li> <li>Taiwan Pharmaceutical Manufacture &amp; Development Association (TPMDA) <a href="http://www.cpmda.org.tw/">http://www.cpmda.org.tw/</a></li> <li>Chinese Association for Pharmaceutical Agents (CAPA) <a href="http://www.capa.org.tw">http://www.capa.org.tw</a></li> <li>Taiwan Generic Pharmaceutical Association (TGPA) <a href="http://www.tgpa.org.tw">http://www.tgpa.org.tw</a></li> <li>National Pharmaceutical Commercial Association of R.O.C (NPCA) <a href="http://www.npca.org.tw">http://www.npca.org.tw</a></li> <li>Taiwan Research-based Biopharmaceutical Manufacturers Association (TRPMA) <a href="http://www.trpma.org.tw/">http://www.trpma.org.tw/</a></li> </ol>	<ul style="list-style-type: none"> <li>Pharmaceutical Research &amp; Manufacturers Association (PReMA) <a href="http://www.prema.or.th">www.prema.or.th</a> [Thailand's research based pharmaceutical association]</li> <li>Thai Pharmaceutical Manufacturers Association (TPMA) [Thai domestic industry association]</li> <li>The Medical Device Technology Industry Association (THAIMED)</li> <li>Thai Self Medication Industry Association (TSMIA)</li> </ul>	<p>Pharma Group – represents innovative pharmaceutical industry (operating under EuroCham)</p> <p>Vietnam Pharmaceutical Companies Association (VNPCA) – represents local pharmaceutical industry</p>

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Access & Medical Services	<p>In March 2025, the National Health Commission issued the "2025 National Medical Quality and Safety Improvement Targets," with a key focus on enhancing the mutual recognition rate of medical examination and test results among healthcare institutions. By promoting cross-institutional result recognition, the initiative aims to further improve resource utilization efficiency, reduce costs, and enhance the patient experience, while also refining the professional quality control improvement targets across various medical specialties.</p> <p><a href="https://www.nhc.gov.cn/yzygj/c100068/202503/ad63fb8ce9e24013a68db52049ecc524_shtml">https://www.nhc.gov.cn/yzygj/c100068/202503/ad63fb8ce9e24013a68db52049ecc524_shtml</a></p> <p>On September 7, the State Council formally approved the "Implementation Plan for Strengthening the Foundation of Medical and Health Services." The approval emphasizes that implementing this initiative is a major measure to carry out the guiding principles of health work in the new era, enhance the capabilities of primary medical and healthcare services, and advance the construction of a Healthy China.</p> <p><a href="https://www.gov.cn/zhengce/content/202509/content_7039977.htm">https://www.gov.cn/zhengce/content/202509/content_7039977.htm</a></p>	<p><b>Policy Address 2025:</b> The Government will set up the Hong Kong Medical Products Centre for Regulation and submit a legislative proposal on regulating medical devices in 2026, with a view to establishing the centre as an internationally recognised regulatory authority for medical products as soon as possible</p> <p>The HA will set up the <b>Office for Introducing Innovative Drugs and Medical Devices</b> in the first half of 2026 to <b>actively identify needs and benefits of innovative drug treatments</b> for local patients <b>through big data analytics</b>, and contact innovative drug and medical device manufacturers to make good use of the "1+" registration mechanism to proactively introduce into Hong Kong innovative drugs and medical devices that are cost-effective and beneficial to patients. (HKB) [64]</p>	<p>The Indian healthcare system is evolving towards better healthcare implementation and coverage. However, even today, the health-care system faces several challenges,</p> <p><b>Key Challenges</b></p> <p><b>Low Health Expenditure</b></p> <p>The National Health Policy 2017' envisaged increasing health spending as a percentage of GDP to 2.5 percent by 2025'. However, as per the National Health Estimates for 2021-22, Government Health Expenditures (GHE) as percentage of GDP stood at 1.84 per cent. In fact in India, only one-third of all health expenditure is covered by government funding, which is significantly lower than other countries.</p> <p>In comparison to other nations' expenditure (7.6% on average for countries under Organization for Economic Co-operation and Development (OECD) and 3.6% on average for BRICS countries), the country's expenditure on public health system is approximately 1.3%.</p> <p>This low Government expenditure on health has constrained the capacity and quality of healthcare services in the public health sector leading to high Out of Pocket Expenditure on healthcare</p> <p><b>Source:</b> How healthy is the health budget of <i>Amrit Kaal: 2023-24?</i> <a href="https://pmc.ncbi.nlm.nih.gov/articles/PMC10931870#:~:text=To%20conclude%2C%20the%20health%20budget,will%20boost%20the%20healthcare%20sector.">https://pmc.ncbi.nlm.nih.gov/articles/PMC10931870#:~:text=To%20conclude%2C%20the%20health%20budget,will%20boost%20the%20healthcare%20sector.</a></p> <p>National Health Estimates 2021-22 <a href="https://nhscindia.org/sites/default/files/2024-09/NHA%202021-22.pdf">https://nhscindia.org/sites/default/files/2024-09/NHA%202021-22.pdf</a></p> <p><b>Inadequate Infrastructure</b></p> <p>The Hospital Industry Accounts For 80% Of the Healthcare Market In India. However, inadequate physical infrastructure with lack of proper equipment &amp; facilities has crippled the overall healthcare delivery in India.</p> <p>As per National Health Profile 2018, India had 1 bed per 1844 population or 0.54 beds per 1000 population. As per national Health Profile 2021, India has 8,25,235 beds or 0.6 beds per 1000 population which is much lower than the world average of 3 beds/1000 population . In November 2023, Knight Frank in a report also stated that India needs an additional 2.4 million (24 lakh) hospital beds to reach the recommended ratio of 3 beds per 1,000 people.</p> <p>Recently Brickwork Ratings India in a report titled Private Hospitals Sector in India released in November 2025 stated that needs 2.4 million more hospital beds</p> <p><b>Source:</b> <i>Key sectors within the healthcare industry</i> <a href="https://www.wrightresearch.in/encyclopedia/chapter-report/chapter-3-key-sectors-within-the-healthcare-industry#:~:text=Hospital%20industry,USD%20193.59%20billion%20by%202032.">https://www.wrightresearch.in/encyclopedia/chapter-report/chapter-3-key-sectors-within-the-healthcare-industry#:~:text=Hospital%20industry,USD%20193.59%20billion%20by%202032.</a></p> <p>Brickwork Ratings India report titled Private Hospitals Sector in India <a href="https://www.brickworkratings.com/Research/Private%20Hospitals%20report_10Nov2025.pdf">https://www.brickworkratings.com/Research/Private%20Hospitals%20report_10Nov2025.pdf</a></p> <p><b>Source:</b> Lok Sabha Q/A dated March 22m 2022 <a href="https://sansad.in/getFile/loksabhaquestions/anne/x/178/AJ3683.pdf?source=pqals#:~:text=As%20per%20national%20Health%20Profile%202021%2C%20India%20has%208%2C25%2C235,0.6%20beds%20per%201000%20population.&amp;text=Public%20Health%20and%20Hospitals%20is,the%20re.">https://sansad.in/getFile/loksabhaquestions/anne/x/178/AJ3683.pdf?source=pqals#:~:text=As%20per%20national%20Health%20Profile%202021%2C%20India%20has%208%2C25%2C235,0.6%20beds%20per%201000%20population.&amp;text=Public%20Health%20and%20Hospitals%20is,the%20re.</a></p> <p>The recent health sector reforms in India have laid emphasis on strengthening health infrastructure as well as human resource in the public sector system. This can be observed in the rise in the number of Sub-centres (SCs), Primary Health Centres (PHCs), and Community Health Centres (CHCs) in rural areas, along with the rise in doctors, nurses, and other medical personnel over time. Ayushman Bharat Health Infrastructure Mission (ABHIM) to play a key role in strengthening the public health infrastructure to fill the critical gaps. Government has also launched the Viability Gap Funding Scheme (VGF) to create hospitals in PPP mode.</p> <p><b>Lack of skilled workforce</b></p> <p>According to MoH data, there are 13,86,136 allopathic doctors registered with the State Medical Councils and the National Medical Commission (NMC) as of July 2024. The doctor-population ratio in the country is around 1:836 which is better than the WHO standard of 1:1000.</p> <p>Health Ministry's own data – Rural Health Statistics Report 2021-22 released in January 2023 revealed there is an 80% shortfall of specialists at community health centres   This includes surgeons (83/2%), obstetricians and gynecologists ( 74.2%) , Surgeon ( 83.2%) and pediatricians (81.6%)</p> <p><b>Lack of Health Coverage</b></p> <p>Low Government expenditure on health has constrained the capacity and quality of healthcare services in the public sector. It diverts majority of individuals – about two-thirds – to seek treatment in the costlier private sector. However, low financial protection leads to high out-of-pocket expenditure (OOPE). India's population is vulnerable to catastrophic spending, and impoverishment from expensive trips to hospitals and other health facilities.</p> <p>The catastrophic effect of healthcare spending is not limited to the poor impacts all segments of the population . At least 30% of the population, or 40 crore individuals – called the missing middle are devoid of any financial protection for health. The AB-PMJAY and State Government extension schemes, provide comprehensive hospitalization cover to the bottom 50% of the population – around 70 crore individuals. Around 20% of the population – 25 crore individuals – are covered through social health insurance, and private voluntary health insurance. The remaining 30% of the population is devoid of any health insurance. The actual uncovered population is higher due to existing coverage gaps in PMJAY and overlap between schemes. Therefore, in the absence of a low-cost health insurance product, the missing middle remains uncovered despite the ability to pay nominal premiums.</p> <p><b>Source:</b> Niti Aayog Report Health Insurance for Missing Middle. October 2021 <a href="https://www.niti.gov.in/sites/default/files/2023-02/Health-Insurance-for-India%E2%80%99s-Missing-Middle_08-12-2021.pdf">https://www.niti.gov.in/sites/default/files/2023-02/Health-Insurance-for-India%E2%80%99s-Missing-Middle_08-12-2021.pdf</a></p> <p><a href="https://mohfw.gov.in/sites/default/files/9147562941489753121.pdf">https://mohfw.gov.in/sites/default/files/9147562941489753121.pdf</a></p>	<p>• Differences in status of doctor deployment depending on the region: There is still a shortage of doctors, but the pattern of deployment is a bigger problem than the number of doctors. Fifty percent of the hospitals in eastern Indonesia have a doctor shortage, whereas the hospitals in western Indonesia have more doctors than they need. This regional difference in the deployment of healthcare professionals is a major problem.</p> <p>• Necessity of disease countermeasures including measures to reduce HIV/AIDS and lifestyle disease countermeasures against diabetes, etc.</p> <p>• Correction of regional differences in medical services (correction of uneven distributions of doctors and nurses)</p> <p>• Expansion of facilities that accommodate medical tourism (accommodating tourists going overseas)</p> <p>[ "Report on the survey a nd analysis of medical ne eds overseas and the sta tus of Japanese compani es' entry into foreign mar kets": <a href="http://www.mhlw.go.jp/file/06-Seisakujouhou-10800000-Iseikyoku/0000074947_3.pdf">http://www.mhlw.go.jp/file/06-Seisakujouhou-10800000-Iseikyoku/0000074947_3.pdf</a>]</p>		<p>[KRPIA] It is necessary to see if it is applied during the actual PE review process, and to respond to various drug price reduction mechanisms. In particular, the industry is paying attention to the PE waiver track for new drug listing, which has improved patient accessibility for rare diseases and anticancer drugs with very small number of patient, as the government recognizes it as a preferential exemption system and is expected to control various things such as RWE and performance based RSA scheme.</p>	<p>PhAMA conducted a survey in 2024 which captured top market access challenges faced by industry. They are:</p> <p>Regulatory approvals: The process and timelines to approve medicines in Malaysia are slower compared to peer countries, therefore potentially causing negative impact to patient care.</p> <p>Formulary listing: Key challenges are unavailability of funding, no sustainable financing mechanism and lack of guidance to HTA requirements to advocate access</p> <p>The criteria, process and timelines to include medicines into the MOH Medicines Formulary (or Blue Book) are delayed and may be unclear.</p> <p>Tender challenges: The criteria, process, advance notice, timelines, and transparency for MOH tenders are unclear especially post CPTPP implementation. MNCs/pharmaceutical companies are systematically not invited to tender briefings/updates.</p>	<p>• The UHC Act has generated much hope and expectation for Filipinos. However, several hurdles must be addressed before UHC can be truly felt in the country, especially against the backdrop of the COVID-19 pandemic. For example, there is still very limited health facilities and healthcare professionals in the country, especially in the primary care setting. This is coupled by patient perception that in case of illnesses, a hospital is the first place to visit. This results to flocking at tertiary level hospitals, even for cases that can be handled in primary care facilities. Another is the very limited funding and subsequently, government support/ subsidy</p> <p>• Health facilities and healthcare workers are maldistributed, with large concentration in urban areas</p> <p>• Health information system is also lacking, making data-driven decision-making difficult. There is also no central patient information system.</p> <p>• Infrastructure for pooled procurement and price negotiations is being built but needs further improvement. Central pooled procurement and multi-year obligations provide opportunities to leverage greater volumes to bring down prices.</p> <p>• Traceability for logistics management is also lacking.</p> <p>• This year, PhilHealth launched its outpatient medicine program, entitled Guaranteed and Accessible Medications for Outpatient Treatment (GAMOT). This new program reimburses around 75 medicines with plans for expansion.</p>	<p>• <b>Ageing population and increasing chronic disease burden</b>, driving sustained demand for hospitals, primary care, community and long-term care services.</p> <p>• <b>Rising healthcare costs and affordability pressures</b>, particularly for non-subsidised drugs, private care and newer high-cost therapies.</p> <p>• <b>Public-private access divide</b>, with longer waiting times for public-subsidised specialist care and elective procedures, contrasted with faster but significantly more expensive access in the private sector.</p> <p>• <b>Hospital capacity constraints and bed shortages</b>, especially during peak periods and as patient stays become longer and more complex with ageing.</p> <p>• <b>Healthcare manpower shortages and workforce burnout</b></p> <p>• <b>Delayed or deferred care due to cost concerns or bill uncertainty</b>, even among insured patients, affecting early diagnosis and timely treatment.</p> <p>• <b>System complexity in navigating subsidies, insurance and MediSave</b>, leading to confusion, delayed decisions and financial anxiety for patients.</p>	<p>No restriction for patient access medical services, patients can seek for medical services from NHI contracted medical organizations island wide.</p>	<p>No new significant issue</p>	<p>Throughout the last years, multiple legislations from Law to Circular level has led to several positive developments to improve the process for drug registration in Vietnam, further attention and support from the Government is needed to ensure the regulation itself and the implementation phase can ensure (i) quality assurance for patient safety, (ii) harmonization of regulatory requirements, (iii) reduction of unnecessary administrative burden, and (iv) fair and equal access to the market. With the new Pharmaceutical Law No. 44/2024 coming into effect, it is expected that the Ministry of Health will increase their efforts to provide detailed guidance, and the partner role of the industry will become more pronounced in terms of continuing to highlight sound, reasonable international best practice.</p>

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Generic Policy and advance	<p>On March 28, 2019, the National Medical Products Administration (NMPA) issued the Announcement on the Selection and Determination Procedures for Reference Preparations of Chemical Generic Drugs (2019 No. 25). As of June 30, 2025, the NMPA has released a total of 93 batches of reference preparation catalogs, encompassing 8,094 specifications across 2,787 varieties.</p> <p>Building upon previous explorations, the National Medical Products Administration (NMPA) will summarize experiences and continue advancing the selection of reference preparations for domestically developed innovative drugs. This initiative aims to ensure drug safety, efficacy, and quality control, thereby better meeting public medication needs. <a href="https://www.nmpa.gov.cn/zwgk/jyta/rdjy/20251013163452161.html">https://www.nmpa.gov.cn/zwgk/jyta/rdjy/20251013163452161.html</a></p>	N/A	<p>The applicable regulations on the registered medical practitioners, i.e., Medical Council (Professional Conduct, Ethics and Etiquettes), Regulations 2002 was amended in 2016 mandating every physician to prescribe drugs with generic names.</p> <p>Further, vide office order dated May 12, 2023 addressed to all doctors, in the central government hospitals/CHGS wellness centers/ polyclinic, the DGHS reiterated that prescription has to be for generic medicines only. It is also stated that all head of institutions may ensure strict compliance by doctors working under them and if anyone continues to be non-compliant he/she shall be liable for further action.</p>	-	<p>Increasing the rate of generic to 80% (quantity base) in all prefectures until the end of FY2029.</p>	<p>[KPBMA] The MFDS revised the Pharmaceutical Affairs Act to restrict joint use of BE test to prevent the issue of excessive number of identical generic drugs flooding the market. According to the newly established bill on July 20, 2021, the number of items that may be approved by using previously submitted BE test or clinical trial data shall be limited to three.</p>	<p>Public facilities have been practicing generic-first policy since 2017. The National Generic Medicines Policy Framework was launched in March 2025. This also explains the declining market shares for innovator pharma once the product loses its patent and a generic version is available.</p> <p>In 2025, insurance companies also sent out official letters to private hospitals to adopt the generic-first policy to reduce treatment cost and cap medical inflation. One insurance company instructed a generic-only medicine policy for patients with long-term conditions.</p> <p>Source: <a href="https://pharmacy.moh.gov.my/en/documents/national-generic-medicines-framework.html">https://pharmacy.moh.gov.my/en/documents/national-generic-medicines-framework.html</a></p>	<p>• The DOH advocates the use of generics. While market reports already confirmed the dominance of generics as a whole, the DOH pushes for the use what they call as "true generics", ie generic medicines without brand names. DOH continue to claim that generics (true generics) is still not widely available in the country, and uses this as justification for their policy recommendations such as:</p> <ul style="list-style-type: none"> <li>◦ The use of maximum retail price (mandatory price cuts). DOH sees that there is little/lack of competition in the market, making medicines prices high. Due to market failure, DOH believes that MRP should be used.</li> <li>◦ Generics-only prescribing</li> <li>◦ Mandatory generic substitution at the retail level</li> <li>◦ Mandatory price reduction at patent expiry</li> </ul>	<p>A consortium between regulators in Australia, Canada, Singapore and Switzerland has selected generic drug review as a priority area for collaboration. This consortium, ACCESS has included UK since October 2020.</p> <p>• The fast-track registration process for generic drugs imported from India (the verification-CECA evaluation route) was set up under a Memorandum of Understanding (MoU) on economic cooperation between Singapore and India. This obviates the need for Indian manufacturers to obtain clearances to export drugs to Singapore, provided that the generic has been approved by at least one of the five international agencies referenced by the HSA. The process does not guarantee automatic market entry, as it is also subject to certain qualification criteria.</p> <p>• Branded products dominate the generic market, Indian manufacturers are expected to increase their foothold in Singapore's generics market, with more companies following the lead of Ranbaxy Laboratories, Strides Arcolab, Intas and Dr Reddy's by taking advantage of the fast-track approval system for Indian generics.</p> <p>• Chinese manufacturers do not enjoy a particularly good reputation in Singapore, and Chinese generics companies are unlikely to play a major role in the market during the next five years.</p>	<p>In the drug policy reform proposal, NHIA indicated that the pricing methodology would be possible changed to give 10% price premium for generic and biosimilar, which are manufactured in Taiwan and conduct BA/BE study in Taiwan.</p>	<p>Primary Care system Telemedicine and telepharmacy</p>	<p>Resolution 29 (17 November 2022) at the 6th Plenary of the Communist Party of Vietnam reiterates the country's blueprint for development goals to 2030, vision 2045. This Resolution emphasized the key role of innovation in helping Vietnam to address current and future challenges. The Resolution also identifies pharmaceutical as one of the priority sectors that will enable and drive innovation. Resolution 36 (30 January 2023) of the Politburo envisions Vietnam becoming a significant partner in the global life sciences sector, in particular being a hub in Asia for biotechnology and having this industry as an important economic driver.</p> <p>The National Steering Committee should develop and oversee the implementation of national strategies, including Decision No. 376/QĐ-TTg dated 17 March 2021 of the Prime Minister. This committee is recommended to direct the development of policy incentives to attract further investments from innovative industries, with a focus on three key pillars: i. Attract investment in clinical trial activities as an enabler to further develop Vietnam's R&amp;D capabilities; ii. Enable Vietnam to become the destination of choice for investment in brand name manufacturing and technology transfer activities in the region; and iii. Develop and embed leading digital healthcare infrastructure. Resolution 72 (09 September 2025) of the Politburo asserts that "health is the most valuable asset and the most importation for the prosperous and sustainable development of the country". This Resolution suggests a shift in the healthcare objectives from treatment to prevention by adopting a holistic, life-course approach to health and strengthening preventive health across all aspects (funding, infrastructure, service quality, reach, and workforce). Furthermore, Resolution 72 emphasized improvement to primary care, reformation of health financing, mobilization and efficient use of diverse resources, among other policies.</p>

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Health insurance system challenges	<p>In 2025, the National Healthcare Security Administration (NHSA) advances healthcare security reform across four key areas:</p> <ol style="list-style-type: none"> <li>1. the NHSA continues to deepen centralized volume-based procurement of drugs and high-value medical consumables. It carries out the eleventh round of national drug procurement and the 6th round of consumables procurement, aiming to curb inflated prices, strengthens access to innovative drugs, and further improves the efficiency of healthcare fund utilization.</li> <li>2. Effort accelerate to establish a long-term care insurance system with universal coverage, improving mechanisms such as immediate enrollment for newborns at birth and bedside processing, and expanding medical insurance coverage for assisted reproductive technologies, thereby enhancing protection for both the elderly and children.</li> <li>3. the NHSA optimizes direct cross-provincial settlement for medical services and expands the cross-provincial mutual-aid use of individual accounts under the employee medical insurance personal accounts, improving the convenience of medical services for the mobile population.</li> <li>4. the NHSA refines the multi-tiered healthcare security system by issuing the first edition of the Category C Drug List to guide commercial health insurance in covering innovative drugs. Meanwhile, it promotes the standardization of the medical service pricing system to better meet the diverse healthcare needs of the population.</li> </ol> <p><a href="https://www.gov.cn/zhengce/202501/content_6999594.htm">https://www.gov.cn/zhengce/202501/content_6999594.htm</a></p> <p>On December 13, 2025, the National Medical Security Working Meeting in Beijing was held in Beijing. The meeting emphasized that China's healthcare insurance reform in 2026 will focus on consolidating universal coverage, improving the basic medical insurance system, supporting the development of commercial health insurance, establishing a multi-tiered healthcare security framework, strengthening the management of healthcare insurance funds to safeguard their security, and actively responding to population development strategies by promoting the development of maternity insurance and long-term care insurance.</p> <p><a href="https://www.nhsa.gov.cn/art/2025/12/13/art_14_19020.html">https://www.nhsa.gov.cn/art/2025/12/13/art_14_19020.html</a></p>	<p>Voluntary Health Insurance Scheme</p>	<p>Health insurance penetration in the country is still minuscule. Millions of people end up spending significant earnings on healthcare services which makes their financial situation more difficult. According to a National Insurance Academy (NIA) report, 31% of India's population still lacks health insurance. Several factors contribute to this protection gap, such as low health insurance penetration, insufficient coverage, rising medical costs, lack of understanding of insurance products, and high costs. Government insurance covers also sometimes limit of expenses to be incurred on individual per year &amp; process to avail these insurance seeking reimbursement is sometimes challenging. Since health insurance is a crucial aspect of financial security for families and essential for a robust healthcare ecosystem, there is a need to bridge the protection gap. IRDAI, and the government are taking many initiatives to improve the health insurance penetration in India.</p>	<p>• Universal health insurance: The plan is to sequentially unify all services into a universal health insurance system by 2019. The due date for mandatory enrollment of company employees in BPJS is January, 2015, but it will be a matter of waiting for results to see how far enrollment has progressed.</p> <p>• Increase in enrollee coverage rate in universal health insurance system.</p> <p>• Under the new system that came into force in January, 2014, coverage of all citizens by 2019 was established as the goal, and it is gradually being implemented. Other challenges include securing financial resources, enrollment of the self-employed and farmers, the greater part of the "uninsured" who make up about 40% of the population, and the lack of medical facility infrastructure development, and the shortage of healthcare personnel.</p> <p>• Securing financial resources . . . A fund of 1.3 to 1.6 trillion is necessary for full-scale operation of a PBI for low-income people, and this is a burden on government resources.</p> <p>• Promotion of the e-catalog system (electronic procurement system that supports the universal health insurance system)</p>	<p>Sustainability of Public Health Insurance</p>	<p>[KRPIA] As the health care environment changes due to aging society, health insurance expenditure continues to increase. In response, the government has sought to stabilize the cumulative finance by continuously pursuing spending efficiency measures through streamlining the ratio of the medical fee structure, adjusting the copayment rate, and reducing drug prices, and improving the tax system. Nevertheless, the financial condition of health insurance is expected to deteriorate due to the continuous increase in the elderly population and the expanding of coverage. Accordingly, the government keeps up the scrutiny to secure fundamental sustainability of the health insurance system through social consensus as well as the fundamental system improvement plan such as reform of payment system, drug price system and financing for stabilization of health insurance.</p>	<p>With MOH increasingly pressured to manage rising medical inflation, there are concerted plans for a robust Health Financing System.</p>	<p>• Financial protection from PhilHealth is limited, resulting to high level of household OOP (out of pocket) in the country. While the benefit packages are purported to cover from diagnosis to treatment, there is no specific allocation for each component of the package. Since the value/support is limited and most medicines are taken outside the hospital, medicines are excluded in the benefit and paid for by patients OOP.</p> <p>• The establishment of health technology assessment (HTA) as a prerequisite for PNF inclusion, as well as the concurrent review of all existing products in the PNF has put the process in a transition phase, halting the nomination process for new products. The process and requirements described in the HTA process could take as long as two years and undermine patient access to innovative medicines. Given the importance of PNF inclusion for government procurement and product inclusion in benefit packages, it is imperative that a fit-for-purpose and a transparent and efficient PNF listing process be put in place by the government.</p>	<p><b>Rising Healthcare Costs:</b> Managing the financial sustainability of health insurance schemes amidst escalating healthcare costs driven by technological advancements and an ageing demographic. <b>Insurance-driven cost inflation and "buffet syndrome"</b>, where generous Integrated Shield Plan (IP) and rider coverage reduces price sensitivity and encourages over-utilisation of specialist consultations, diagnostics and procedures, contributing to higher overall healthcare charges, especially in the private sector.</p>	<p>Because payment to individual medical facilities is on a fee-for-services basis, there are problems with frequent Outpatient Department visits of 15 visits in average and the so-called 3-minute consultation. They are experimenting with a number of systems, including a total budget control system, three-month chronic prescriptions, but frequent OPD visits remain as a challenge to NHIA. Taiwan introduced individual hospital global budgeting in January 2025, shifting from system-wide allocation to hospital-specific budgets. The reform aims to strengthen accountability, encourage efficient resource use, and stabilize National Health Insurance (NHI) spending. Early outcomes show expenditure growth has slowed, with hospitals more cautious in expanding services and admissions. This has promoted greater focus on efficiency and prioritization of high-value care. However, challenges remain. Preventable hospitalizations continue to strain capacity, and emergency room overcrowding has not eased significantly. To address these issues, the government has introduced complementary measures, such as separating ER nursing fees from consultation charges and allocating NT\$3 billion annually to improve staffing and bed availability. Overall, the reform has delivered better cost control and hospital-level accountability, but persistent bottlenecks in ER services and uneven resource distribution highlight the need for further adjustments. Continuous monitoring of hospital performance and integration of patient access safeguards will be critical to ensuring that global budgeting achieves both financial sustainability and quality care.</p>	<p>No significant issue</p>	<p>Government policy seeks to broaden access to healthcare and improve the quality of provision. This will involve further investment in expansion and restructuring of the public hospital sector and efforts to strengthen primary care provision. Both are sorely required, as major city hospitals continue to battle chronic overcrowding, but effective implementation of healthcare reforms could be hampered by funding issues, staff and equipment shortages, and poor management. Pressure on the healthcare system will intensify as social health insurance (SHI) coverage increases. 95.2% of the population is now covered by the SHI system with full nationwide coverage targeted by 2030'. Most uninsured patients are poor, and funding coverage for this segment of the population will drive up public health expenditure.</p> <p>While the network of hospitals, composed of both branch, provincial level and national level facilities, provides the country with a high number of beds per inhabitant, it still has not solved the issues of high bed occupancy rate and Vietnam continues to far exceed the 80% threshold occupancy rate recommended by the WHO. Having too many patients in higher level hospitals has become an urgent problem in recent years, with two to three patients sharing a bed becoming common in many central and provincial hospitals. Bed occupancy rates have reached 120–160%, especially in the central hospitals of some large cities. Overcrowding in higher level healthcare facilities may have several causes, including limited healthcare quality in lower level facilities in districts and communes, and even in provincial hospitals; increasing expectations of service quality; improvement in convenience of transportation from remote areas to central areas; and limited differences in hospital fees at different administrative levels. This may lead to a drain on resources in higher level hospitals and subsequent wastage at lower levels.</p> <p>Beyond the inequality of care, the overall quality of services provided is the major reason for the high occupancy rate. The average length of stay is significantly longer on average in Vietnam than in other South-East countries. The outdated medical equipment, combined with the limited access to the latest drugs in Vietnamese public hospitals (and specifically in the small provincial level hospitals) are commonly cited as the major challenges to improving the quality of care in Vietnam.</p>

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Reimbursement or payment system challenges	<p>On August 15, 2025, the National Healthcare Security Administration issued the <i>Interim Measures for the Management of Diagnosis-Related Group (DRG)-Based Payment under Medical Insurance</i>. Aiming to improve the efficiency of medical insurance fund utilization, regulate medical service practices, and optimize resource allocation, the Measures establish a nationally unified, vertically coordinated, and standardized DRG-based payment system. Key provisions systematically regulate supporting measures, including total budget management, disease group classification and biennial adjustment, composition and negotiation mechanisms of payment standards, exceptional case-based negotiation, and prepayment arrangements. <a href="https://www.nhsa.gov.cn/art/2025/8/15/art_104_17573.html">https://www.nhsa.gov.cn/art/2025/8/15/art_104_17573.html</a></p> <p>On December 13, 2025, the National Medical Security Working Meeting in Beijing was held in Beijing. The meeting emphasized that in 2026, China's healthcare insurance payment system will focus on optimizing payment and settlement mechanisms to promote the healthy development of medical services, enhancing multi-channel payment capabilities for innovative drugs, accelerating the implementation of direct settlement for maternity medical expenses across provincial insurance pools, and achieving full cross-province utilization of individual accounts under the employee medical insurance system. <a href="https://www.nhsa.gov.cn/art/2025/12/13/art_14_19020.html">https://www.nhsa.gov.cn/art/2025/12/13/art_14_19020.html</a></p>	N/A	<p>Most of the private medical insurance companies provide cashless hospitalization for the patient in designated hospitals but the amount for the same is limited to an extent &amp; cost of medicines is often not covered, critical illness like cancer are omitted from some insurance offering .Government insurance covers also sometimes limit of expenses to be incurred on individual per year &amp; process to avail these insurance seeking reimbursement is sometimes challenging. For the medicines which are not in formulary patients have to purchase the medicines and seek reimbursement</p>	<p>• Until the new system is complete, the uninsured bear all costs themselves. • Generic drug prescriptions are expected to increase with the introduction of the universal health insurance system, and prescribing of generic drugs is in fact increasing. • The government legally obligates public medical institutions to use low-cost generic products. • In many cases, new drugs are not covered by public insurance, and since non-branded generics are listed under public insurance to begin with, it is assumed that the importance of having their products listed in insurance drug lists will increase for pharmaceutical companies that sell branded generics.</p> <p>INA-CBG reimbursement system The INA-CBG reimbursement system for the provision of JKN inpatient services is accompanied by clinical guidelines, which encourage doctors to reduce drug costs by prescribing cheaper alternatives to help manage capped budgets. Together with the e-catalogue, it places the burden of cost-containment on the shoulders of hospitals and their physicians. The regulation of prescribing in public hospitals has been tightened and treatment guidelines enforced more strictly, requiring adherence to the FORNAS and clinical pathways in order to secure reimbursement. Prescribers have a little more leeway for the treatment of some serious conditions, reflecting the fact that certain flat-sum tariff calculations exclude drug costs. The limited nature of JKN coverage and the financial status of patients can affect drug choice and the duration of prescriptions, however, while moves to limit coverage for some cancer drugs have affected physician choice (see National Drug Formulary). Source :IQVIA Market Prognosis</p>		<p>[KRPIA] Under the RDRG, numbers of healthcare institutions are applying the scheme. -RDRG was applied to 27 private hospitals in two stages in August 2018 and January 2019. As of October 2022, based on HIRA data, the total number of medical centers which implement RDRG system turned out 98 across the nation, including both public hospitals and private hospitals.</p>	<p>1) Navigating complex tender and procurement processes 2) Negotiating with payers and insurers for favourable terms 3) Ensuring compliance and accuracy in dossier submissions</p>	<p>Hospitals have threatened to cut ties with the PhilHealth for its continuing delays in payment. The last amount is around P25.45 billion (486 Million USD) which the state insurer promises to pay in 6 months.</p> <p>Past reports of fraudulent claims, with the organization facing several investigations on corruption allegations, were identified as a reason for careful disbursement process</p>	<p><b>Implementation of Healthier SG:</b> Aligning reimbursement models with the Healthier SG initiative, which emphasizes preventive care and may require restructuring current payment systems.</p>	<p>The average time required from regulatory approval of a new drug to price listing is 427 days [2016 MOHW New Drug Control Summary]. It takes that long because there must be HTA evaluation and a meeting of an expert committee (corresponds to Central Social Insurance Medical Council of Japan). Moreover, Price Volume Agreement, Manage Entry Agreement or both negotiations must be conducted between the corporation and the MOHW for drugs whose annual projected sales within the 5 years after price listing exceed NTD 200 million, and this leads to delays in reimbursement.</p>	<p>Even more patients visited hospitals, but as of budget limitation there were various new policies announced and implemented to limit the cost mainly for CSMBS for example OCPA for oncology treatment and will be expanded to other high-cost medicines.</p>	<p>Under current practice, even when a pharmaceutical product is granted an MA/visa number, it is still not eligible for reimbursement, as it has to be enlisted into the National Reimbursement List (NRL).</p> <p>Circular 30/2018/TT-BYT was replaced by list stipulated by Circular 20/2022/TT-BYT dated 31 Dec 2022 List of modern medicines, biologicals, radiopharmaceuticals and tracers covered by health insurance, insurance coverage ratio and payment conditions. Meanwhile, multiple legislations concerning the health insurance and NRDL are being revised in 2025 and 2026. Altogether, with current practice, new pharmaceuticals may have to wait several years for MA and inclusion in the NRL thereafter, effectively causing considerable delay in bringing new reimbursed treatments to Vietnamese patients and contributing to medical tourism. In order to ensure faster access to new, innovative pharmaceuticals, it is recommended that reimbursement should be possible as soon as they receive MA, in line with other ASEAN markets.</p>

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Drug price and pricing system challenges	<p>On July 24, 2025, the National Healthcare Security Administration announced that the selection principle for centralized drug procurement will no longer rely solely on the lowest bid. In the eleventh round of centralized drug procurement, the NHTSA optimized key rules: selection will no longer be based purely on the lowest price, and set an "anchor price".  <a href="https://www.gov.cn/zhengce/202507/content_7033699.htm">https://www.gov.cn/zhengce/202507/content_7033699.htm</a>                      In 2025, the National Reimbursement Drug List for the first time establish a Commercial Health Insurance Innovative Drug List, the drugs included in which are not covered by the basic medical insurance fund.  <a href="https://www.nhsa.gov.cn/art/2025/12/7/art_53_18971.html">https://www.nhsa.gov.cn/art/2025/12/7/art_53_18971.html</a></p>	<p>The Hospital Authority rolled out the new drug enlistment system (DAC system) in February 2025. Cost-Assessment Panel was set up to cost effective assessment for new drug enlistment.</p>	<p><b>Arbitrary and unpredictable price control orders under DPCO 2013</b>                      Arbitrary and unpredictable price fixations by using NPPA's plenary powers under Para 19 to price regulate even non-scheduled formulations cause considerable business uncertainties whereby manufacturers lose the foresight of future business. Price Controls in certain cases are not in a transparent manner giving the industry adequate foresight and flexibilities to implement the same.                      In addition, the remit of direct price control should not be expanded beyond the specific inclusions in NLEM. Innovative formulations (Modified Release, Sp. delivery routes), isomers, prodrugs, analogues, derivatives, advanced drug-device products must not be considered included unless specifically included in NLEM. Further, Ceiling Prices once fixed must not be subjected to revision/re-fixation every time the National List of Essential Medicines (NLEM) is revised as it leads to re-averaging of already reduced prices.  <b>Patented Product Pricing</b>                      Though there is a provision in the National Pharmaceutical Pricing Policy (NPPP), 2012 for a separate pricing regime for patented drugs, currently, under the DPCO 2013, pricing of patented drugs is treated at par with non-patented and generic drugs and fixed based on market-based pricing, wherever possible.                       Government price setting provisions which do not recognize the value of the research and development, stymies innovation. Patents and other intellectual property protections are required to provide economic incentives to inventors and investors to invest risk capital in inventive activity – a very high-risk undertaking. Research and development of life saving new treatments and cures for unmet medical needs are necessary and must be encouraged.                       Also, there are concerns regarding the application of Trade Margin Rationalization (TMR) on high value non-scheduled medicines where trade margin is arrived at by a formula that does not exclude free medicines provided under Patient Assistance Programs (PAP), which results in deep price cuts on patented and proprietary medicines. Further, the 2019 amendment to Para 32 of DPCO 2013 that allows manufacturers of patented medicines to apply for exemption from price controls for five years from the commencement of marketing in India (as well as a permanent exemption for orphan drugs) has not been implemented for importers of patented medicines and orphan drugs. The overall lack of transparency, predictability and reasonableness in implementing policies that impact pricing of patented medicines creates an unviable business environment.   <b>Retrospective implementation of price controls under DPCO 2013</b>                      Ceiling prices once fixed or revised by NPPA are expected to be implemented by companies immediately even for the batches already in the retail chain and pharmacies across the country. Such price fixations can never be practically implemented by manufacturers at the retail level. Such provisions only add up to delinquency and causes business uncertainties. Ideally, the implementation of price fixation orders must be mandated only prospectively, i.e. for products manufactured after date of price notification.</p>	<p>Self-estimated price (HPS) is currently used as one of the references in the drug procurement system and selection process in e-catalogue. Challenge is, this HPS system is thought to have restricted the tender and negotiation process and lack of explanation and transparency of the calculation.                      • The economic fallout from the COVID-19 pandemic will intensify pressure on drug prices. The MOH is attempting to extract savings through the widespread procurement of unbranded generics, while branded generics and innovative drugs face tough negotiations for e-catalogue drug procurement contracts. However, more price flexibility could be awarded to manufacturers of essential medicines that are in short supply due to pandemic-related disruptions.                      • The MOH's cost conscious approach to drug procurement, which is handled by the National Public Procurement Agency (LKPP), will continue to favor unbranded generics in e-catalogue tenders. Existing e-catalogue procurement contracts were repeatedly extended through 2020 as a result of the COVID-19 pandemic, before a backlog of agreements was negotiated during the fourth quarter of 2020 through to April 2021. These will guide public sector purchasing until 2023.                      Source :IQVIA Market Prognosis</p>	<p>Response to inflation in drug pricing</p>	<p>[KRPIA]                      1. Long review process                      - By regulation, new drug listing process should complete in 240 – 270 days but in practice it takes much longer time. In 2017, based on what HIRA reported, it took 348 days for new oncology drugs however, if all days for Reply-To-Question submission counted, it went up to 757 days in total from the initial submission to the final listing. More than 3 folds of what's written in regulation.                      - Similarly, reimbursement coverage expansion review process becomes much longer as well in 2020.                      2. Lack of value recognition for innovation                      (1) Low flexibility with ICER application                      The government is said to grant reimbursement for new drugs which fall in 1 – 2 times GDP per capita range as the ICER evaluation threshold however the government keeps applying US\$ 20,000 – 45,000 based on GDP per capita back in 2010. Korea's GDP per capita was US\$23,087 in 2010 but US\$31,846 in 2019. ICER threshold should be updated properly along Korea's economic growth.                       (2) Limited scope with RSA system                      It is true that the government made improvement with target scope of RSA system in 2020 where a follower drug to initial RSA drug may also be granted RSA eligibility, but overall RSA target therapeutic areas still limited to only life-threatening cancer/rare diseases. The government should open up RSA system for other diseases including chronic diseases.                       (3) CEA waiver products to be subject of RSA refund                      Upon newly revised regulation as of '20 Oct 8th, CEA waiver products will be mandated not only for expenditure cap as previous but also for refund.                       3. Ongoing scrutiny for cost-containment                      Cost containment efforts including drug price reduction should go hand in hand with funding efforts for access to innovation, but the government keeps focusing on the former.                      (1) Evidence-based reevaluation of drug benefits                      - Part of the task of reinforcing the pharmaceutical benefits scheme through reevaluation of insurance benefits.                      - Plan full-fledged implementation of reevaluation system based on drug clinical efficacy following a pilot program (choline alforserate) in 2020.                      - Differentiation and gradual application of evaluation methods by type of listing process are being prepared. Based on the results of the reevaluation, follow-up measures such as adjustment of drug prices, reimbursement standard, and determination of whether to maintain health insurance benefits will be implemented.                      (2) Finance-based reevaluation of drug benefits                      - Part of the task of reinforcing the pharmaceutical benefits scheme through reevaluation of insurance benefits.                      - Plan to introduce 'regular re-pricing system' in 2021, where drug reimbursement prices are adjusted based on overseas drug prices from IRP basket countries, as another post-listing price control measure.                      - Methodology and details of re-pricing system are to be drafted during 1H 2021.</p>	<p>The Parliamentary Public Accounts Committee held a series of 10 stakeholder engagements in Q1-2025 to analyse the reason for medical inflation and compile a thorough report to be raised to the Cabinet in July 2025.                      Pharmaceutical industry players were among one of the stakeholder groups, where we presented on the complex eco-system of the pharmaceutical sector.                       There is a general call to reduce prices, and increase local manufacturing of medicines to tackle rising medical inflation.</p>	<p>IN 2020 and 2021, the government imposed draconian price cuts on 204 products ranging up to 96%. The medicines included those for hypertension, diabetes, cardiovascular disease (CVD), chronic lung diseases, neonatal diseases, major cancers, chronic renal disease, psoriasis and rheumatoid arthritis, among others.                       Executive Order No. 104: <a href="https://do.h.gov.ph/sites/default/files/health_advisory/EO%20No.%20104.pdf">https://do.h.gov.ph/sites/default/files/health_advisory/EO%20No.%20104.pdf</a> and Executive Order No. 155: <a href="https://www.officialgazette.gov.ph/downloads/2021/12dec/20211207-EO-155-RRD.pdf">https://www.officialgazette.gov.ph/downloads/2021/12dec/20211207-EO-155-RRD.pdf</a>                       These policies are the start of further price regulations in the future, as the DoH intends to cover 1,154-2,394 preparations or 26-54 percent of the medicines available in the market, which is estimated to reduce industry's annual revenues by approximately PHP 57 billion or almost USD 1.1 billion if fully implemented. To fully institutionalize the MRP policy, the DoH released its guidelines containing the: (1) constitution of a Drug Price Advisory Council, responsible for drug price evaluations and for recommending which drugs will be under price regulation and at what level; (2) the medicine review process, including the basket of countries for external reference pricing, medicine selection algorithm (incorporating public nomination of medicines for MRP), and formula for calculating MWP and MRP; (3) implementation guidelines, including exhaustion of inventory, publication and posting requirements; and (4) monitoring and evaluation (impact assessment).                       In addition, the DoH also proposed a legislation for the creation of a Drug Price Regulatory Board (DPRB) to oversee the MRP mechanism, with the sole task of regulating medicine prices.                       The MRP policy has contributed to a contraction in the prescription medicine market by as much as 18.2 percent (Q3 2020 vs. Q3 2019). Three products covered in the first wave of MRP were also withdrawn from the market, as the price cuts were unsustainable to maintain.                       An industry study found the following regarding the MRP policy:                      • Spending on medicine remains burdensome for patients because it is mostly sourced out-of-pocket.                      • MRP has a negative impact to health &amp; economy, affecting medicine availability &amp; launches, patient support programs, workforce, and investment appetite of companies.                      • Majority of doctors did not observe improved access despite improved affordability.                      There are alternative tools that can improve access sustainably.</p>	<p><b>Cost Management:</b>                      Balancing the introduction of advanced medical technologies and treatments with the need to keep drug prices affordable for the general population.</p>	<p>Because the previous year's drug expenditures are not taken into account when setting the DET target price, they calculate it by establishing the growth rate on the basis of the preceding year's target, and for this reason, there have actually continued to be negative revisions since DET trial calculation was introduced. DET will continue to be used on a trial basis until 2022, and expected to remain.</p>	<p>Median Price</p>	<p>Risk mitigated in 2025 with the recent (2024) issuance of both Price Negotiation Circular (Circular 05/2024/TT-BYT) and Tender Circular (Circular 07/2024/TT-BYT).</p>

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Intellectual property rights challenges	<p>According to the "Opinions on Comprehensively Deepening the Reform of Drug and Medical Device Regulation to Promote High-Quality Development of the Pharmaceutical Industry" emphasizes the improvement of intellectual property protection systems for drugs and medical devices, the acceleration of patent layout for original achievements, and the enhancement of patent quality and the efficiency of their commercialization in the pharmaceutical industry.</p> <p><a href="https://www.gov.cn/zhengce/content/202501/content_6996115.htm">https://www.gov.cn/zhengce/content/202501/content_6996115.htm</a></p>	No patent linkage	<p>i. Despite India's TRIPS obligation under Article 39.3, RDP is not enforced, leading to unfair commercial use of originator's data. Current rules allow reliance on originator's data for subsequent approvals without proper RDP, granting generics a commercial edge. Rules 75 and 80 of the New Drugs and Clinical Trials Rules, 2019 permit local clinical trial waivers, enabling faster generic entry without proper safeguards which consequently allows for approvals for subsequent drug applications to be made relying on regulatory dossiers submitted by the original applicant in other well-regulated jurisdictions.</p> <p>Thus, subsequent applicants are able to obtain marketing authorizations using the original applicant's regulatory data resulting in unfair commercial use of the innovator's data. This becomes even more of a public health issue when such data is used for approval of biologics, which differ from small molecules. Though there are ongoing deliberations to establish a level-playing field and on RDP, nothing has been firmed up as yet.</p> <p>ii. Section 3(d) imposes an additional efficacy hurdle, beyond TRIPS requirements, discouraging improvements in existing drugs.</p> <p>Varied application of 'enhanced therapeutic efficacy' by patent offices leads to unpredictability.</p> <p>Section 3(d) is indiscriminately applied in First Examination Reports, shifting the burden of proof entirely on the applicant.</p> <p>Absence of standard definitions for 'efficacy' or 'enhanced therapeutic efficacy' creates ambiguity and inconsistency.</p> <p>iii. India lacks PTE provisions, unlike countries such as the US, UK, Singapore, and Japan, which provide additional protection to account for regulatory delays. Lengthy regulatory approval processes shorten the commercial lifespan of pharmaceutical patents. Repeated oppositions extend patent grant timelines, reducing effective market exclusivity.</p> <p>iv. There is a lack of transparency and co-ordination between the Indian Patent Office and Indian Drug Regulatory Authorities, which leads to issuance of market approvals &amp; manufacturing licenses to companies during the term of a patent.</p> <p>There is a pressing need to establish a notification system, whereby patent holders are made aware in a timely manner in respect of applications made for market &amp; manufacturing licenses, so that appropriate action may be initiated.</p>	<ul style="list-style-type: none"> <li>• They have little experience with reviews, and there are disparities in the quality of reviews.</li> <li>• Reviews take time and are slow (throughout ASEAN).</li> <li>• Only the native language is recognized as the language for use in applications, and the burden of translation costs is large.</li> <li>• Movement to invoke compulsory licenses.</li> <li>• Drug inventions that could be subject to patented inventions are limited.</li> </ul>			<p>[KRPIA]</p> <p>• <b>Patent Term Extension (PTE) – Procedural Limitations and Ongoing Reform Discussions</b></p> <p>Unlike the prosecution of a patent application, a Patent Term Extension (PTE) applicant in Korea does not have an opportunity to partially amend or separately appeal rejected portions of a PTE request. If the Korean Intellectual Property Office (KIPO) issues a Preliminary Rejection, and the applicant fails to fully overcome all objections—even where KIPO acknowledges that a substantial portion of the requested extension is allowable—KIPO will issue a Final Rejection covering the entire PTE request. At that stage, the applicant cannot appeal only the disallowed portion while retaining the allowable extension. As a result, PTE applicants facing a Preliminary Rejection are often compelled to accept KIPO's initial determination of the allowable extension period, rather than risk a total rejection by contesting the disputed portion. This procedural structure continues to raise concerns regarding fairness and efficiency in the PTE system. In 2025, discussions on revising the Patent Act were initiated to address these issues, including proposals to allow partial appeals of rejected portions of a PTE request while preserving the allowable portion. As of 2026, however, no amendment introducing such a mechanism has been enacted, and the existing PTE examination and appeal framework remains in force.</p> <p>• <b>Patent–Regulatory Approval Linkage – Structural Challenges in Sales Stay Mechanism</b></p> <p>Under Korea's patent–regulatory approval linkage system, when multiple generic applicants seek approval for versions of the same original drug, a listed patentee must seek a sales stay against all such generics—typically by filing patent infringement litigation—within the statutory period. Failure to do so results in the forfeiture of the right to a sales stay against any generic applicant, including those that may infringe the listed patent. Practical difficulties arise because the scope of products considered the "same drug" under the Pharmaceutical Affairs Act does not always align with the scope of protection afforded by the listed patent. For example, different crystalline forms or hydrates of an active ingredient may be treated as the same drug for regulatory purposes, while different salts may be treated as different active ingredients. However, a listed patent may only cover a specific crystalline form or formulation, leaving no legal basis to assert infringement against certain generic products that nonetheless fall within the regulatory definition of the same drug. In such circumstances, the current linkage framework effectively forces patentees to choose between forgoing sales stay protection altogether, even against infringing generics, or initiating litigation against clearly non-infringing products, which may expose the patentee to competition law risks. This structural imbalance in the linkage system continues to be cited as a key challenge for patent holders and remains unaddressed as of 2026.</p> <p>• <b>Related Legislative Developments</b></p> <p>In parallel, legislative proposals introduced in 2025, including a bill to expand the scope of non-commercial compulsory licensing in public health emergencies, have further highlighted ongoing policy debates regarding the balance between patent protection and public interest considerations. These proposals remain under legislative review and have not resulted in enacted amendments affecting the patent-regulatory approval linkage or PTE systems as of 2026.</p>	<p>The Compulsory licensing imposed on a Hepatitis C drug in 2017 has been touted at international conferences as Malaysia's victory in increasing patient access to an expensive drug by defying the patent in the production of a generic substitute. There are concerns that CP could be imposed on other therapeutic areas such as oncology, which will dis-incentivize R&amp;D and innovation.</p> <p>Patent Linkage to be implemented by May 2027 according to the CPTPP requirements, however, terms of implementation are still unclear.</p>	<ul style="list-style-type: none"> <li>• There is a need for a more effective patent enforcement in the Philippines. In the past FDA would check the patent status of products, preventing the registration of follow-on products if patent is still valid. However, this was revised when a 2005 DOH Administrative Order (A.O. No. 2005-0001) took effect, effectively allowing applicants of follow-on products to continue with their registration and put the responsibility of monitoring patent validities to applicants and patent holders. This meant that patent holders if follow-on products passed FDA evaluation but the innovator still had patent validity, patent holders must pursue costly and time-consuming legal remedies to protect products from patent infringement.</li> </ul> <p>[A.O. No. 2005-0001:https://ww2.fda.gov.ph/attachments/article/15853/ao%201%20s%202005.pdf]</p> <p>A coordinated effort between the Intellectual Property Office of the Philippines (IPOP) and the FDA should be in place to prevent the FDA registration of a follow-on product until the expiration of the patent of the innovator product, or a sufficient time for the resolution of a patent infringement dispute.</p> <ul style="list-style-type: none"> <li>• In May 2021, a revised joint policy was issued by the DOH, DTI, FDA, and IPOP covering the issuance of Special Compulsory Licenses (SCLs). While the policy provides certain protection to patent holders (e.g. the requirement to negotiate first prevention of re-exportation, additional labeling requirements), concerns arise with the immediate granting of SCLs. According to the policy, failure to file an answer will warrant the immediate issuance of the SCL, notwithstanding the non-satisfaction of the requirements. This should not be the case, as the SCL must only be issued upon finding of the existence of a valid ground, in accordance with international rules, only in exceptional circumstances, and as a last resort. Decisions should be made through fair and transparent processes that involve participation by all stakeholders and consider all relevant facts and options.</li> </ul> <p><a href="https://pharma.doh.gov.ph/2021/08/12/supplemental-guidelines-to-joint-doh-dti-ipo-bfad-administrative-order-no-2008-01-the-implementing-rules-and-regulations-of-republic-act-9502-otherwise-known-as-the-universally-accessible-c/">https://pharma.doh.gov.ph/2021/08/12/supplemental-guidelines-to-joint-doh-dti-ipo-bfad-administrative-order-no-2008-01-the-implementing-rules-and-regulations-of-republic-act-9502-otherwise-known-as-the-universally-accessible-c/</a></p>	<p><b>Innovation vs. Accessibility:</b> Navigating the tension between protecting intellectual property to encourage pharmaceutical innovation and ensuring that essential medications remain accessible and affordable.</p>	N/A	<p>Patent situation is the same and based on new Drug Act in 2019, the application for registration of a drug formula will require disclosure of all patent or petty patent application numbers which went through the publication process according to the patent law.</p>	<p>Vietnam's international commitments in the CPTPP and EVFTA recently have some separate provisions on IP protection in the pharmaceutical sector, especially related to the security of trial data in drug registration and some measures to protect pharmaceutical inventions related to drug registration procedures. Furthermore, Vietnam's current security mechanism is purely security (keeping secrets), not protection of trial data in drug registration, and has not created market advantages for drug research and development pioneers. However, measures to safeguard Intellectual property rights are still lacking in both the current Pharma Law, its draft revision, the newly revised 2022 intellectual property law and Decree 65/2023 guiding its implementation. Only financial compensation, not patent term extension, as compensation in case of delayed MA issuance is available. Cross-ministerial collaboration will be crucial in address IPR challenges.</p>

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Challenges on government policy for pharmaceutical industry promotion, etc.	<p>The challenges faced by China's biopharmaceutical industry during its development primarily manifest in three areas: policy coordination and implementation efficiency, the construction of an innovation ecosystem, and globalization competitiveness and industrial chain autonomy. On one hand, processes such as regulatory review and approval, medical insurance reimbursement, and hospital market access involve multiple government departments, and inter-departmental coordination mechanisms remain to be improved, limiting the accessibility of innovative drugs. On the other hand, gaps remain in original innovation capabilities and key core technologies, research and development homogeneity is still prominent, and the integration of industry, academia, and research urgently needs strengthening. In addition, as enterprises expand internationally, they must build independent global industrial chains and commercialization capabilities while addressing external challenges such as differences in international regulatory frameworks. Policy optimization and corresponding measures to address these challenges include:</p> <p>1) deepening regulatory reform and establishing efficient inter-departmental coordination mechanisms, such as streamlining review and approval processes and exploring smart regulation;</p> <p>2) supporting innovation across the entire value chain by encouraging original and differentiated innovation and strengthening industry-academia-research collaboration;</p> <p>3) optimizing import/export and related policies to support enterprises in enhancing international competitiveness through technology licensing, localized production, and other means.</p> <p><a href="https://www.gov.cn/zhengce/202501/content_6996200.htm">https://www.gov.cn/zhengce/202501/content_6996200.htm</a>  <a href="https://www.gov.cn/zhengce/202504/content_7020850.htm">https://www.gov.cn/zhengce/202504/content_7020850.htm</a>  <a href="http://www.ce.cn/cysc/newmain/yc/jsxw/202507/t20250708_2353792.shtml">http://www.ce.cn/cysc/newmain/yc/jsxw/202507/t20250708_2353792.shtml</a></p>	<p>Most of the domestic makers are producers of generics. In particular, drugs imported from the EU and the US make up a large share of the market. 23 local licensed manufacturers.</p>	<p>The contribution from the government in the areas of health care is not satisfactory, which is approx 1.84 % of the GDP.</p> <p>Securing investments for R&amp;D funding remains a formidable challenge due to the extensive financial commitments required over an extended period and the high risk of failure. India's gross expenditure on R&amp;D and innovation (GERD) is relatively low with the country allocating merely about 0.7% of its GDP to research, trailing behind the developed and also some of the emerging economies such as the US (3.5%), Sweden (3.4%), Germany (3%), Israel (5.6%), and South Korea (5%) (as of 2021).<sup>34</sup> To accelerate and amplify the scope of innovation in India, it is imperative to increase the percentage of GDP spend on the R&amp;D India's regulations on clinical trials and new drugs is still evolving.</p> <p>Other challenges arising from recent government decisions to cut healthcare costs by forcing doctors to prescribe cheaper unbranded generic medicines and extending the range of drugs that are subject to price controls. It is also discouraging high-margin combination drugs and phasing out loan licensing (a form of contract manufacturing that increases pharmaceutical industry capacity) for safety reasons.</p> <p>The government also proposes to raise import duties on active pharmaceutical ingredients, the key elements of drugs, to boost the domestic industry and reduce India's over-dependence on imports from China for bulk drugs and APIs. This will likely increase manufacturers' costs for finished products.</p> <p>India Pharma's export prospects have been dampened by a strong rupee and a series of nontariff trade barriers in importing countries that either raise the costs of compliance, or -- in extreme cases -- lead to a denial of market access</p> <p>International Journal of scientific research and management (IJSRM)   Volumell4  Issue  06  Page sll4287-4302  2016   <a href="https://asia.nikkei.com/Business/Business-Insight/India-s-pharmaceutical-prescription-is-unhealthy2">[https://asia.nikkei.com/Business/Business-Insight/India-s-pharmaceutical-prescription-is-unhealthy2]</a>                      [MP India Q3 2020]</p>	<p>1. Decree 1010(local manufacturing) – in the future will be regulated in Minister of Health Decree on Health Supplies that is still being developed as per January 2025.</p> <p>2. Local Content Requirement(TKDN)</p> <p>3. Halal Law</p> <p>4. Patent Law</p>	<p>Promotion of innovation</p>	<p>[KPBMA]                      A bill that calls for fostering and supporting the pharmaceutical industry to be made a pan-governmental strategy will be reviewed. According to the bill, the Pharmaceutical Industry Promotion and Support Committee, which is currently under the Minister of Health and Welfare, will be upgraded to the Pharmaceutical &amp; Bio Industry Innovation Committee under the Prime Minister, and preferential provision for drugs manufactured by innovative pharmaceutical companies will be discussed.</p>	<p>The revised Guidelines on Advertising Medicines and Medicinal Products to the Public is far more extensive and places more restrictions upon promotions or publicity.</p>	<p>While ethical promotions are regulated by the Philippine FDA, challenge persists in monitoring establishments. Several reports of unethical behavior have been observed and no violations have been imposed by FDA.</p>	N/A	<p>In particular, at large hospitals, which have a major impact on drug expenses, there is fierce price competition for many kinds of drugs, and there is a need to promote "separation of dispensing from medical practice" as well as "measures to reduce drug price differentials" as means of eliminating this.</p> <p>There is also a need for revision of the OTC monograph (examination standards for designated drugs), including the relaxation of restrictions on ingredients and amounts thereof so that import and sale of drugs that are already on the market in the EU, US, and Japan will be possible, as well as a need to expand the list of Switch OTC ingredients with reference to Switch OTC products that have a track record of sales in Japan.</p>	<p>The healthcare sector in Vietnam is at a crossroads: as per capita income rises, infrastructure investments by the Government are increasing, and demand for quality healthcare products and services continue to rise. At the same time, Universal Healthcare Coverage and limited private sector financing are putting pressure on the State budget. Conscious of the huge challenges the country is currently facing, the Vietnamese government has set up a comprehensive roadmap to 2020 (which is being reviewed with new vision to 2035) to improve all major aspects of the country healthcare system. Several master plans have thus been issued since 2012 addressing key areas such as public health insurance, hospital services or access to drugs. Yet growth in these segments is subject to the evolution of regulations related to pharmaceuticals. The modernization of the Vietnamese healthcare system will require better and faster access to drugs and will need to go hand in hand with the predictability simplification of the current regulatory environment and bidding processes.</p>	

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Challenges of pharmaceutical industry	<p>According to McKinsey's analysis in the report "Building Bridges to Global Innovation," China's biopharmaceutical industry still faces multiple structural challenges in its core process of advancing onto the global innovation stage. At the level of original innovation, there remain gaps in upstream innovation capabilities and core platform technologies, and the ability to translate patent achievements into commercial value requires further improvement. At the level of global value realization, the industry urgently needs to upgrade from "China new" to "Global new," with the development of independently controllable global commercialization capabilities representing a key bottleneck. At the level of the global competitive landscape, Chinese enterprises continue to face significant challenges in transforming from "participants" in the global industrial chain to "rule-makers," while also needing to effectively respond to external uncertainties such as geopolitical factors.</p> <p><a href="https://mp.weixin.qq.com/s/h4vqYtLXbayDHucYvS4tcg">https://mp.weixin.qq.com/s/h4vqYtLXbayDHucYvS4tcg</a>  <a href="https://mp.weixin.qq.com/s/?_biz=MzkyMTc1Mjc0NQ==&amp;mid=2247489029&amp;idx=1&amp;sn=6fa451de99a2e5a69d13910a387a147b&amp;chksm=c02eaba2b2ec9410cfb7695d7c26ea6d64b7b2e4565952ab196e049b6f063db60ee4cf597874#rd">https://mp.weixin.qq.com/s/FHda-SnMeVBR5osRY1N1WQ</a></p> <p>In recent years, innovative drugs included in the National Reimbursement Drug List through national healthcare negotiations have seen an average price reduction of up to 60%, with some drugs experiencing even greater cuts. While this has improved patient access, it has also imposed significant revenue pressure on enterprises. For high-cost innovative therapies such as CAR-T, improving accessibility remains a major industry challenge. The National Healthcare Security Administration is implementing the "Initial Pricing Mechanism for Newly Listed Drugs" to establish a price stability period for high-level innovative drugs, providing predictable support for innovation from the payer side. <a href="https://zlx.zjmr.zj.gov.cn/news/331000161/14395.html">https://zlx.zjmr.zj.gov.cn/news/331000161/14395.html</a></p>	N/A	<p>Challenges faced while operating in global market</p> <p><b>Challenges in domestic market:</b></p> <p>The pharmaceutical industry is facing an unprecedented fast-changing environment, with new market and technological trends impacting the companies' operational strategies. Challenges that further exacerbate the situation include talent shortages, slow progress in research and innovation and pharmaceutical supply chain vulnerabilities exposed by global disruptions, such as the COVID-19 pandemic.</p> <p>Apart from that the aging population continues to remain a challenge, there is increasing demand for drugs and treatments to address the health issues that come with aging. In September 2023 a report titled India Ageing Report 2023 by United Nations Population Fund (UNFPA) India &amp; International Institute for Population Sciences (IIPS) stated that unprecedented rise in the ageing population will require having the right policies and programmes as one of the immediate priorities of the government and other relevant stakeholders.</p> <p>II. Public and government pressure to make drug prices more affordable: Pharmaceutical companies in India have been constrained to live with continuing focus of the government and also of the civil society on 'reasonably affordable medicines' irrespective of the fact whether they are generic or patented. All essential drugs are already price controlled under DPCO 2013. The ceiling prices so fixed are in certain cases so low, that the continued production of such drugs become unviable for manufacturers and discontinued. Further, based on complaints from consumers and civil society groups, NPPA has the power to put certain drugs under price control by using its plenary powers under Para 19 of DPCO 2013 without resorting to inclusion in the NLEM.</p> <p>One of the critical challenges of the Indian Pharmaceutical Industry continues to be delivering affordable medicines for a large section of the population of the country, as expected by the government. Reported high profitability, at least, of the listed pharmaceuticals companies gives an impression to the stakeholders, including the government, that there is a scope for further reduction of pharmaceutical prices in India.</p> <p>III. Inadequate penetration of current health insurance schemes: Health insurance coverage is still very low in India as compared to, among many other countries. Majority of the population end up spending significant earnings on healthcare services which makes their financial situation more difficult. 31% of India's population still lacks health insurance. Several factors contribute to this protection gap, such as low health insurance penetration, insufficient coverage, rising medical costs, lack of understanding of insurance products, and high costs.</p> <p>IV. Pricing of Patented Drugs: Innovative pharmaceutical products patented in India are expected to facilitate access to latest modern medicines to the country's population to meet their unmet needs, if available at a reasonably affordable price.</p> <p>Though there is a provision in the National Pharmaceutical Pricing Policy (NPPP), 2012 for a separate pricing regime for patented drugs, currently, under the DPCO 2013, pricing of patented drugs is treated at par with non-patented and generic drugs and fixed based on market-based pricing, wherever possible.</p> <p>Patented drugs constitute less than 5% of the Indian Pharmaceutical Market. These innovative drugs address several unmet medical needs and involves years and years of research and huge investments. New drug development is a complex, lengthy, expensive, and risky process and the innovator company invests significant amount of capital, time, and expert human resource for development of a new molecule.</p> <p>Government price setting provisions which do not recognize the value of the research and development stymies innovation. Patents and other intellectual property protections are required to provide economic incentives to inventors and investors to invest risk capital in inventive activity – a very high-risk undertaking. Research and development of life saving new treatments and cures for unmet medical needs are necessary and must be encouraged.</p> <p>Also, there are concerns regarding the application of Trade Margin Rationalization (TMR) on high value non-scheduled medicines where trade margin is arrived at by a formula that does not exclude free medicines provided under Patient Assistance Programs (PAP), which results in deep price cuts on patented and proprietary medicines. Further, the 2019 amendment to Para 32 of DPCO 2013 that allows manufacturers of patented medicines to apply for exemption from price controls for five years from the commencement of marketing in India (as well as a permanent exemption for orphan drugs) has not been implemented for importers of patented medicines and orphan drugs. The overall lack of transparency, predictability and reasonableness in implementing policies that impact pricing of patented medicines creates an unviable business environment.</p> <p>V. Ethics and Compliance: Concerns spanning from clinical trials to ethical marketing practices, are hugely bothering a large section of the as the pharmaceutical industry is increasingly facing stringent regulatory and media scrutiny in gradually expanding areas of business operations. UCPMP 2024 has several disclosure requirements that has raised confidentiality concerns. Ambiguities in respect of many provisions and clarifications issued under UCPMP 2024 have remained open to subjective interpretations.</p>	<p>1. Halal Law : Bill on Halal Product Assurance (called UU Jaminan Produk Halal No. 33/2014) contains mandatory of halal certificates &amp; labels for pharma products. Action taken : To exclude pharma products from halal requirements. Status: Pharma products (ethical) have to be certified in 2034 at the latest (Religious Affairs Minister's decree No 26/2019)</p> <p>2. Local Content Requirement as stipulated in the presidential regulation on government procurement No.16/2018 (prioritization on local pharmaceutical &amp; medical device products in the e-procurement system) – the new Minister of Industry's decree No. 35 of 2025 on Terms and Procedures for Domestic Component Level (TKDN) Certification and Corporate Benefit Weight (BMP) is in effect starting 12 December 2025.</p> <p>3. Drug procurement in JKN (National Health Security) à Sustainable healthcare financing; late payment from the hospital to the pharma industry; guarantee &amp; quality of drug services; focus on price. Adoption of MCDA (Multi Criteria Decision Analysis) as a tool / solution for multi-criteria (no more focus solely on price), multi-winner and multi-year policy implementation</p> <p>4. Patent Law (Article 20, Bill No.13/2016 stipulating the requirement of domestic processing for patented products). Current status à A Ministerial regulations (MoLHR) No.15/2018 about patent implementation stipulating 5 (five) years postponement and can be extended under certain reasons Additional:</p> <p>5. Decree 1010, first implemented in 2010, only companies registered as 'local manufacturing industry' can obtain marketing approval. Foreign companies without local manufacturing capabilities – including some multinationals – are classified as distributors, or 'PBF' (pharmaceutical wholesaler) enterprises. Those without a local manufacturing facility must contract with a domestic partner. Decree 1010 also stipulates that imported drugs must be manufactured locally within five years of initial shipments into the Indonesian market. The BPOM has pursued a flexible approach to local manufacturing requirements in practice, permitting the import of drugs that would otherwise not be available to the local patient population</p>	<p>Ecosystem, MFN, Tariff</p> <p>[KPBMA] Korean pharmaceutical related associations recently formed a pharmaceutical &amp; bio healthcare alliance for cooperation in the pharmaceutical and digital sectors. Participating organizations agreed that the pharmaceutical sectors are at an inflection point that is completely different from existing product development or treatment by combining them with digital technology, and decided to continue cooperation for preemptive responses in the future.</p>	<p>Increased movements within key industry players (restructuring, demerging, etc) creates instability, which makes it challenging for the industry to come together collectively as one against common issues. Preference for local manufacturers are also on the rise, with Generic-First Policy being included as a key priority in 13<sup>th</sup> Malaysia Plan 2025-2030.</p>	<p>Slow regulatory processes remain a major hurdle in providing access to innovative medicines. Current committed turnaround time for Certificate of Product Registration (CPR) is 180 calendar days. In practice, turnaround time ranges from two to four years. While another government agency, the Anti-Red Tape Act has been monitoring FDA performance, the industry is yet to see improvements.</p>	<p>HTA Processes</p> <ul style="list-style-type: none"> <li>• Current timelines and costs for Health Technology Assessment (HTA) evaluations can impact the speed at which patients gain access to innovative therapies and vaccines.</li> <li>• Broader Value Considerations in HTA <ul style="list-style-type: none"> <li>◦ Societal and economic benefits, such as productivity gains and reduced caregiver burdens, could be applied more consistently and transparently in HTA evaluations to fully capture the value of innovative therapies.</li> </ul> </li> </ul> <p>Affordability of High-Cost Therapies</p> <ul style="list-style-type: none"> <li>• The rising costs of advanced therapies present challenges in ensuring affordability for patients while maintaining sustainable healthcare financing.</li> </ul> <p>Supply Chain Resilience</p> <ul style="list-style-type: none"> <li>• Global disruptions highlight the importance of bolstering medicine security to address potential risks of stock shortages and reduce reliance on external manufacturing sources.</li> </ul> <p>Demand Predictability</p> <ul style="list-style-type: none"> <li>• Greater stability and predictability in procurement volumes would encourage long-term supplier investment.</li> </ul> <p>Streamlining Clinical Trial Start-Up Processes</p> <ul style="list-style-type: none"> <li>• Clinical trial start-up processes, including approvals, contract negotiations, and site activation, could benefit from greater standardization and efficiency to reduce delays.</li> </ul> <p>Enhancing Digital Infrastructure for Clinical Trials</p> <ul style="list-style-type: none"> <li>• Strengthening digital systems for trial recruitment, coordination, and management would improve operational efficiency and support the timely execution of clinical trials.</li> </ul>	<p>There are 9 associations in existence, but a good cooperative relationship has not There are 9 associations in existence, but a good cooperative relationship has not been established because of the underlying competition of interests between the original makers in Japan, EU, and US and the local generic makers, and a consolidation of opinions for the industry as a whole has not been achieved.</p>	<ul style="list-style-type: none"> <li>•Cost Containment</li> <li>•Median Price</li> </ul>	<p>1. Legal Entity: the pharmaceutical industry is going through a major change, companies are reconsidering their business models in Vietnam following new regulations (i.e. opportunity to establish FIEs), in order to ensure viable and sustainable model for business operations.</p> <p>2. Speed of access for new drugs: currently slow compared to neighboring countries, but the industry is positive that new regulations regarding registration will speed up the access time.</p> <p>3. Government procurement: there is a need for a sustainable and predictable environment that encourages investment and sector development while addressing short-term State budget concerns.</p> <p>4. IPR protection: The adoption of IP protections that conform to international obligations and standards, including meaningful regulatory data protection (RDP), clarification of the scope of patentable subject matter and implementation of effective patent enforcement and restoration mechanisms, consistent with its international commitments, would greatly assist Vietnam in creating a more predictable environment for investment in innovation and enhance transparency and predictability</p>	

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Foreign Investment Restriction/trade barrier	On July 7, 2025, The National Development and Reform Commission together with six other ministries and agencies, issued the "Notice on Implementing Several Measures to Encourage Domestic Reinvestment by Foreign-Invested Enterprises." The notice aims to promote the sustained and long-term development of foreign-invested enterprises in the Chinese market through a series of multi-dimensional measures. <a href="https://www.mofcom.gov.cn/zwgk/zcfb/art/2025/art_0ff6a6e5d284400fa600b24083ee2382.html">https://www.mofcom.gov.cn/zwgk/zcfb/art/2025/art_0ff6a6e5d284400fa600b24083ee2382.html</a>	N/A	Tariffs, Taxes & Duties  Trade in India is often conditioned by inadequate infrastructure, bureaucratic delays, high tariff and technical barriers to trade. Tariff barriers moreover constitute a significant trade barrier. Tariffs in India vary from sector to sector and between product groups. Tariff rates have been reduced over the past years, but are still quite high compared to other countries. Additional duty is generally applied to the import tariff, which means the total import duty often adds up to 30 pct. or more.  Corporate tax for foreign companies is approx. 30 pct. India has a high corporate tax rate of 30%, which is higher than the average of 23% in the OECD. This makes it less attractive for foreign investors to set up shop in India.  Procurement: The Indian Government's Make in India policy has increasingly excluded or disadvantaged suppliers that do not manufacture in India from participating in tenders. In September 2020, the Department for Promotion of Industry and Internal Trade (DPIIT), Ministry of Commerce and Industry issued a revised Public Procurement Order (PPO) that discriminates against non-local bidders (i.e., products with less than 20 percent local content) in all government tenders (except in permitted international tenders), although there are some exemptions to ensure operational continuity. Further, in December 2020, the DoP issued yet another restrictive order requiring a minimum 80 percent local content to qualify as a favored Class 1 local supplier and more than 50 percent local content to qualify as a Class 2 local supplier. The revised PPO was partially modified in July 2024 to further tighten its scope and implementation. In November 2022, the Indian Government created a list of Global Tender Enquiry (GTE) exceptions (exempt from localization requirements) that currently included 128 patented drugs. Further, PPO allows a price preference for local suppliers in government contracts.	• Preferential tax treatment under the law exists as a business incentive for making inroads into Indonesia, but this incentive is not actually functioning, because the taxation authorities sometimes will not permit preferential treatment. [ "Report on the survey and analysis of medical needs overseas and the status of Japanese companies' entry into foreign markets": <a href="http://www.mhlw.go.jp/file/06-Seisakujouhou-10800000-Iseikyoku/0000074947_3.pdf">http://www.mhlw.go.jp/file/06-Seisakujouhou-10800000-Iseikyoku/0000074947_3.pdf</a> ] • New entrants to the Indonesian market must select a partner, because investment is restricted to 85% by the negative list. • Moreover, foreign businesses must have their manufacturing facilities inside Indonesia.		Challenges for pharmaceutical companies • Shortening time to market investment Establish a clinical development schedule wherein new drug licenses could be obtained at the same time as in the country where the drug was first developed. Acquire skills for obtaining drug price approval in the shortest possible time. • Dealing with drug prices Frequency of drug price calculation rule revision is high. Insurance drug price for new drug approval is low compared to other foreign countries. There are various systems for drug price adjustment, and major drops in drug prices.  Challenges for companies associated with medical devices • Regulatory review The regulatory review period is long. The regulatory review criteria are unclear. • Insurance system Since product prices are determined by the insurance system, the products cannot be provided at appropriate prices. Fall in insurance prices. Limitations on the scope of insurance coverage. • Competition with local companies and Chinese companies Under the South Korean government's FTA, products are imported at low Customs duties or zero Customs duties from China and other signatories, and price competition is fierce. Once new entrants have formed a market for their products, the local companies start providing similar products at somewhat lower prices, which makes for tough competition. (See World Business Associates Co., Ltd.: "Report on the survey and analysis of medical needs overseas and the status of Japanese companies' entry into foreign markets (2015)	No new challenges	N/A	Proposed U.S. tariffs on imported pharmaceuticals, which could affect Singapore's pharma exports, are currently on hold pending ongoing negotiations with pharmaceutical companies and Singapore-specific trade discussions, but continue to pose a potential medium-term trade risk.	The following issues have been cited by pharmaceutical industry for years, however, these remained as challenges. 1. Re proper use of medical financial resources (eliminating the large price differentials) This means "promoting separation of dispensing from practice" and "measures to reduce price differentials", but in order for promotion of the separation of dispensing from practice to lead to elimination of price differentials, it will be necessary to promote chiefly at large hospitals, which have a major impact on drug expenditures. 2. Re promoting the introduction of new drugs The criteria for Category 1 (epoch-making new drugs) are strict, and the criteria for price calculation are also low, in addition to which prices are markedly decreased by the existing PVS or DET. This situation must not delay accessibility for patients or become a factor inhibiting the introduction of new drugs. Efforts need to be made to obtain speedy price approval so that expenditure on new drugs can be properly recovered. 3. Re revision of OTC monographs Since there are many regulations on ingredients and quantity, drugs that have already been marketed in Japan, EU, or US cannot be imported and sold. Another issue is the continuing growth in the number of Switch OTC ingredients in Taiwan with reference to Switch OTC products that have been sold in Japan.	-	Vietnam continues to reserve the right to distribute to hospitals for local companies.

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Counterfeit medicines, etc.	On March 12, 2025, the National Healthcare Security Administration, the Ministry of Human Resources and Social Security, the National Health Commission, and the National Medical Products Administration jointly issued the "Notice on Strengthening the Collection and Application of Drug Traceability Codes in the Fields of Medical Insurance and Work-Related Injury Insurance." The notice stipulates that the use of drug traceability codes in regulatory oversight will be strengthened, with a focus on building a big data-based supervision model centered on traceability codes, aiming to combat illegal activities such as drug substitution and unauthorized resale. <a href="https://www.gov.cn/zhengce/zhengceku/202503/content_7014584.htm">https://www.gov.cn/zhengce/zhengceku/202503/content_7014584.htm</a>	N/A	The 2020 ASSOCHAM study titled 'Fake and Counterfeit Drugs In India –Booming Biz' revealed that fake drugs constituted \$4.25 billion (Rs 352 crore) of the total \$14–17 billion (Rs 14 trillion) of the Indian domestic drug market. Additionally, patentees often face challenges in the form of the counterfeit drugs being illegally imported into India from the neighboring countries like Nepal and Bangladesh and sold through online pharmacies. The Government of India has no mechanism to curtail such illegal imports leaving the patentees to track the potential infringers and file patent infringement suits.	BPOM has further developed counterfeit and substandard drug reporting mechanisms (through HALOBPOM's multiple channels: phone call, SMS, WhatsApp, email, official social media and website) due to the increasingly widespread circulation of counterfeit drugs.  Healthcare practitioners in hospital and health centers are recommended to report directly via the BPOM Mobile application that hosts more reporting features.  Based on the report by MIAP (Indonesian Anti-Counterfeiting Society), counterfeit drugs problem continues to increase due to increased recommendation for license revocation by BPOM, as first quarter 2018 BPOM has issued 230 recommendations for revocation of licenses. In addition to field monitoring and regulatory enforcement, BPOM has conducted intensive digital tracking, removing around 1.35 million online links distributing illegal products over the past three years. In July 2025 alone, 190 thousand new links were found and taken down.  Source: 1. <a href="https://www.pom.go.id/siaran-pers/siaran-pers-pengawasan-dan-pengendalian-peredaran-obat-palsu#:~:text=Apabila%20masyarakat%20memerlukan%20informasi%20lebih,Loka%20POM%20di%20seluruh%20Indonesia.">https://www.pom.go.id/siaran-pers/siaran-pers-pengawasan-dan-pengendalian-peredaran-obat-palsu#:~:text=Apabila%20masyarakat%20memerlukan%20informasi%20lebih,Loka%20POM%20di%20seluruh%20Indonesia.</a> 2. <a href="https://en.antaranews.com/news/391657/bpom-ensures-tight-supervision-of-illegal-products-across-indonesia#:~:text=Current%20Issue,BPOM%20ensures%20tight%20supervision%20of%20illegal%20products%20across%20Indonesia,track%20down%20and%20apprehend%20offenders.">https://en.antaranews.com/news/391657/bpom-ensures-tight-supervision-of-illegal-products-across-indonesia#:~:text=Current%20Issue,BPOM%20ensures%20tight%20supervision%20of%20illegal%20products%20across%20Indonesia,track%20down%20and%20apprehend%20offenders.</a>		The pharmaceutical serial number system is a mechanism where a serial number is assigned to allow tracking of drugs throughout the manufacture, import, distribution and use stages. This prevents counterfeit or illegal drugs from entering the market and allows those with issues to be recalled before reaching patients, leading to improved drug safety. With clearer distribution paths that can block potential prescription drug kickbacks, pharmaceutical distribution has become more transparent. (Source: "This is how, 'Pharmaceutical Serial Number system will be implemented," Pharmaceutical Management General Information Center, November 2015)	Increased online purchases of medicines exposes the public to new and greater dangers of counterfeits.	According to a report from the United Nations Office on Drugs and Crime report, the Philippines leads in the number reported cases of pharmaceutical crime in Southeast Asia. The report said that the Philippines accounted for 193 of the 673 incidents reported from 2013 to 2017.  The current pandemic has highlighted the issue of counterfeiting, and the proliferation of unauthorized online sellers of prescription medicines and vaccines, which may also be counterfeit. Counterfeit medicines were reported at the height of the lockdown, with some claiming to be used for the treatment of COVID-19. Unregistered COVID-19 vaccines were also reported to be smuggled in the country.	<b>Market Surveillance:</b> HSA is strengthening measures to detect and prevent the distribution of counterfeit medicines, particularly with the rise of online pharmaceutical products sales.	N/A	GLP1	The definition of "counterfeit medicines" is defined in the 2016 Pharma Law. In 2023, Vietnam saw an increase in incidents involving counterfeit medicines uncovered. Intervention by responsible authorities is dependent upon violations reports from companies and the public. Violations are penalised in line with Article 194 of the 2015 Criminal Law. Besides, trademark registration conducted in bad faith and misleading naming (including both names of companies and medicines) have become a challenge for many companies.
Other Market access challenges	-	N/A	Population: India has the world's second-largest population & existing healthcare infrastructure is just not enough to meet the needs of the population. The central and state governments do offer universal healthcare services and free treatment and essential drugs at government hospitals. However, the hospitals are understaffed and under-financed, forcing patients to visit private medical practitioners and hospitals  Insurance: India has one of the lowest per capita healthcare expenditures in the world. The high out-of-pocket expenses in India stem from the fact that at least 30% of the population, or 40 crore individuals – called the missing middle are devoid of any financial protection for health. Rural-urban disparity: In India, there is a significant disparity in healthcare access between rural and urban areas, with rural communities facing a severe shortage of healthcare services due to a lack of doctors, hospitals, and infrastructure, while the majority of healthcare resources are concentrated in urban centers, leading to poor health outcomes in rural populations; this disparity is further exacerbated by factors like poverty and limited access to transportation in rural area.	Single winner policy that affects sustainability of pharma industry in Indonesia; BPJS is constantly plagued with deficit (estimated > 2 billion USD) created late payment from hospital to pharma companies		none	Long registration timelines of around 2-3 years, resulting in Malaysia not being a preferred country for first launch of new drugs.  Challenges in getting drugs registered into the National Drug Formulary. Currently, a Budget Impact Analysis is the only requirement, without taking into account societal perspectives.	• The Philippines imposes a mandatory discount scheme, wherein the pharmaceutical industries pay for the discount of certain population groups such as Senior Citizens, Persons with Disability, National Athletes, and proposals to include Solo Parents.  The unclear formula and inequitable sharing has led to the higher burden of cost being carried by the manufacturers with no contribution from the government, adversely impacting the pharmaceutical industry.	Public spending on medicines in Singapore remains relatively low as a proportion of overall healthcare expenditure. As a result, the inclusion of new therapies into public funding schemes is influenced by system-level budget considerations, particularly for treatments with large eligible patient populations or higher anticipated budget impact. This can affect the timing and extent of public sector coverage for new medicines.  In addition, although ALPS conducts centralised procurement for public healthcare institutions, hospital formularies and adoption timelines can still vary across clusters. Differences in institutional implementation may lead to variation in the speed and scale of patient access across public hospitals, and contribute to uncertainty in real-world uptake patterns.	N/A	-	

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