White Paper

FIFARMA Patient W.A.I.T. Indicator & Root Causes 2026 — Latin America

Panama

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Overview of the study

- Improving the availability of innovative medicines in Latin America is a priority for all stakeholders in the healthcare system, especially policymakers, pharmaceutical manufacturers, and patients. Since 2004, the European pharmaceutical industry association (E.F.P.I.A.) has run the Patients W.A.I.T. (Waiting to Access Innovative Therapies) Indicator, enabling stakeholders to measure the availability rate of innovative medicines in 37 European countries. This study has been replicated to understand availability rate in ten Latin American Countries.
- The first EFPIA Patients W.A.I.T. Indicator was developed to understand the "availability" of innovative molecules, by creating a standardized method of comparing access to innovative medicines across distinct healthcare systems, and across years. FIFARMA (Federación Latinoamericana de la Industria Farmacéutica) developed indicators in a similar vein in Colombia (2016), Chile (2018) and Peru (2019), eventually leading to the first official LATAM W.A.I.T. Indicator study conducted in 2022.
- This year's FIFARMA Patient W.A.I.T. survey marks the fifth regional edition and measures the level of availability to innovation across ten Latin American countries, covering >80% of the LATAM population. These countries are Argentina (AR), Brazil (BR), Chile (CL), Colombia (CO), Costa Rica (CR), Dominican Republic (DO), Ecuador (EC), Mexico (MX), Panama (PA), and Peru (PE).
- The following pages feature analyses that benchmark the rate of availability and accessibility of innovative medicines in each of the ten LATAM countries, including analysis on regional availability, and how it has evolved over the period of investigation. This year's study includes 447 innovative molecules globally approved* from 2014-2025, which represent >80% of the globally approved NAS** in this period. These molecules span treatments across five therapeutic areas (TA): oncology, inflammation and immunology, central nervous system, cardiometabolic, and transversally, orphan drugs.
- Local pharmaceutical member associations (eight in total, see appendix for more details of the methodology and associations participating) worked in partnership with FIFARMA and IQVIA to develop the W.A.I.T Indicator study, chiefly in ensuring local market nuance is captured within parameters for the study, as well as local/regional directors of market access from manufacturer organizations who provided and validated the relevant aspects of the dataset.
- Ultimately, the goal of this reoccurring study is to create a lens into what access looks like across LATAM, with a specific eye towards understanding if, why, and in what direction the needle has moved in recent years. The learnings that are outlined are intended to serve as a catalyst for meaningful discussions across stakeholders to improve access to innovative medicines.

*'**Availability**' is used throughout to permit **standardized measurement** across 10 healthcare systems; **availability** represents the local reimbursement of a globally approved innovative medicine*

*Global approval is defined as a molecule that has regulatory approval in the United States of America by the FDA, or in Europe by the EMA
**NAS refers to New Active Substances as defined by the IQVIA Institute, see appendix for definitions and selection criteria

Additional scope and validation

- Access to innovative medicines across LATAM remains highly uneven, with notable disparities between countries and between public and private healthcare sectors. To further understand these disparities, this year's report includes a Root Causes section that adds quantitative and qualitative insight into the structural drivers of access delays and barriers. It focuses on the tension between innovation development and the healthcare systems and processes that govern access at the country level, as well as broad regional trends.
- Key areas explored include:
  - High-level disease burden, innovation, and novel medicine development trends
  - Structural features of healthcare systems that influence access
  - A deeper view into how these dynamics translate into access outcomes and the challenges faced along the route to access
  - Series of core principles to support constructive, multi-stakeholder dialogue and initial ideas to explore and build upon
- Together, the WAIT Indicator and its Root Causes section aim to support more informed, collaborative, and equitable decision-making across LATAM, ultimately contributing toward the multi-faceted effort to improve patient access to innovative medicines across the region.

The study is undertaken with private/public sector validation through multiple sources:









Added in 2026



"It's an optimistic view still, there are more challenges for real-life access than what we see here."

- ex-Minister of Health

Acronyms: NRC: Non-Retail Channels; AFIDRO: Asociación de Laboratorios Farmacéuticos de Investigación y Desarrollo; AMIIF: Asociación Mexicana de Industrias de Investigación Farmacéutica; MoH: Medical Officer of Health; TA: Therapeutic Area

Drug usage and spend analysis

- In addition to evaluating access, the 2026 WAIT report incorporates an analysis of drug usage (units) and spending (USD). Leveraging the FIFARMA WAIT Indicator 2025 alongside IQVIA MIDAS and country-level usage and spending datasets, this analysis quantifies not only availability but also extent of investment at a high level to reflect adoption of innovative therapies across LATAM.
- **Data sources and scope*:** Pharmaceutical spending and utilization data are derived from IQVIA MIDAS, and IQVIA country-level NRC databases, representing standardized estimates of market activity adjusted to support international comparability. Data reflects spend estimates based on list prices and projections, not net spending. It quantifies total market activity (all drugs) versus WAIT-specific activity (403 innovative drugs). The analytic period corresponds to MAT October 2025 (Moving Annual Total), a standardized measure representing cumulative sales or volume observed over the preceding twelve months, ensuring alignment with the WAIT reference window. A constant exchange rate (local currency to USD) methodology is applied for most countries; an exception is made for Argentina, where inflationary pressure and controlled exchange rates required a variable exchange rate methodology.
- **Channel segmentation*:** Usage and spending data are segmented between Retail and Non-Retail distribution channels. In many LATAM countries, Non-Retail channels are predominantly financed by government sources, while Retail channels are largely private and funded through patient out-of-pocket expenditures. This segmentation provides a useful proxy for assessing public-sector involvement and drug funding. In Brazil, only the public Non-Retail channel is considered, removing private payer (HMO) activity. Argentina and Colombia may show less direct correlation between channel and financing due to some public/private funding of Retail channels, but financing source separation is not possible in these cases. Data is also segmented into prescription and Over-the-Counter (OTC) drugs, with OTC defined as products that do not require a prescription and may be dispensed directly to consumers.
- **Normalization and context*:** Macroeconomic and demographic indicators were obtained from the WHO Global Health Expenditure Database (GHED) and the World Bank. These enable normalization of pharmaceutical spending across countries, allowing consistent evaluation of metrics such as drug spending per capita and drug spending as a share of GDP, providing essential economic framing for interpreting access and market behavior.

Full scope of the FIFARMA 2026 WAIT report

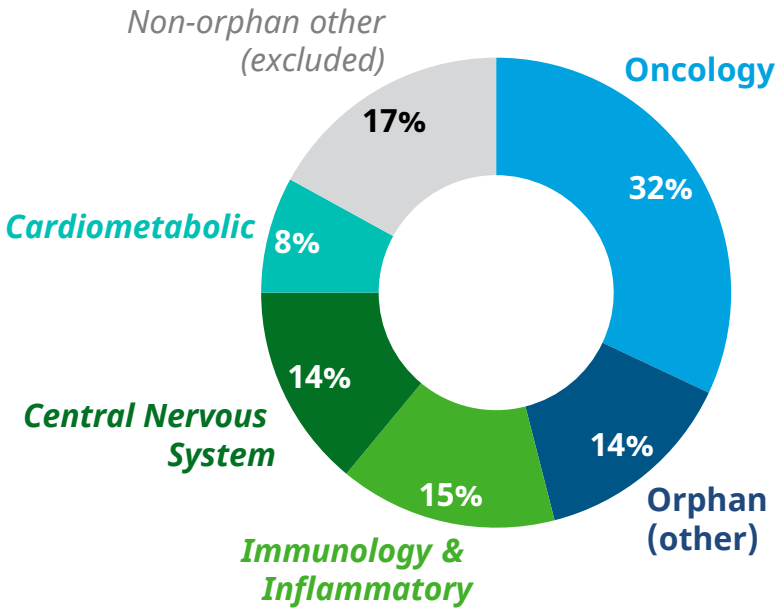


*See appendix for definitions, exchange rates, and indicators
Acronyms: NRC: Non-retail Channels; USD: US dollars; WHO: World Health Organization

Methodological considerations

A total of 447 new active substances approved between 2014-2025 by FDA/EMA across five therapeutic areas are analyzed

Molecule selection by therapeutic area 2026



The selection accounts for >80% of new active substance (NAS) in the study period (see appendix for further detail)

- A total of 447 molecules were selected based on several primary criteria:
  - New active substance
  - FDA or EMA approved between 2014-2025 (with no generics/biosimilars available in LATAM)
  - Global launch in the US, EU, UK, JP, so as to reflect molecules that are most likely to reach the global market, excluding agents that are launched predominantly for a given local market (e.g., local Chinese PDL1 inhibitors)
  - Utilization in treatment of disease (i.e., diagnostics, imaging agents, etc. are excluded)

Additional detail is outlined in the appendix

After initial filtering of NAS molecules based on primary criteria, therapeutic areas were selected in conjunction with FIFARMA to optimize the percentage of NAS included in the study, as well as the representativity and comparability of the molecules. Three main criteria were used:

- Percentage of NAS molecules
- Procurement e.g., TAs with percentages of supranational purchases like infectious disease, were excluded
- Global sales as per IQVIA MIDAS data

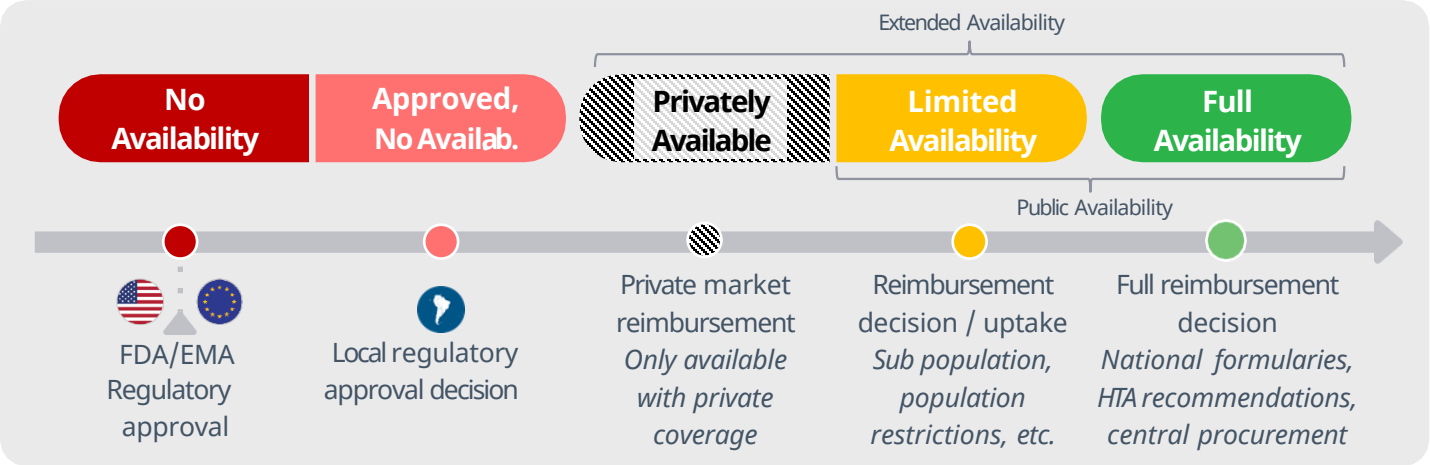
Orphan status may be determined by either the FDA or EMA, as per the first-approved indication

Acronyms: FDA: US Food & Drug Administration; EMA: European Medical Agency; NAS: New Active Substance; JP: Japan; US: United States; EU: European Union; UK: United Kingdom; PDL1: programmed death-ligand 1; TA: Therapeutic Area

Methodological considerations

Results from the study are shown in terms of different levels of availability and compared across countries

Availability definitions



NO AVAILABILITY

Not submitted, or in regulatory evaluation process

Marketing authorization is not granted either because it is in process of regulatory review, or not submitted for local approval

APPROVED, NOT AVAILABLE

Commercially available, but not reimbursed

Molecules that have obtained regulatory approval but are not available through either private or public healthcare; patients typically pay fully out-of-pocket, importations or compassionate use

PRIVATELY AVAILABLE

Reimbursed in the private market only

Medicines available only in the private market but not the public sector, generally limiting the overall patient population that has access

LIMITED AVAILABILITY

Reimbursement but not for a broad population, or uptake

The molecule is available to some extent in the public sector, but not to the broad population either because of discrepancies sub-nationally, or it is limited to specific patient sub-populations, limited number of treatment centers, or has significant volume of legal injunctions / administrative processes that result in a meaningful level of uptake

FULL AVAILABILITY

Broad, national reimbursement

Medicines are fully available at national level for a broad population in both the public and private sectors; full availability is frequently tied to national formulary listing, positive HTA recommendations, and/or central procurement

Extended Availability

Availability in either public or private sector; in a bottoms-up access paradigm, is indicative of the system reach and potential but not broad access

Public availability

Availability either via limited or full availability; indicative of the level of access to the broader national population, and where governments are investing

Acronyms: FDA: US Food & Drug Administration; EMA: European Medical Agency; HTA: Health Technology Assessment

Methodological considerations

The detailed definitions for molecules' availability status in Panama involved inclusion to public health formularies like CSS and the ION Basic Formulary

Country	Availability	Definitions	Public Data	IQVIA Data
	**Full**	*Listed on CSS and ION* Basic Formulary (LOM)*	MOH website CSS Document (LOM) ION Document (LOM)	**Retail:** *Available* **Hospital / Non-Retail:** *Not broadly available*
	Limited	*Medicines available via special purchase process for non-LOM medicines on CSS / ION*		
	Only Private	*Broad coverage by prepaid plans, no special purchase negotiations, no CSS formulary*		
	Not Available	*Ministerio de salud approval, no CSS, no special purchases negotiations, no broad coverage by prepaid plans* *Only OOP sales, mostly in the Retail Setting*	Not available	

**ION Basic Formulary is only for oncologic medicines.*

Methodological considerations

The study focuses on four key metrics that provide a panorama of availability of innovative medicines to patients in LATAM

Metric	Research Question	Content
1 Availability Status	***What is the availability of innovative medicines across LATAM?***	Breakdown of availability across the region, by country and by therapeutic area
2 Time to Availability	***How long does it take for innovative medicines to become available?***	Time from global regulatory approval to local approval, and local availability
3 Availability Over Time	***What is the maturity of innovative medicines available?***	Evolution of availability status by year of global approval
4 Improvement Index	***At what rate does availability for innovative medicines improve?***	Comparison of availability status of molecules from 2025 W.A.I.T. to 2026 W.A.I.T.

Important considerations

1. The study results reflect a snapshot of the **current availability of innovative medicines in LATAM** as of April 2026, and aims to increasingly shed light on its evolution over the years



2. The five therapeutic areas selected allow for an ample view of innovative medicines **with >80% of global, new active substance approvals (NAS)*** captured, and >80% of Latin America's population across ten countries



3. The study considers the **first locally approved indication** for analysis at the molecule level as the most consistent comparison subsequent indications are not captured due to inconsistent availability of data (public or otherwise)



4. **Comparability by countries to the extent possible** is ensured through rigorous validation across a wide group of local and regional experts, and further detail can be found in accompanying country-level reports



*NAS refers to New Active Substances as defined by the IQVIA Institute, see appendix for definitions and selection criteria

Summary of key W.A.I.T. metrics - Panama

Time to Availability

Represents the length of time from both global and local market authorization until full, limited, or private availability is reached

- Total time to availability is on average 68 months between the countries in scope, which reflects the total of time to marketing authorization and time to reimbursement (full or limited), as of FDA/EMA approval
- The average time to local availability, post-marketing authorization, is 32 months between the countries in scope, approximately 2.7 years

- Panama's time to approval is higher than the regional average (47 vs 36 months), as well as local time to availability, which is 16 months over the regional average (48 vs 32 months)
- Time to availability varies substantially in Panama across therapeutic areas, with orphan showing the longest delays taking ~43 months to become locally approved and ~75 months of to become locally available. CNS therapies have the shortest time to availability of all TAs.

Patients on average have been waiting over 5.7 years to get access to an innovative medicine in LATAM; meanwhile they may have no means of obtaining it in their country, or face significant out of pocket costs

Availability Status

Represents the degree of availability of an innovative medicine in a given country according to regional definitions

- ~60% of molecules that are globally approved are approved in at least one of the geographies in scope in LATAM; out of these regionally approved, 33% are approved in Panama
- 25% of molecules with regional public availability (limited or full availability) have public availability in Panama
- 24% of molecules approved in Panama have some level of availability; out of this extended availability, only 19% have reached full availability status
- While there aren't any CM therapies with full availability, this TA relies on private channels as well as oncology and CNS

Availability Over Time

Pinpoints the degree of current availability according to global market authorization year to estimate the maturity of available molecules

- Between 20% and 44% of molecules that received global approval from 2014 to 2018 are approved in Panama; availability varies from 20% to 43%
- For therapies approved globally after 2018, approval and availability rates decline sharply, both reaching 0% by 2025

Improvement Index

Outlines the extent that molecules have changed availability status from year to year between reports

- 4% of the molecules in Panama have improved their availability status over the past year, 3 percentage points less than regional average of 7%
- Panama had 4 newly approved molecules this year

Acronyms: FDA: US Food & Drug Administration; EMA: European Medical Agency; TA: Therapeutic Area; CNS: Central Nervous System; CM: Cardiometabolic

Summary of Regional Root Causes and Opportunity

Innovation is outpacing system capacity, driving saturation and delays

The volume and complexity of globally approved medicines continue to rise, creating mounting challenges for Panama's regulatory and healthcare systems, which have not expanded capacity at the same pace. As a result, approval timelines have lengthened, backlog pressures persist, and gaps between global innovation and local access remain evident—despite recent improvements in approval activity.

Low investment constrains institutions, fragments processes, and reduces competitiveness

Healthcare spending in Panama is broadly aligned with LATAM peers, though still below OECD levels, indicating that overall funding is not the primary constraint. However, significantly lower investment in innovative treatments highlights a structural imbalance, limiting the system's capacity to adopt newer therapies. This gap contributes to slower uptake of innovation, more limited patient and less readiness to manage higher-complexity care

Access improves when clinical value and system readiness are mutually reinforcing

Regulatory approval alone does not ensure access in Panama. Timely uptake requires alignment between local evidence generation, diagnostic infrastructure, delivery capabilities, and budgetary frameworks. When these elements are in place, access becomes more predictable and scalable; when they are not, complexity translates into delays and restricted availability.

Emerging opportunities signal potential for strategic repositioning

Growing pharmaceutical investment, increased adoption of innovative therapies, and gradual system modernization present an opportunity for Panama to strengthen its position within the global landscape. Targeted improvements in governance, infrastructure, and cross-sector collaboration could translate into faster access, improved outcomes, and greater readiness for complex innovation.

Sustained progress requires collaboration, integration, and forward planning

Delivering sustainable access in Panama will depend on coordinated action across regulatory authorities, payers, and providers. Priorities include improving institutional collaboration, integrating new technologies to enhance efficiency and transparency, and strengthening long-term planning to manage rising complexity and demand.

Panama's access challenges are not due to a lack of innovation, but rather a mismatch between accelerating therapeutic complexity and the system's ability to absorb it. While progress is underway, closing this gap will require sustained investment, structural reforms, and a proactive approach to managing complexity across the healthcare ecosystem.

Acronyms: OECD: Organization for Economic Co-operation and Development

Key regional takeaways



Innovation is accelerating as disease burden evolves

A growing and complex disease burden in Panama is driving demand for more targeted and advanced therapies, placing additional pressure on the system to adapt to higher-impact innovation



Access challenges are intensifying as innovation grows

As the volume and complexity of innovation increases, Panama's reliance on fragmented, sequential processes is becoming less effective, contributing to delays and variability in patient access



Structural underinvestment amplifies access inefficiencies

Persistent capacity constraints and relatively low healthcare investment limit Panama's ability to absorb innovation efficiently, leading to delays, operational misalignment, and uneven access outcomes



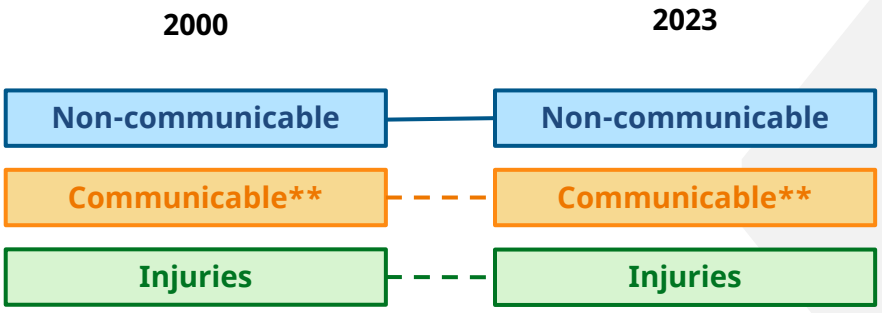
A window for transformation is emerging

Ongoing system evolution, increasing focus on innovation, and gradual investment growth create a timely opportunity to improve access pathways, and enhance readiness for more complex therapies

Non-communicable diseases drive Panama's health burden

The epidemiological transition toward chronic conditions creates rising demand for innovative medicines and sustainable access pathways

Evolution of Disease Burden in Panama - DALYs per 100,000



Diseases with the Highest Burden of Morbidity Classified by Level 2, 2023, excl. injuries

1	Cardiovascular disease
2	Diabetes & CKD
3	Neoplasms
4	Musculoskeletal disorders
5	Mental Disorders
6	Other non-communicable
7	Unintentional inj
8	Neurological disorders
9	Respiratory infections & TB
11	Maternal and neonatal

- Panama's disease burden is driven by non-communicable diseases, confirming a mature epidemiological profile. Panama has completed the epidemiological transition seen across LATAM, moving decisively away from infectious and early-life conditions toward chronic diseases.
- This shift has critical implications for healthcare systems and pharmaceutical needs. Unlike acute infectious diseases, NCDs are chronic in nature, requiring long-term management. Yet, the decline on the burden from communicable diseases, does not eliminate the dual pressure. The system must be able to support simultaneously infectious disease control while scaling capacity for chronic disease management.
- Many of the most significant advances in NCD treatments have come from innovative medicines (e.g., targeted oncology therapies, novel immunomodulators for inflammatory diseases, advanced treatments for metabolic and cardiovascular conditions) that address unmet needs and improve survival, function, and quality of life; key drivers of productivity.
- As NCD burden rises, so does the demand for access to both new and existing treatments. The therapeutic areas prioritized in this report are those most aligned with the region's disease profile
- However, the growing need for innovative therapies comes at a time when healthcare budgets face competing pressures, regulatory and systems manage increasing submission volumes, and access pathways remain fragmented. The alignment between disease burden and pharmaceutical innovation underscores the urgency of understanding where and why access gaps persist.

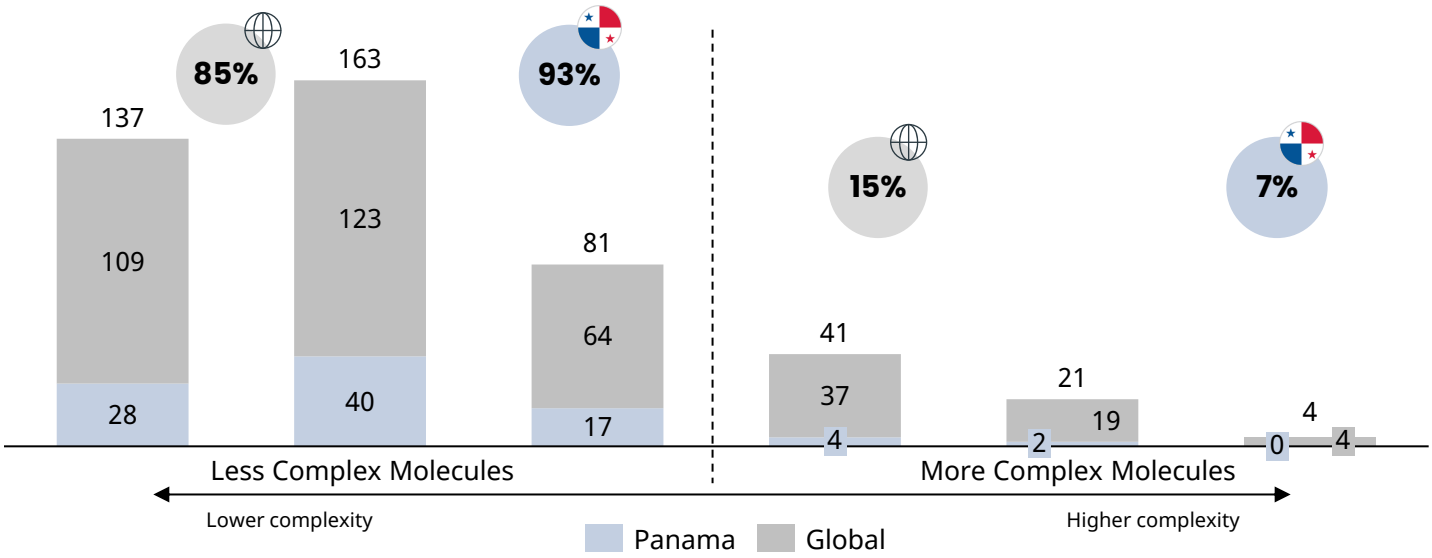
Panama's disease profile justifies the focus on innovative medicines for NCDs, while the rising burden underscores the importance of timely access to novel therapies

Acronyms: DALYs: disability-adjusted life year; NCD: non-communicable diseases
Sources: Institute for Health Metrics and Evaluation

Complexity introduces additional considerations for systems

Panama complexity distribution favors less complex molecules, with ~93% of them approved concentrated in lower-complexity segments

Complexity of Global and Local Approved Molecules – WAIT Dataset



- The complexity levels shown reflect a set of factors that place additional strain on health systems and require capabilities or expertise beyond standard regulatory, , and implementation processes.
    - Biologic or next generation therapies (e.g., nucleotide, RNAi, gene, cell, tissue, immunotherapy): Require specialized manufacturing, handling, and regulatory expertise beyond small-molecule drugs
    - Innovative / first-in-class therapies: Novel mechanisms may lack precedent, requiring deeper reviews and raising uncertainty around long-term safety and real-world efficacy
    - Precision medicine (i.e., diagnostic required): Companion diagnostics require parallel validation and infrastructure deployment before therapies can be administered effectively
    - Orphan population: Often target smaller populations, making large-scale trials difficult and limiting the availability of robust comparators
    - Route of administration: Complex routes (e.g., infusion, intrathecal, one-time delivery) demand specialized infrastructure, trained staff, and coordinated care pathways
- From a system-facing perspective, complexity magnifies capacity constraints. From a technical perspective, complex molecules pose greater challenges in evidence generation and interpretation.
- Panama's complexity index shows that ~93% of molecules are concentrated in the lower-complexity side versus ~7% in higher complexity, indicating a clear tendency towards less complex molecules

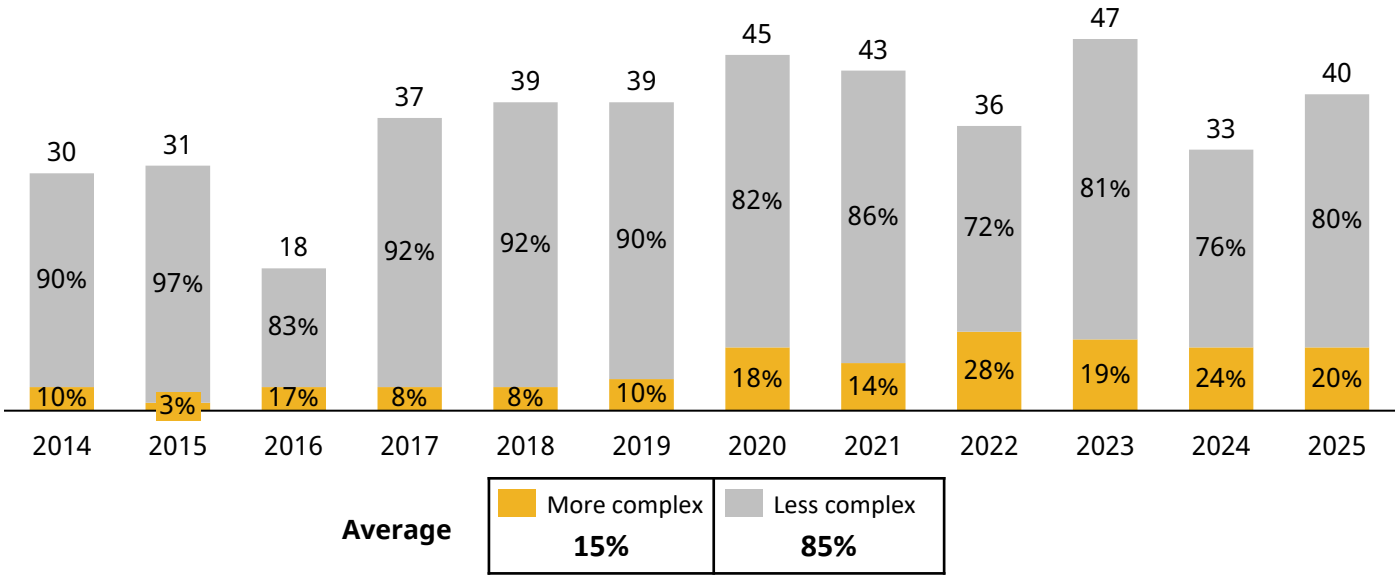
Innovation often introduces technical challenges during evaluation and creates downstream system constraints for regulators, payers, and providers in resource-limited settings

Acronyms: RNAi, RNA interference

Innovation is also becoming more complex

The share of complex therapies among global approvals has doubled since 2014, creating evidence and assessment challenges for regulatory and payer systems

Complexity of Global Approvals - WAIT Dataset



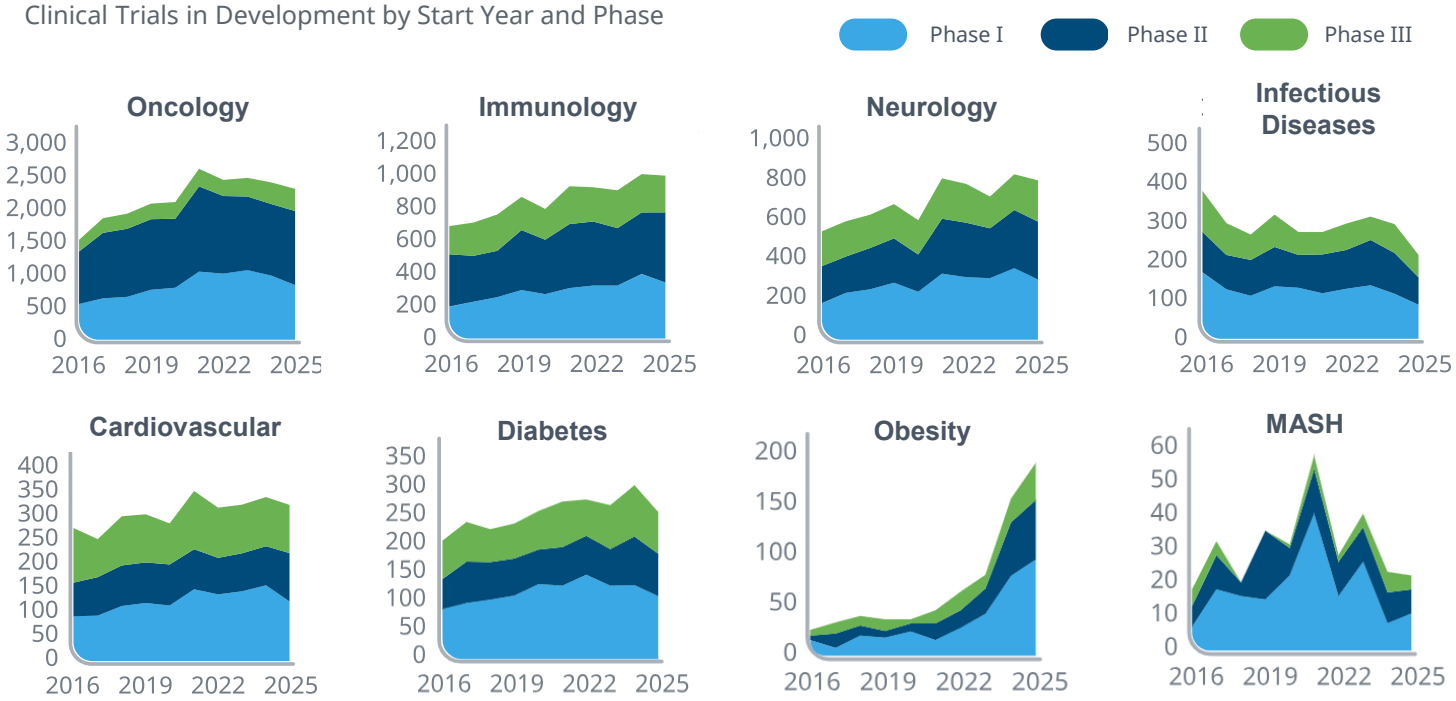
- Among globally approved molecules in this study, the proportion of complex molecules has risen from 10% in 2014 to 20% in 2025. This increase reflects growing reliance on precision medicine, orphan disease therapies, novel mechanisms of action, and advanced modalities (e.g., gene and cell therapies)
- While these innovations address persisting unmet needs and offer transformative benefits, they also introduce challenges across the access pathway
- Complex therapies often face inherent difficulties in evidence generation, related to demonstrating efficacy and safety in sufficient patients, over sufficient timeframes, and versus a relevant clinical comparator. Thus, creating additional operational and technical challenges for regulators and payers
- This can increase uncertainty around real-world efficacy, long-term safety, and budget impact, creating tension between the desire to provide early access and the need for robust evidence to inform reimbursement decisions
- For regulators and payers in LATAM, rising complexity compounds existing operational and technical challenges. Regulatory agencies may lack specialized expertise to evaluate novel modalities or interpret endpoints and accelerated approval pathways. Systems often rely on traditional frameworks, which may not adequately address uncertainty, value over time, or broader societal benefits
- As complexity increases without matching capacity-building, timelines risk lengthening, and access decisions may become more conservative or inconsistent across systems. Each additional point on the scale, to some extent, reflects an additional layer of uncertainty to contend with

Rising therapeutic complexity requires evolution of regulatory and frameworks in LATAM as well as renewed focus on technical capacity; without adaptation, complexity becomes an additional barrier

A robust global pipeline signals sustained innovation and mounting system pressure

This continued innovation creates opportunity, but only if access bottlenecks are eased

Clinical Trials in Development by Start Year and Phase



- The global pharmaceutical pipeline remains strong, with a sustained flow of new treatments expected in the short and long term. Ongoing clinical trial activity suggests that the number of innovative medicines reaching regulatory review will continue to grow rather than level off.
- Advances in biologics, precision medicine, gene-based therapies, and novel small molecules are expanding treatment options across a wide range of chronic and complex diseases
- Pipeline concentration closely aligns with LATAM's disease burden. These areas reflect global priorities in addressing cancer, cardiovascular disease, diabetes, obesity, and related metabolic conditions, many of which require long-term treatment and sustained system engagement.
- While this innovation momentum represents progress for patients, the increasing volume of molecules, often with novel mechanisms and higher uncertainty, will further strain already saturated health systems. As more therapies seek regulatory approval, pricing, reimbursement, and delivery within existing capacity constraints, access challenges are expected to intensify, particularly in systems with limited sources, fragmented pathways, and budgetary pressures.
- The continued expansion of the pipeline underscores the importance of ensuring that access frameworks evolve alongside innovation

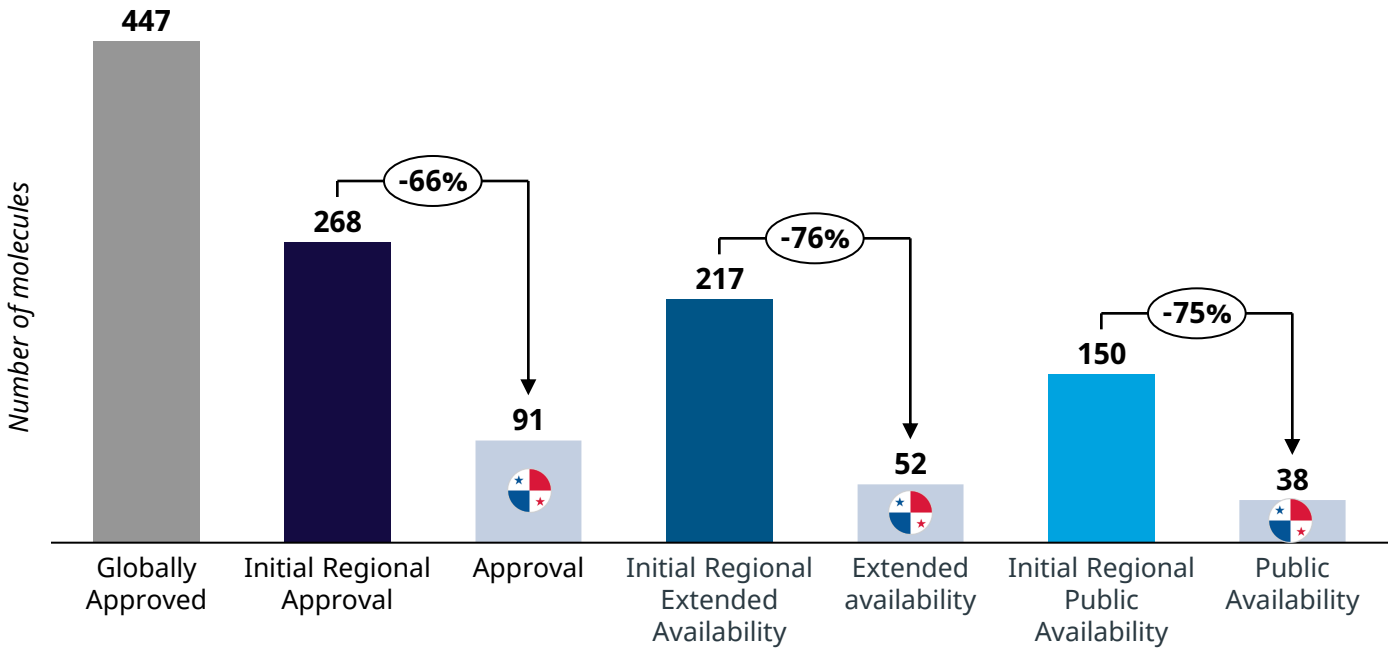
A continued pipeline growth will drive advances in healthcare, but will amplify existing system bottlenecks if unaddressed

Acronyms: MASH: Metabolic dysfunction-associated steatohepatitis
Sources: IQVIA – Global R&D Trends 2026

Panama’s gaps emerge early and persist across the pathway

Significant losses occur from regional approval to local approval and continue through extended and public availability stages, limiting overall access

Breakdown of Initial Regional and Local Availability (2014 - 2025) — Combined



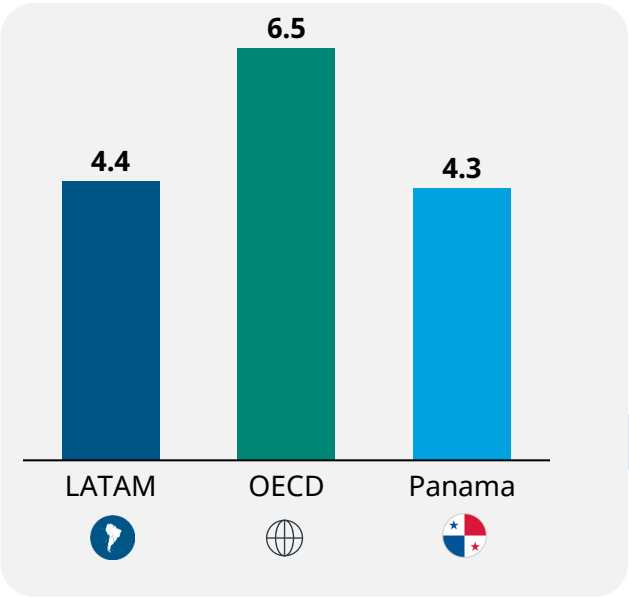
- Initial regional approval and availability represents where a molecule is approved or is available in at least one country in the region, the comparative graph represents Panama’s status
- Panama shows a significant approval gap against the regional benchmark, indicating limited translation of regional innovation to the local market
- The conversion from approval to extended availability is also limited, with only 52 molecules reaching broader availability, which reflects delays in the processes and systematic adoption
- Public availability, although low compared through the regional benchmark, remains aligned with the extended availability; indicating that once therapies reach availability, most are through public pathways
- Panama’s biggest gap, and area of opportunity is the approval stage, highlighting structural barriers of entry to the market at the initial stages
- Overall, Panama’s access pathway shows cumulative losses at each stage, with the largest bottlenecks at approval and extended availability

Panama’s access challenge is driven by limited approval and weak translation into extended availability, rather than losses at the public access stage

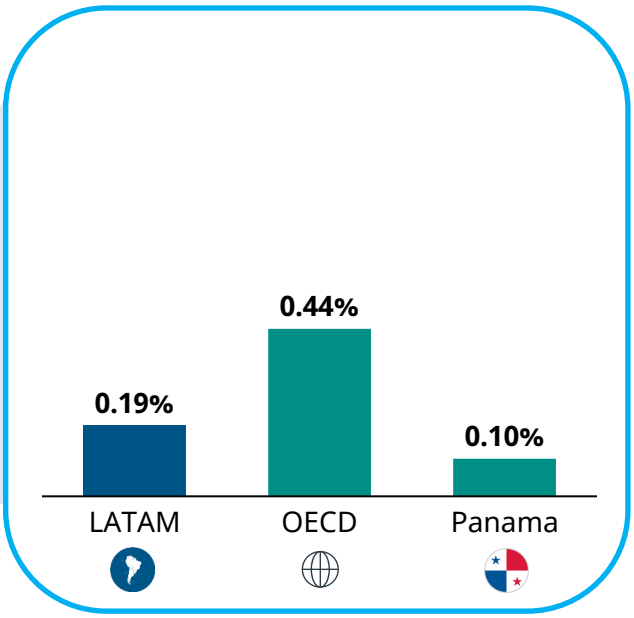
Panama’s health spending is below the OECD target

Public and innovation-specific health spending in Panama remain below OECD and LATAM benchmarks, limiting system capacity and slowing the adoption of new therapies

Average Public Spending on Health (% of GDP, MAT October 2023-2025)



Average Public Spending on Innovative Treatments (% of GDP, MAT October 2023-2025)



- Public spending in Panama remains lower than the recommended 6.5% GDP share by WHO and the OECD average, but remains in line with its LATAM peers, indicating structural underfunding
- Panama allocates a lower share of GDP (~0.10%) to innovative treatments compared to the regional benchmark (~0.19%), limiting the system capacity to grant access to innovation
- This two-part constraint results in strict budget allocation and selective prioritization where funding is directed toward maintaining baseline coverage rather than scaling access to new therapies
- Limited investment in innovation, reinforces selective prioritization, where funding is directed toward maintaining core services rather than scaling access to high-cost or newer therapies
- More broadly, budget constraints impact ability to evaluate and invest in key technologies, capacity for pullthrough on reimbursement decisions once made, and in turn the extent industry is able to invest in the sector

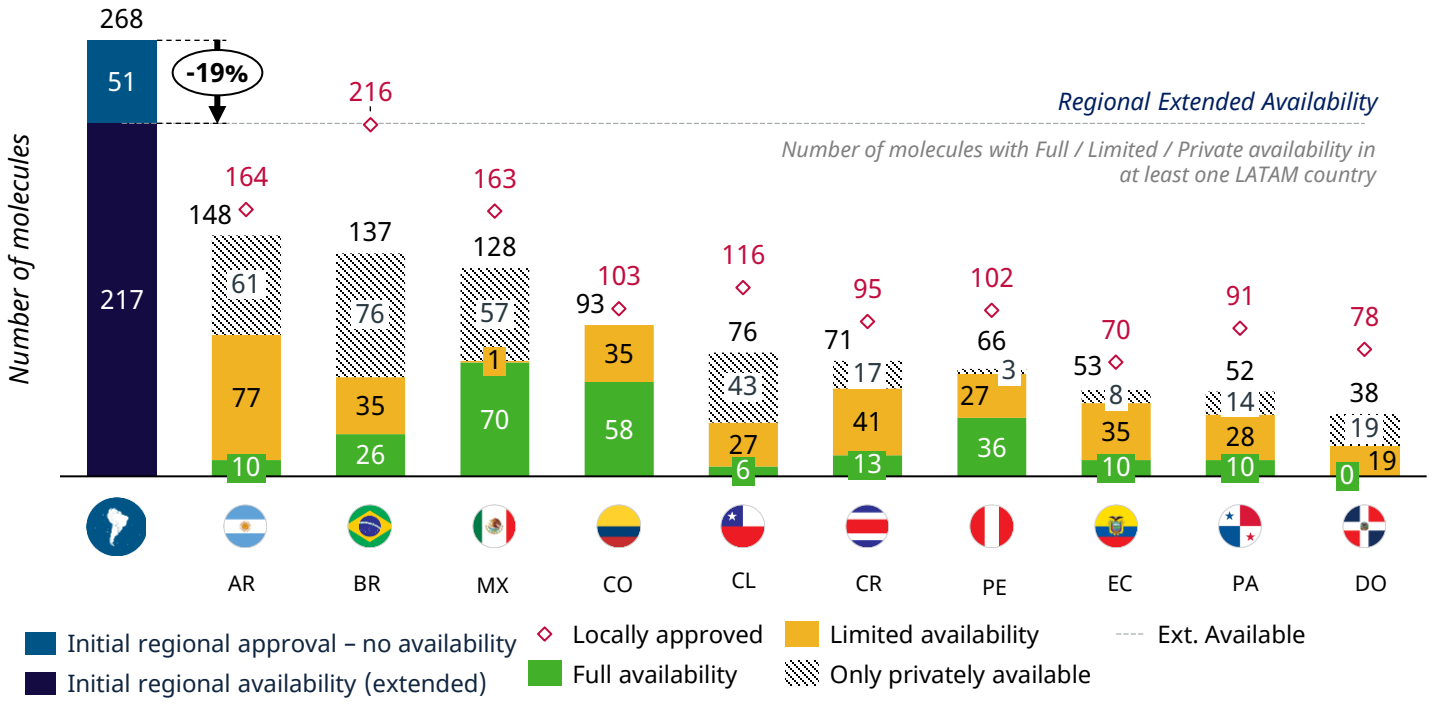
Panama’s main funding gap does not lie in overall health spending, but in its limited investment in innovation, which restricts the system’s ability to absorb new therapies

Acronyms: GDP: Gross Domestic Product; WHO: World Health Organization; OECD: Organization for Economic Co-operation Development; MAT: Moving Annual Total

Availability rates vary widely by country

Brazil drives initial regional approval, Colombia has historically been a leader in public availability but Mexico has made strides recently that have resulted in the highest full availability rate

Breakdown of Local Availability (2014 - 2025) — Combined



- There is a gap of 19% between molecules that are approved in at least one country in LATAM, and those that are available
- The trend in approvals vs. availability is not consistent across countries; Brazil, Chile, Dominican Republic and Panama show a more pronounced gap between approvals and availability
- Argentina and Brazil have a disproportionately high contribution from the private sector vs. the public sector, helping bridge the gap between regulatory approvals and availability, but also potentially exacerbating the delay in time to public availability
- Mexico has the highest levels of full availability by a wide margin, followed by Colombia and Peru
- These patterns reflect underlying system characteristics, where high private contribution is typically associated with fragmented systems and limited public budgets, high public availability aligns with centralized structures and more mature processes, and approval–availability gaps point to regulatory capacity being outpaced by HTA and pricing delays driven by process saturation and limited transparency

Patients face different challenges by country: where private coverage is high it affords better access but for a subset of patients, whereas where there is a high rate of public coverage, typically there are fewer molecules available, heightening inequalities

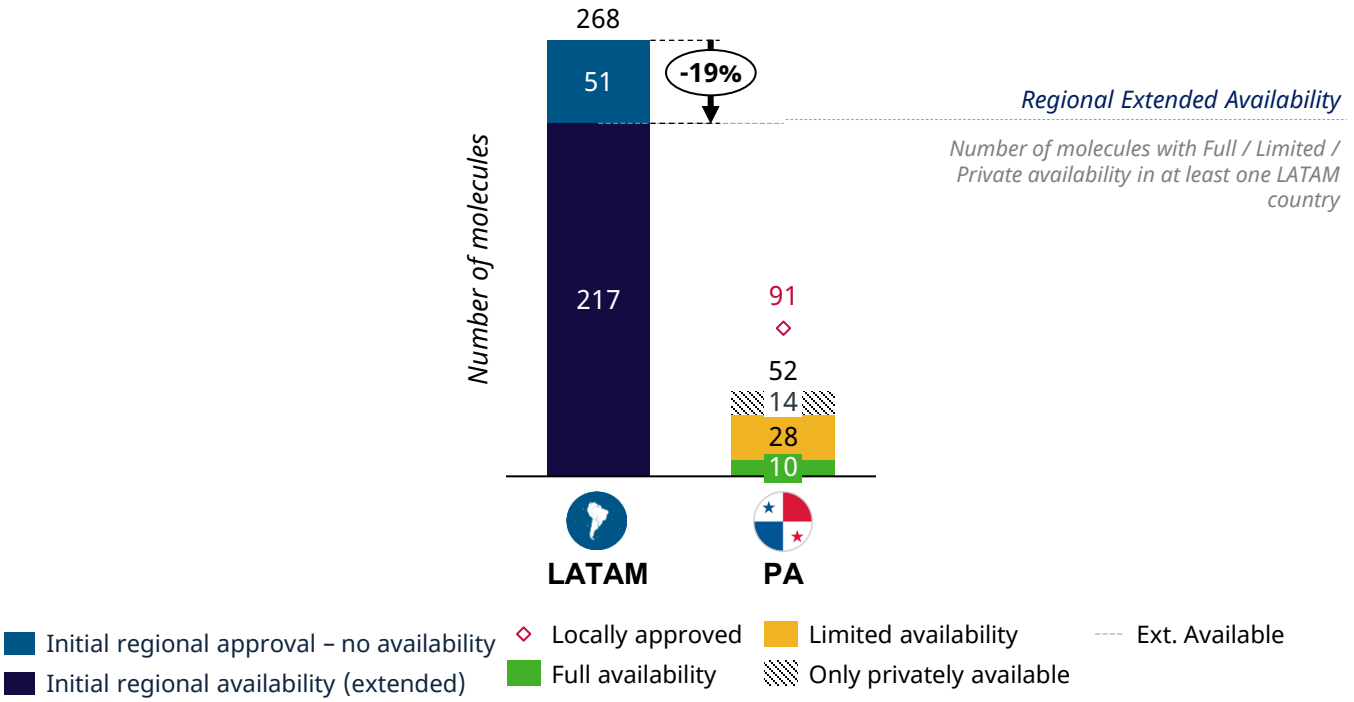
*See appendix for further detail

Acronyms: AR: Argentina; BR: Brazil; MX: Mexico; CO: Colombia; CL: Chile; CR: Costa Rica; PE: Peru; EC: Ecuador; PA: Panama; DO: Dominican Republic; HTA: Health Technology Assessment

Panama’s availability shows a deep gap vs the region

Limited approval throughput, heavy limited availability and slight private-sector reliance constrain patient access in Panama

Breakdown of Regional and Local Availability (2014 - 2025) — Combined



- There is an important gap between the approval and the extended availability, where only ~23% of the approved molecules in Panama have extended availability
- The composition of availability reveals a structural imbalance, where 30% of approved molecules have limited availability and 15% are restricted to private-sector access, indicating that innovation is present in the market but not equitably distributed across the population
- Public system uptake remains constrained, as only 10 therapies achieve full availability, demonstrating that CSS faces significant limitations in scaling access to innovative medicines, driven by funding constraints, prioritization, and implementation capacity
- Panama shows weak regulatory throughput, with only 91 of 268 LATAM-approved molecules reaching local approval, meaning the country is not effectively capturing regional innovation at the entry point; this upstream bottleneck is then compounded by limited public integration, leaving patients doubly constrained, first by approval gaps, then by access gaps

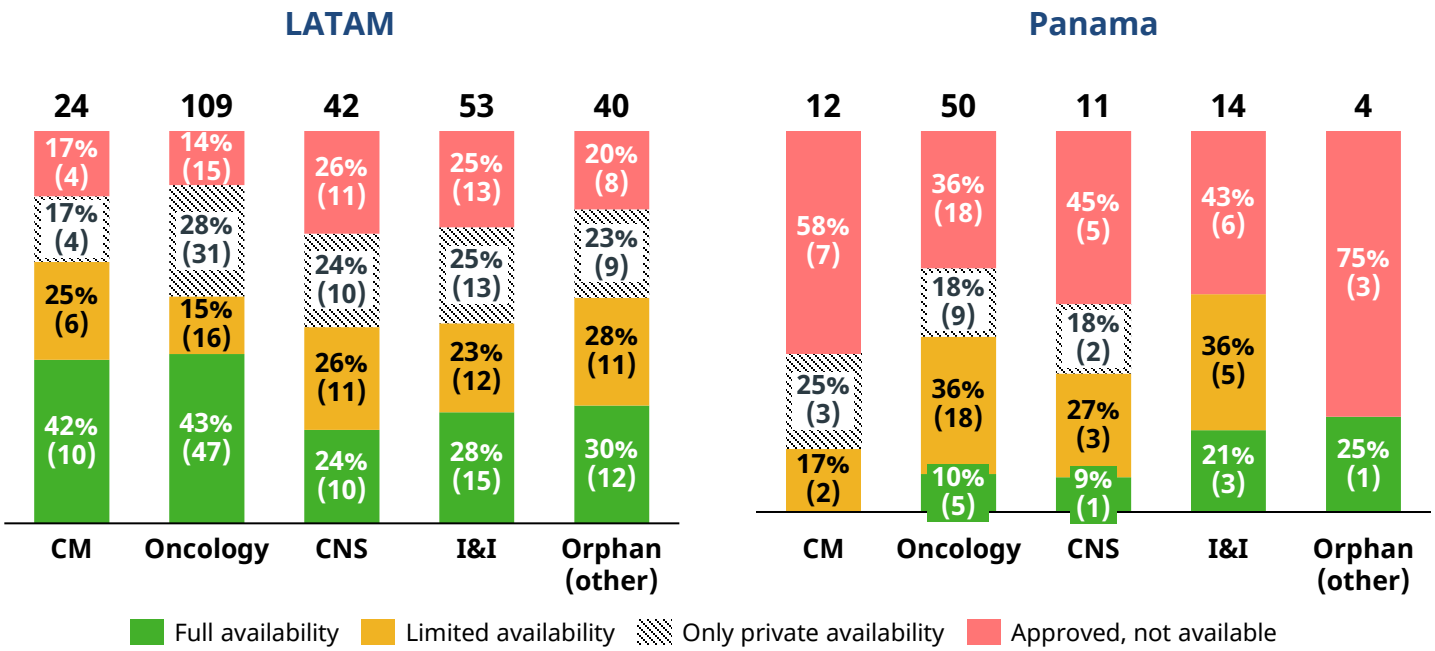
In Panama, access challenges begin at the regulatory stage, with low approval rates limiting the inflow of innovation; the few molecules that do enter rely heavily on limited access, leaving the public system unable to deliver innovation at scale

Acronyms: CSS: Casa de Seguro Social; PA: Panama

Significant differences also exist by therapeutic area

Panama diverges from the regional pattern, with CM lagging the most; Orphan therapies show the highest "approved-not-available" share

Regional and Local Availability Status by Therapeutic Area



- Panama exhibits a more constrained access profile across all therapeutic areas compared to LATAM, with significantly lower full availability levels, particularly in CNS (9% vs. 24%) and Oncology (10% vs. 43%) highlighting systemic limitations in translating approvals into access
- In cardiometabolic therapies, Panama shows extreme access limitations, with 58% of approved treatments not available and 0% full availability, indicating that even high-burden, high-volume disease areas are severely deprioritized or constrained within CSS, and overly dependent on the OOP sector
- Oncology (18%), CM (25%), and CNS (18%) presents a private-driven access pattern in Panama, where availability appears moderate but is heavily reliant on private-sector access
- I&I shows relatively better full access (21%) compared to other TAs, though still fragmented, with 36% limited availability indicating partial coverage rather than broad public uptake
- Orphan therapies stand out as the weakest segment, with 75% approved-not-available and only 25% full availability, reflecting both a very narrow approved portfolio and limited public mechanisms to fund high-cost rare disease treatments

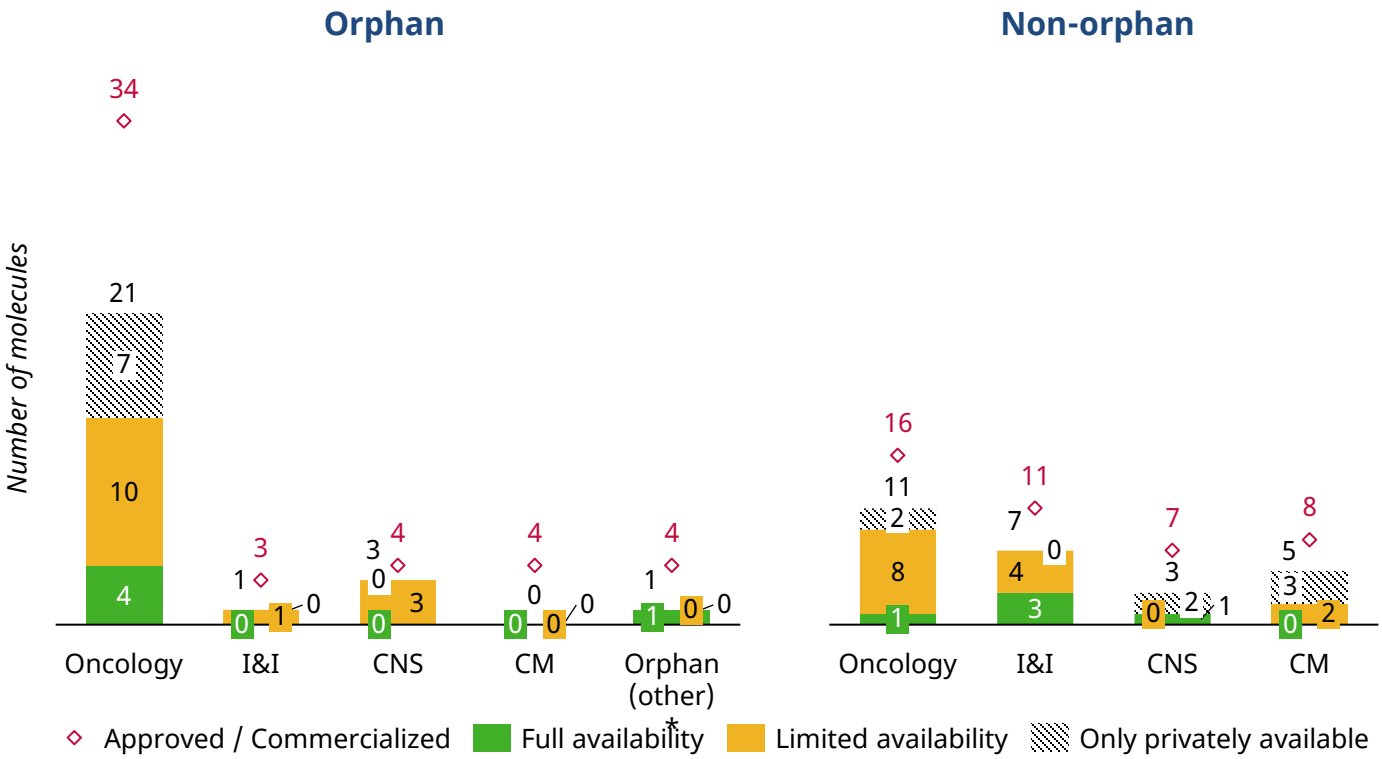
The biggest gaps in Panama compared to the region are concentrated in approved-but-not-available molecules across CM, CNS, and Orphan therapies; regulatory throughput exists but post-approval access is the core bottleneck

Acronyms: CM: Cardiometabolic; CNS: Central Nervous System; I&I: Inflammation and Immunology; CSS: Casa de Seguro Social; OOP: Out-of-pocket

Non-orphan therapies have better access but weaker approval

Orphan therapies, particularly in Oncology, drive the bulk of Panama's approved portfolio, yet non-orphan therapies show better availability but less approvals

Breakdown of local availability (2025) – Orphan vs. Non-orphan by TA



- Non-orphan therapies show stronger availability conversion in most TAs, particularly in I&I (7 of 11 approved available), CM (~5 of 8), and CNS (3 of 7), indicating that despite a narrower approved base, non-orphan molecules translate more consistently into some form of patient access
- Orphan therapies concentrate the bulk of approvals but show weaker conversion outside oncology, highlighting that a larger approved portfolio does not translate into broader access for rare disease patients
- Oncology is the only TA where orphan dominates both approvals and availability, reflecting a portfolio heavily skewed toward rare oncology innovation that reaches patients mostly through limited and private-only channels
- Full availability remains marginal across both groups, with orphan reaching full access only in oncology (4 molecules) and non-orphan capped at 1–3 molecules per TA, confirming that Panama's access bottleneck is structural and affects both rare and broad-population therapies

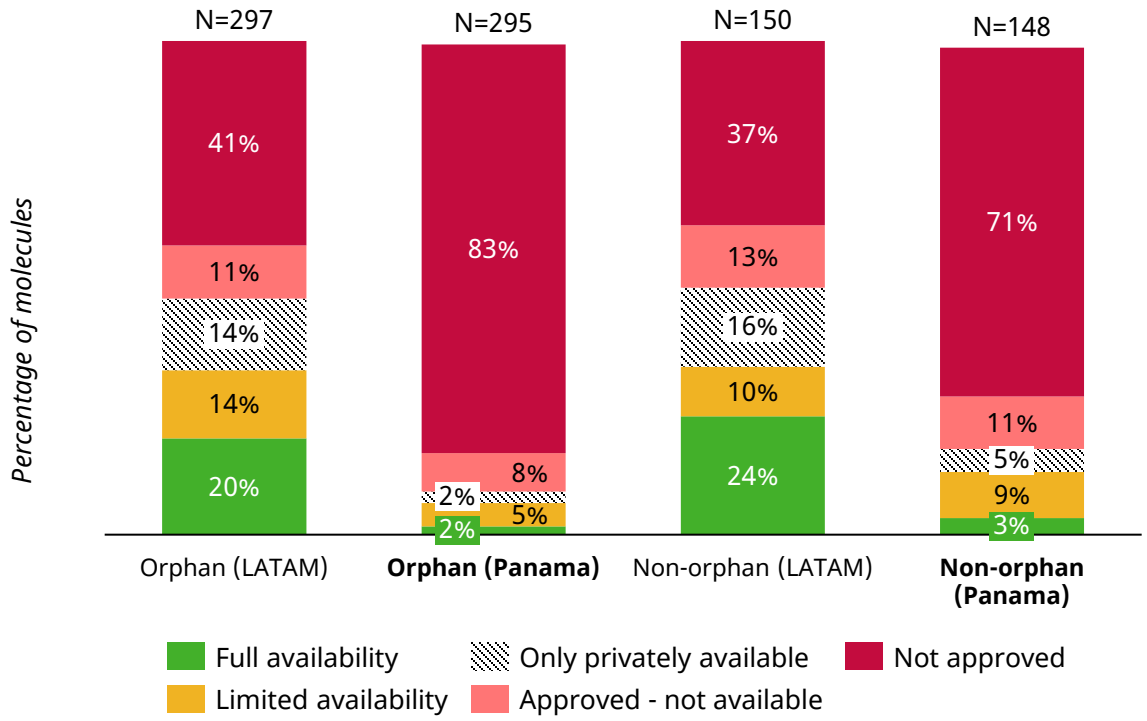
In Panama, non-orphan therapies achieve better availability conversion despite a smaller approved base, while orphan therapies concentrate the bulk of approvals but rely heavily on limited and private channels; full public availability remains marginal across both groups, pointing to structural rather than disease-specific access barriers

* Orphan (other) category considers orphan molecules that are not also part of any of the other TAs
Acronyms: I&I: Inflammatory and Immunology; CNS: Central Nervous System; CM: Cardiometabolic; TA: Therapeutic Area

Availability varies by therapeutic area

Both orphan and non-orphan therapies show high "not approved" rates, indicating that access challenges in Panama begin at the regulatory entry point rather than at post-approval stages

Initial Regional and Local Availability (2014 – 2025) – Orphan vs. Non-orphan



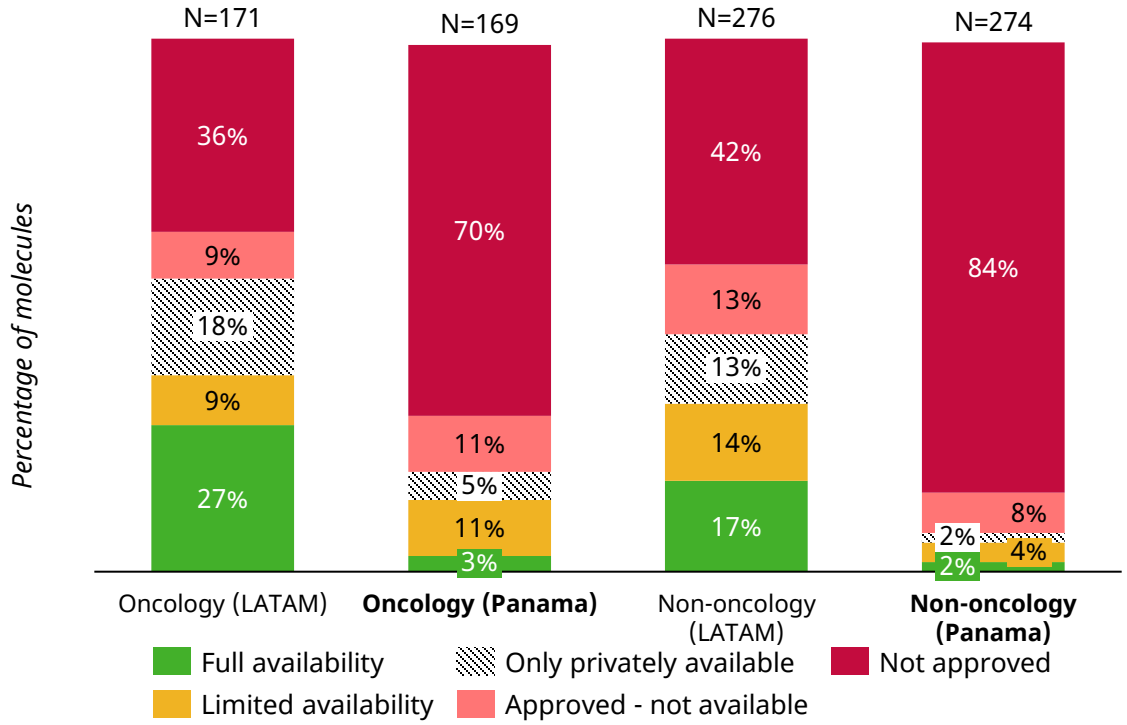
- Panama exhibits consistently low full availability across both orphan and non-orphan therapies, with only 2% (orphan) and 3% (non-orphan) achieving full access, significantly below LATAM benchmarks (20% and 24%, respectively)
- The biggest gap between the general LATAM Benchmark and Panama, is noted on the orphan drugs, where there is a ~42% difference between the not-approved medicines.
- Non-orphan therapies in Panama show slightly better performance than orphan in availability terms, limited (~9%) or private-only (~5%) availability, resulting in extended availability difference of 17% vs. 9% respectively, highlighting the heightened challenges of covering medicines for broad populations
- Across both categories, the distribution of access indicates that availability is a bottleneck in the country, and more so for innovative medicines that are more likely to address the broader population, and in many cases, much higher disease burden

Panama's access challenges are fundamentally driven by regulatory throughput, not post-approval barriers; with over 70% of molecules not approved in both orphan and non-orphan categories, the country is systemically disconnected from regional innovation at the entry point

Non-oncology faces the deepest gap in Panama

Both oncology and non-oncology therapies show severely constrained access in Panama, but non-oncology stands out with 84% of molecules not approved,

Initial Regional and Local Availability (2014 – 2025) – Oncology vs. Non-oncology



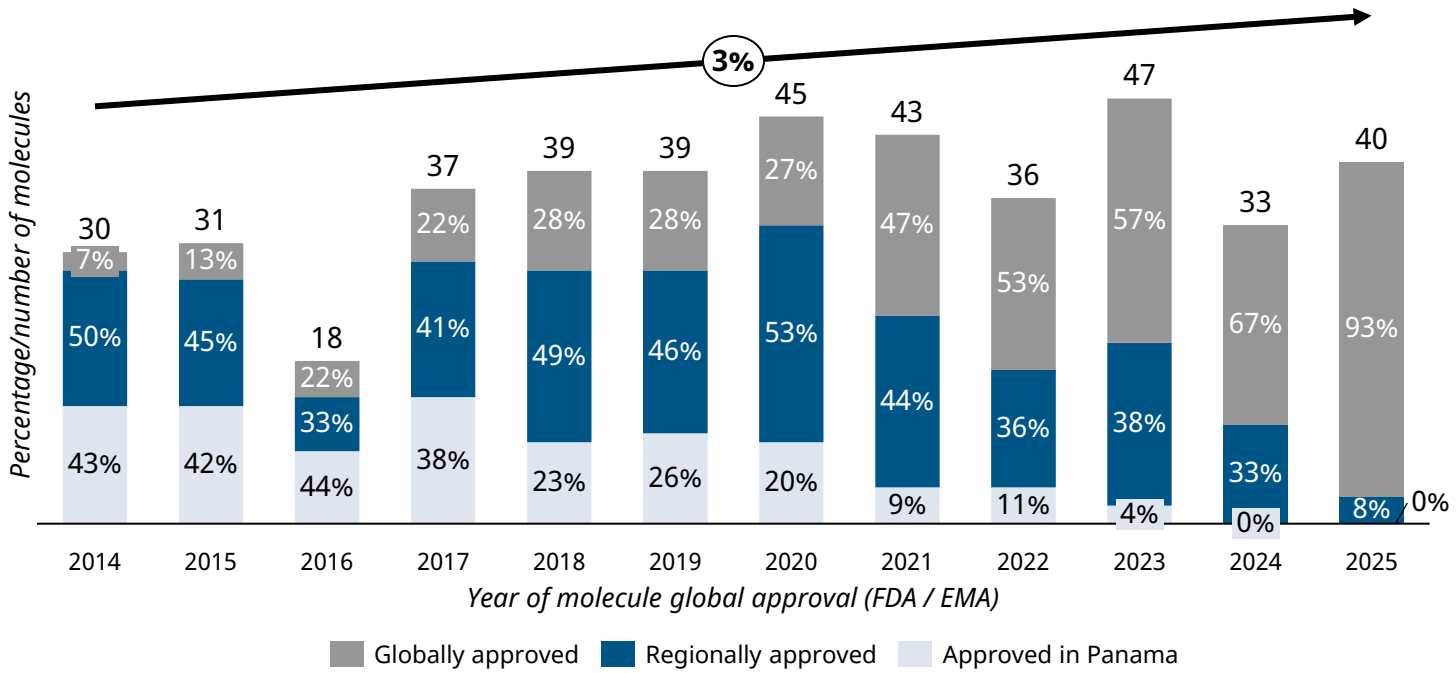
- Non-oncology therapies show the most critical access gap in Panama, with 84% not approved (vs. 42% in LATAM) and only 2% full availability (vs. 17% LATAM), indicating that broad-population therapies are severely underrepresented in the local regulatory xxx
- Oncology in Panama also underperforms the region, with 70% not approved (vs. 36% LATAM) and only 3% full availability (vs. 27% LATAM), confirming that even high-priority disease areas face systemic upstream barriers despite their clinical relevance
- Oncology shows higher reliance on limited and private-only channels (11% limited, 5% private-only) compared to non-oncology (4% limited, 2% private-only), suggesting that when oncology therapies do reach Panama, they flow through private-sector pathways rather than full public coverage
- Approved-but-not-available rates are comparable across both groups (11% oncology, 8% non-oncology), reinforcing that Panama's core bottleneck lies upstream at approval rather than at post-approval availability stages

In Panama, the access bottleneck is concentrated upstream at regulatory approval and is most severe for non-oncology therapies, where 84% remain not approved; oncology fares slightly better but still relies heavily on limited and private channels

New medicines increase, but Panama´s approvals collapse

Significant time-lag effects and widening gaps limit the translation of global innovation into regional and Panama market availability

Global vs. Regional vs. Local Approved Therapies (2014 - 2025) – Combined



- Regional approval rates remain consistently high for older cohorts but show a pronounced decline for more recent approvals, falling from a strong range of 72–93% between 2014 and 2020 to just 33% in 2024 and 8% in 2025
- Panama's local approval share has collapsed in recent years, dropping from ~40% (2014–2017) to single digits since 2021, and reaching 0% in both 2024 and 2025, indicating a near-complete disconnection between global innovation entry and local regulatory uptake
- The proportion of therapies that remain exclusively at the global approval stage has increased markedly over time, rising from 7% in 2014 and 13% in 2015 to 57% in 2023, 67% in 2024, and 93% in 2025, reflecting a widening gap between global approvals and their translation into downstream approval
- A clear time-lag effect is evident, as therapies approved in earlier years have had sufficient time to expand into regional markets and Panama, reaching 93% regional and 30% Panama availability for 2014 cohorts, whereas more recent approvals show substantially lower penetration due to shorter time since launch
- Furthermore, over time the “ceiling”, that is the peak level of approvals in the region for globally approved medicines, is lowering with a very clear downward trend over time, even for the medicines in mid-late lifecycle, indicating compounding challenges to launching in the region

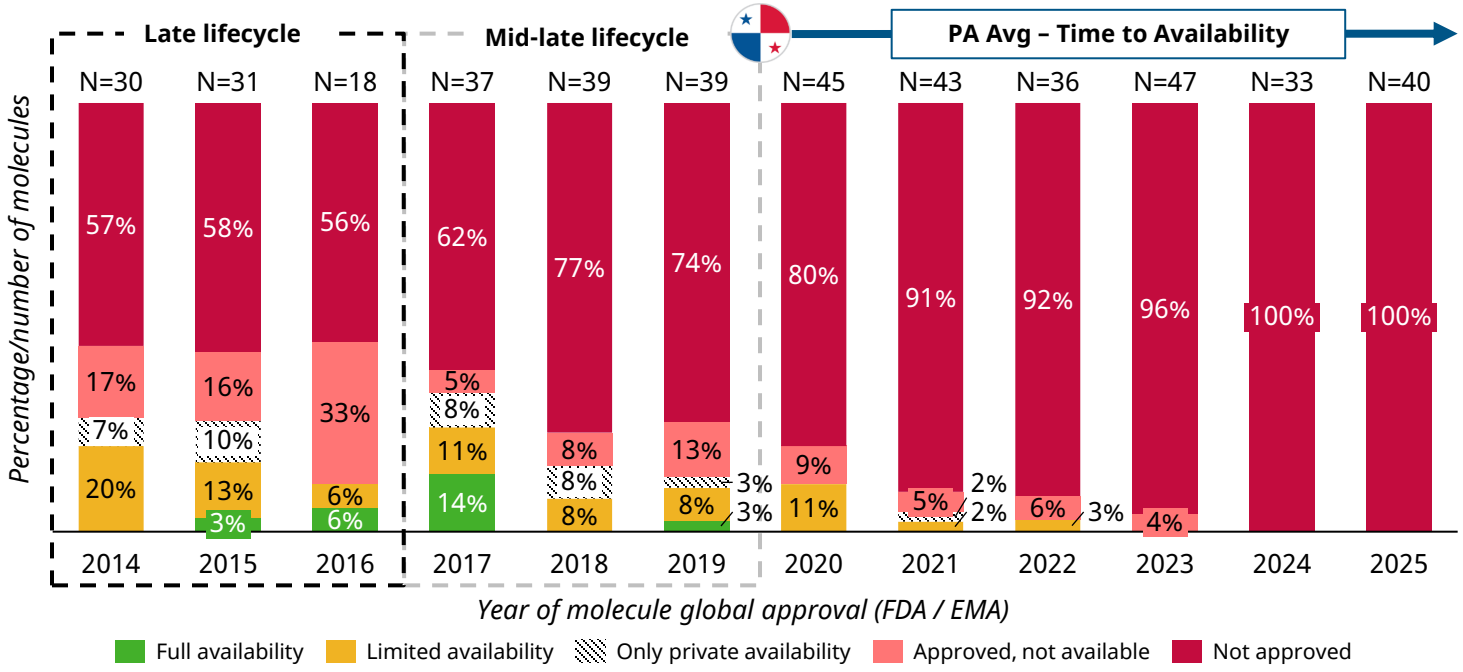
Approval rates are declining in the region and in Panama, whilst global approvals are increasing; the gap will continue to widen without concerted action

Acronyms: FDA: US Food & Drug Administration; EMA: European Medical Agency

Even for older technologies, public access is highly challenging

Newer molecules are highly concentrated in not approved or low-access categories, public access takes time to reach in Panama

Broadest Molecule Availability Status Over Time (2014 - 2025) – Panama Combined



- Full availability remains consistently low across all cohorts and further declines in recent years, dropping from 14% in 2017 to 0% from 2020 onwards, indicating persistent challenges in achieving broad access
- The share of not approved molecules increases sharply for newer cohorts, rising from 57–58% in 2014–2015 to 96% in 2023, and 100% in 2024 and 2025, highlighting the challenges in reaching consensus on both submission and approval
- Approved but not available therapies represent a substantial share, particularly in earlier cohorts, with 17% and 16% of share for 2014 and 2015 respectively, and peaking at 33% in 2016, suggesting delays beyond approval
- Limited and only privately available molecules together account for an unstable portion of access, fluctuating in early cohorts (2014–2018) and dropping sharply to single digits or zero from 2021 onwards, indicating that even partial access pathways have eroded over time rather than expanding to offset the lack of full availability
- The overall distribution shifts toward lower access over time, with recent cohorts increasingly concentrated in not approved and unavailable categories, pointing to a growing backlog and widening access gap despite ongoing innovation

"These technologies being incorporated are older, and I don't know how we can get to the newer ones; there's a backlog."

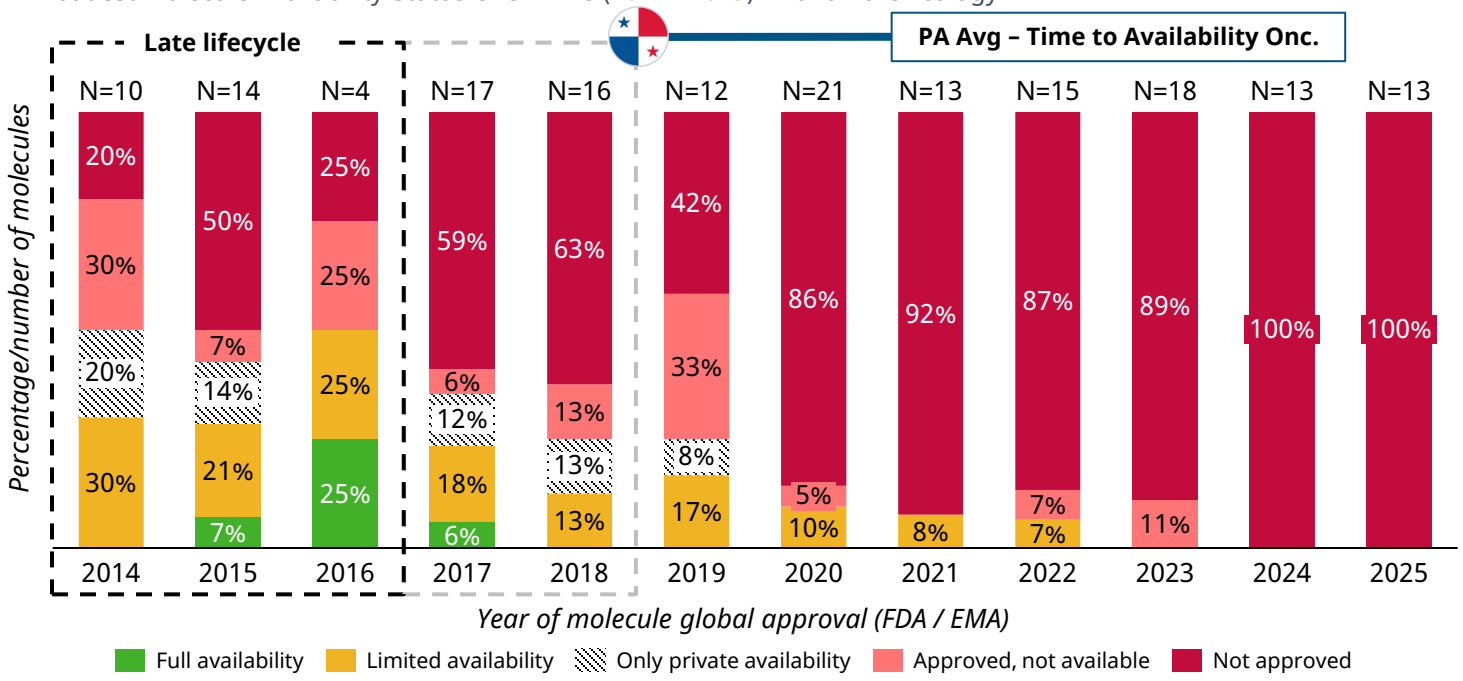
- ex-Minister of Health

Acronyms: FDA: US Food & Drug Administration; EMA: European Medical Agency

Oncology access decreases over time

Approvals drop sharply after 2020, with fewer than 87% of oncology drugs approved since 2021, with partial access achieved through limited and private channels

Broadest Molecule Availability Status Over Time (2014 - 2025) – Panama Oncology



- Full availability of oncology molecules in Panama has historically been marginal and is now absent, peaking at 25% in 2016, but dropping to 0% from 2020 onwards, confirming that recent oncology innovation has not reached the public system at all
- The share of oncology molecules that are not approved rises sharply in recent years, increasing from 20% in 2014 to 87% in 2022, 89% in 2023, and 100% in 2024 and 2025, highlighting major barriers for newer oncology therapies
- Approved-but-not-available molecules represent a meaningful share in earlier cohorts, 30% in 2014 and peaking at 33% in 2019, suggesting that even when regulatory approval was achieved, post-approval bottlenecks delayed real-world availability, a pattern that has since been overtaken by the broader collapse in approvals
- Limited and only-private availability together provided a partial access pathway in early cohorts, accounting for ~30–50% of molecules in 2014–2018, but have eroded sharply since 2020, with most recent cohorts showing zero contribution from these channels
- In Panama, late-lifecycle cohorts (2014–2016) show the most diversified access mix, reflecting that older oncology molecules eventually found pathways through limited or private channels over time; however, this dynamic has not repeated for newer cohorts, pointing to a widening generational gap in oncology access

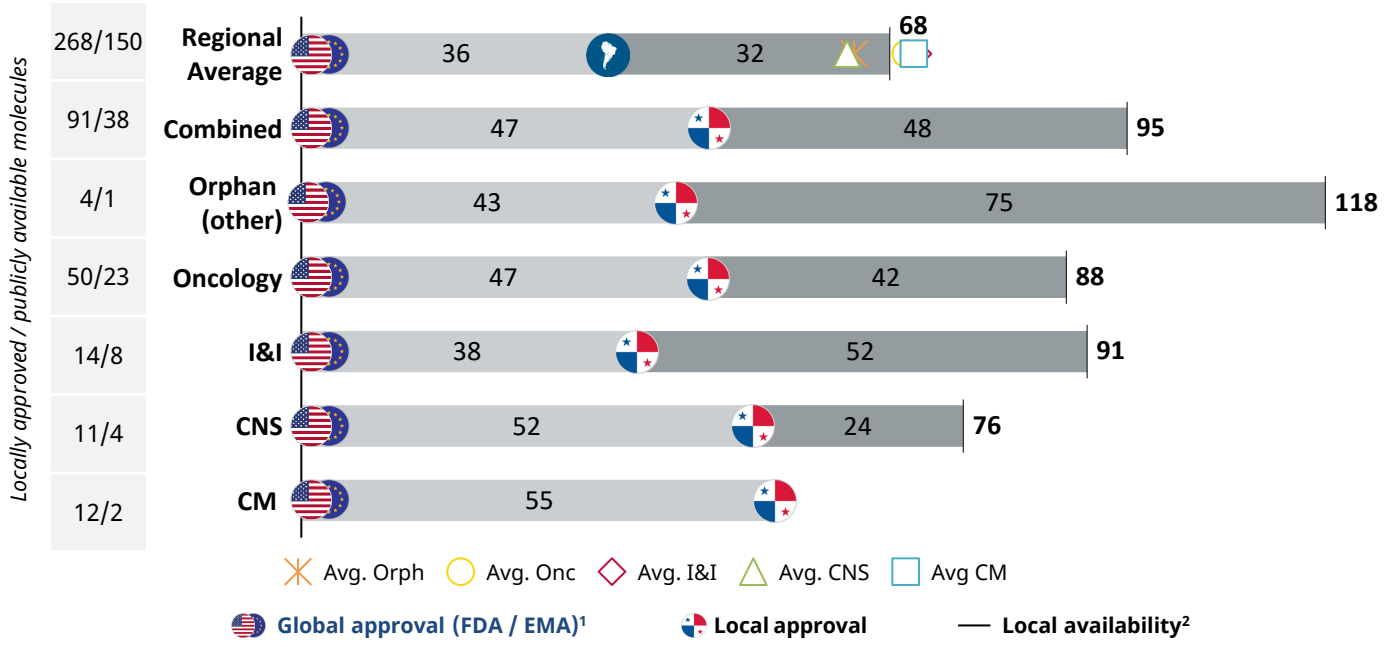
Access to oncology molecules in Panama has worsened over time, with newer cohorts increasingly concentrated in not approved or restricted-access categories

Acronyms: FDA: US Food & Drug Administration; EMA: European Medical Agency

Access is a long and fragmented process

The time to availability in Panama averages 7.9 years, with a time to approval of 3.9 years and a time to availability of 4 years

Time to Availability from Global Approval (2014 - 2025) – Panama Combined



[1] Global approval date considered the earliest date between FDA or EMA
[2] Considering molecules with Full and/or Limited Availability

- Total time to availability in Panama reaches ~95 months (~7.9 years), way above the regional average (68 months), confirming that patient access remains significantly delayed despite earlier innovation approvals in Panama
- Orphan (other) therapies face the longest journey, with 118 months (~9.8 years) from global approval to local availability, driven primarily by an extreme 75-month post-approval delay, the longest of any TA, reflecting structural barriers in funding, prioritization, and procurement of rare disease therapies
- Panama's regulatory pathway adds ~11 months vs. the regional benchmark (47 vs. 36 months), while the post-approval gap is ~16 months wider (48 vs. 32 months), confirming that the country lags the region at both stages but more severely after approval
- Oncology and I&I show similar total timelines (~88–91 months) but with different bottleneck profiles: Oncology delays are more balanced, while I&I is heavily weighted toward post-approval delays, reflecting funding and reimbursement challenges in chronic immune-mediated conditions

Panama's access process is structurally slower than the regional benchmark at every stage, with delays compounding from regulatory approval through post-approval availability

Acronyms: FDA: US Food & Drug Administration; EMA: European Medical Agency; CM: Cardiometabolic; CNS: Central Nervous System; I&I: Inflammation and Immunology

Timelines lengthened in 2026, driven by post-approval delays

Panama's regulatory pathway shows mixed dynamics across therapeutic areas, with approval timelines lengthening modestly in most TAs while availability data remains pending

Time to Availability from Global Approval vs. 2025 – By TA in Panama

	Approved	Available	Total
Regional average	-5.6%	+9.4%	+1.5%
Combined	+2.1%	-	-
Orphan (other)	-	-	-
Oncology	+2.1%	-	-
I&I	-	-	-
CNS	+5.8%	-	-
CM	+5.5%	-	-

- Approval timelines have lengthened across all measurable TAs in Panama, with the combined indicator worsening by an increase of 2.1%, contrasting sharply with the regional improvement of –5.6%, confirming that Panama is moving in the opposite direction of the broader LATAM trend at the regulatory entry stage
- CNS shows the steepest deterioration (+5.8%), followed closely by CM (+5.5%), indicating that high-burden therapeutic areas with large patient populations are facing growing regulatory friction, likely driven by submission backlogs, prioritization gaps, and limited reviewer capacity
- Oncology approval times also worsened (+2.1%), matching the combined average, suggesting that even high-priority disease areas are not benefiting from accelerated pathways in Panama
- Availability times for Orphan and I&I therapies have remained the same compared to the 2025
- The contrast with the regional benchmark is critical: while LATAM improved approval timelines (–5.6%) but saw availability worsen (+9.4%), Panama is deteriorating at the approval stage with no visibility into downstream performance, signaling a deeper structural disconnect

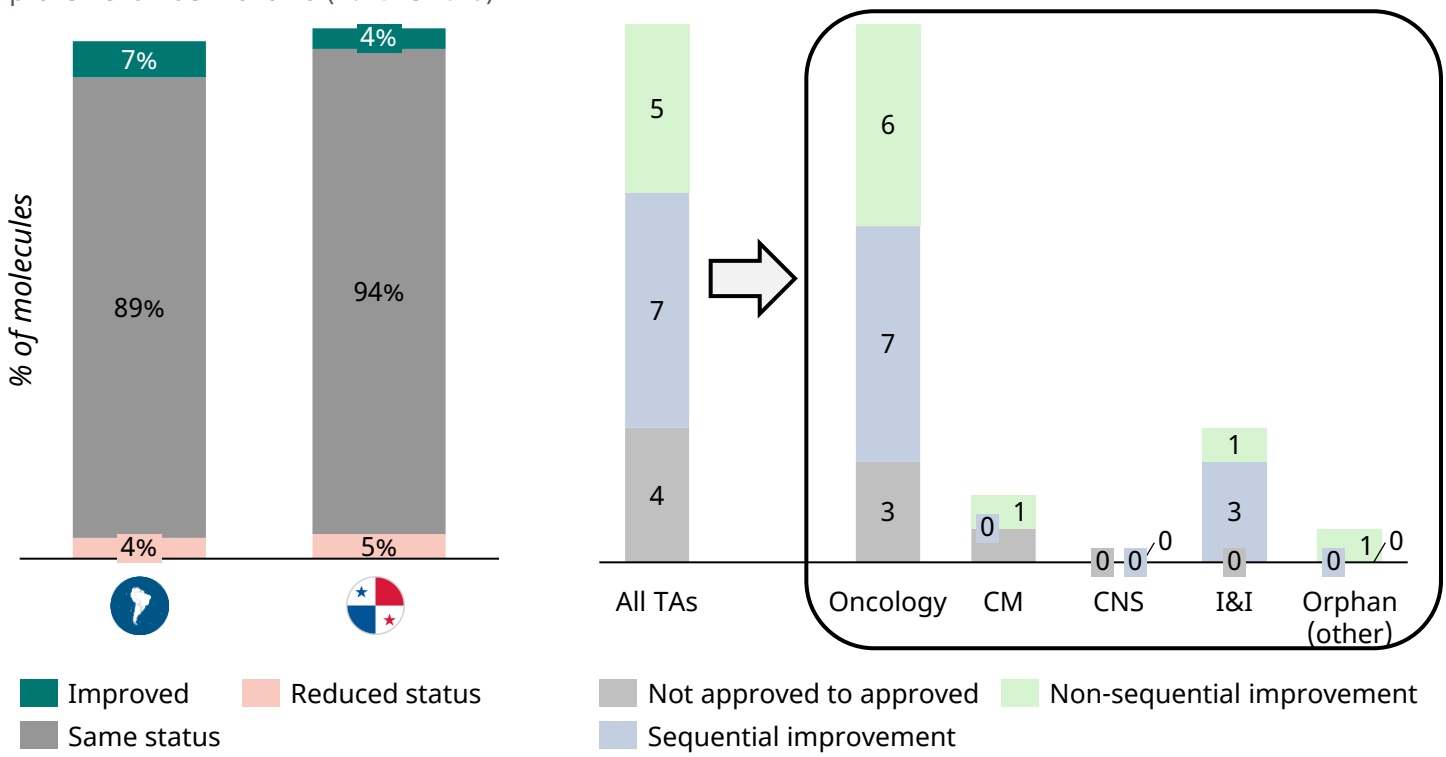
Panama's regulatory pathway has slowed across nearly all therapeutic areas, while the absence of measurable availability data points to a stalled post-approval pipeline

Acronyms: CM: Cardiometabolic; CNS: Central Nervous System; I&I: Inflammation and Immunology; TA: Therapeutic Area

Panama’s improvement rate lags the regional average

Panama shows a lower improvement rate than LATAM in 2026 vs 2025, with progress narrowly concentrated in Oncology and minimal movement across other therapeutic areas

Improvement Index Panama (2026 vs 2025)



- Panama's improvement rate (4%) is nearly half the regional average (7%), while reductions in status are slightly higher (5% vs. 4%), confirming that the country is not only progressing more slowly than the region but also showing modest backsliding in a subset of molecules
- Most molecules (94%) remained in the same status year-over-year, exceeding LATAM's 89% inertia, indicating that Panama's access landscape is highly static, with limited dynamism in either upward transitions or new approvals translating into broader availability
- A portion of molecules (~5%) experienced reduced status, consistent with the regional benchmark (~4%); this can represent molecules that have become obsolete due to clinically superior options becoming available, competitive dynamics, etc.
- Across the therapeutic areas, more improvements are made in Oncology, the least in CNS, but overall, there are low number of improvements

Panama's improvement dynamics are narrower and slower than the regional benchmark, with Oncology absorbing the bulk of progress while most other therapeutic areas remain static or backsliding

Acronyms: CM: Cardiometabolic; CNS: Central Nervous System; I&I: Inflammation and Immunology

Recent system reforms are creating tangible opportunities

Targeted updates to formularies, procurement processes, and access mechanisms are emerging and may support more structured and predictable patient access

Recent Health Reforms in Panama



Panama is introducing targeted system improvements that may support access expansion

- Expansion of CSS medicine list with new molecules
- Updates to procurement processes and supply coordination
- Initial use of innovative access and procurement mechanisms
- Gradual strengthening of institutional processes across CSS and MINSA

- Recent updates to the CSS medicine list, including the addition of new molecules, indicate efforts to expand access to innovative treatments; this represents a key step in improving availability, as formulary inclusion remains a critical gateway for access within the public system
- Panama installed the "Comisión para la Evaluación del Desabastecimiento Crítico de Medicamentos" in October 2025 to strengthen management and availability of medicines in the public system; MINSA stated that this commission reviews and unifies MINSA and CSS medicine lists to identify products that may be declared under critical shortage, enabling joint or individual purchases inside or outside the country through expedited procedure
- CSS has introduced major centralized procurement processes for medicines used in chronic, rare, oncologic, neurologic, hematologic, infectious, and degenerative diseases; in May 2025, CSS launched its first centralized tender for medicines for chronic and rare diseases
- MINSA's 2025 resolution establishes the implementation of the national Telesalud program, grounded in Panama's Law 203 of 2021, which defines telehealth and telemedicine as mechanisms to support access, reduce hospital congestion, enable preventive diagnosis, and allow remote patient monitoring

Panama's reforms are improving the access architecture, but real impact will depend on converting procurement and digital health initiatives into consistent medicine availability

Sources: Global Health Expenditure Database, International Trade Administration, OECD
Acronyms: MINSA: Ministerio de Salud; CSS: Caja de Seguro Social

Panama is evolving toward greater international alignment

The regulatory framework is strengthening through improved global engagement and technical capacity, but remains primarily nationally driven with limited reliance integration

Global Reliance of Panama's Health Agencies



salud
Ministerio de Salud
Panamá

DIRECCIÓN NACIONAL
DE FARMACIA Y DROGAS

Global Reliance

Panama is introducing reliance-based approvals and strengthening regulatory oversight, improving efficiency while remaining primarily a nationally executed system

- Panama has implemented expedited registration mechanisms that recognize approvals from WHO-listed regulatory authorities, allowing medicines already evaluated in high-standard jurisdictions to be registered through a simplified pathway; this reduces duplication of regulatory work and can significantly shorten approval timelines, marking an important shift toward a reliance-based regulatory model
- Recent updates by the National Directorate of Pharmacy and Drugs (DNFD) strengthen regulatory control across the full lifecycle of medicines, including GMP for storage, distribution, and transport, as well as updated certification and verification processes
- The DNFD has advanced digital tools such as the FADDI platform and updated regulatory portals to manage registration submissions, tracking, and documentation, improving transparency and administrative efficiency
- Panama's regulatory framework is evolving toward greater alignment with international standards, combining emerging reliance mechanisms with stronger technical oversight and digital tools; however, the system remains primarily nationally executed, with limited participation in global collaborative review initiatives and only partial reliance integration

Panama is advancing toward a more efficient and aligned regulatory system through reliance pathways and strengthened oversight, but remains in an early stage of integration into global regulatory frameworks

Acronyms: DNFD: Dirección Nacional de Farmacia y Drogas; MINSA: Ministerio de Salud; GMP: Good Manufactoring Practices; FADDI: Farmacia y Drogas Digital; WHO: World Health Organization

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Local trade associations also supported in the development and validation of the study

AMIIF, MX

CAEME, AR

AFIDRO, CO

CIF, CL

FEDEFARMA, CAC

INTERFARMA, BR

ALAFARPE, PE

IFI–Promesa, EC

Definitions and additional notes on methodology

Assumptions and rules to identify a NAS

- A NAS must be an active moiety and therefore cannot be a purified biologic entity (e.g., biosimilar, bio-betters, certain tissue products
- If the new approval is a combination, it needs at least one new compound in the product
- The NAS may be a pro-drug (i.e., a substance which is inactive when administered and which requires metabolism to produce an active metabolite). In such case, the active metabolite may not be novel. However, provided that the pro-drug is novel (i.e., not previously approved by any regulatory authority and not available for commercial sale), the pro-drug would be a NAS
- A different ester form of an existing substance would also not be precluded from consideration for NAS status
- New salts, polymorphs, enantiomers, isoforms, solvates, hydrates, crystalline forms, or other noncovalent derivatives of previously approved substances are not NASs unless they are deemed to be by a regional or national regulatory authority

Selection of NAS molecules

1. NAS with FDA/EMA approval 2014-2025 in relevant TAs
2. Global launch rest of world - (without US launch): Products that are typically not exposed to the global market e.g., homegrown PD-1s in China, endemic response in Africa etc.
3. Pandemic response - outbreaks (e.g., COVID), and respective treatments may be subject to exceptional routes to access and procurement dynamics
4. Vaccines - also have different routes to access, confounding comparison; FIFARMA Time to Vax study in development to assess these separately
5. Other non-comparable agents e.g., imaging/diagnostics - agents not directly used in treatment and also not directly comparable
6. Withdrawn/not launched - typically a repeal of conditional approval based on not meeting evidence requirements and resulting in global withdrawal/or not launched

	Overview of additional TAs selected		
	I&I		**CM**
ATC2 Examples**	L4, M1, D5, A7	N3-7, L04	B1, C2, C10, A10
Class Examples	ILis, JAKis	CGRPis, antiamyloid mAbs	PCSK9i, GLP1s, GH
Product Examples	Skyrizi, Olumiant, Cibinqo, Ultomiris, Tremfya	Leqembi, Zurzuvae, Nurtec, Ubrelvy	Ozempic, Ngenla, Repatha
Indication Examples	RA / CD / UC / PSO / PSA	AD / MS / ALS / DMD	HF / Diabetes / GHD

Notes on sources and validation process

THIS REPORT IS BASED ON THE SOURCES DETAILED BELOW

IQVIA NRC/ MIDAS™ is a unique platform for assessing worldwide healthcare markets. It integrates IQVIA's national audits into a globally consistent view of the pharmaceutical market, tracking virtually every product in hundreds of therapeutic classes and provides estimated product volumes, trends and market share through retail and non-retail channels. MIDAS data is updated monthly and retains 12 years of history. IQVIA MIDAS was used by each local IQVIA team to provide the existing data

PUBLICLY AVAILABLE INFORMATION for each market was incorporated in the study from agencies and regulatory bodies

LABORATORY INTERNAL DATA was asked via a Smartsheet survey and collected from each of the manufacturers included in the study, as well as via interviews to understand underlying dynamics

LOCAL TRADE ASSOCIATION DATA was collected from associations and validated, in addition to the development of the definitions for their respective countries

Former **Ministry of Health stakeholders** were interviewed across a number of countries in scope to provide additional perspective and validation

THE DEVELOPMENT OF THE REPORT FOLLOWS A PROCESS OF MULTI-STAKEHOLDER INPUT AND VALIDATION

The initial selection of molecules as described on page 20 is made the core IQVIA project team and validated by FIFARMA

Definitions for availability are developed/updated by the local IQVIA consulting teams and validated by local trade associations

The approval/availability data is then gathered by IQVIA local consulting teams leveraging the data sources outlined (to the left)

This data is validated by IQVIA and FIFARMA and, in a confidential manner, shared to the respective, marketing-authorization laboratories for validation and complementing

IQVIA local consulting teams perform a final validation of the data and IQVIA core project team performs the relevant analyses

IQVIA core project team develops the preliminary report for final validation by the FIFARMA and local trade organization representatives prior to publication

For local country reports, trade associations perform a further validation prior to publication

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