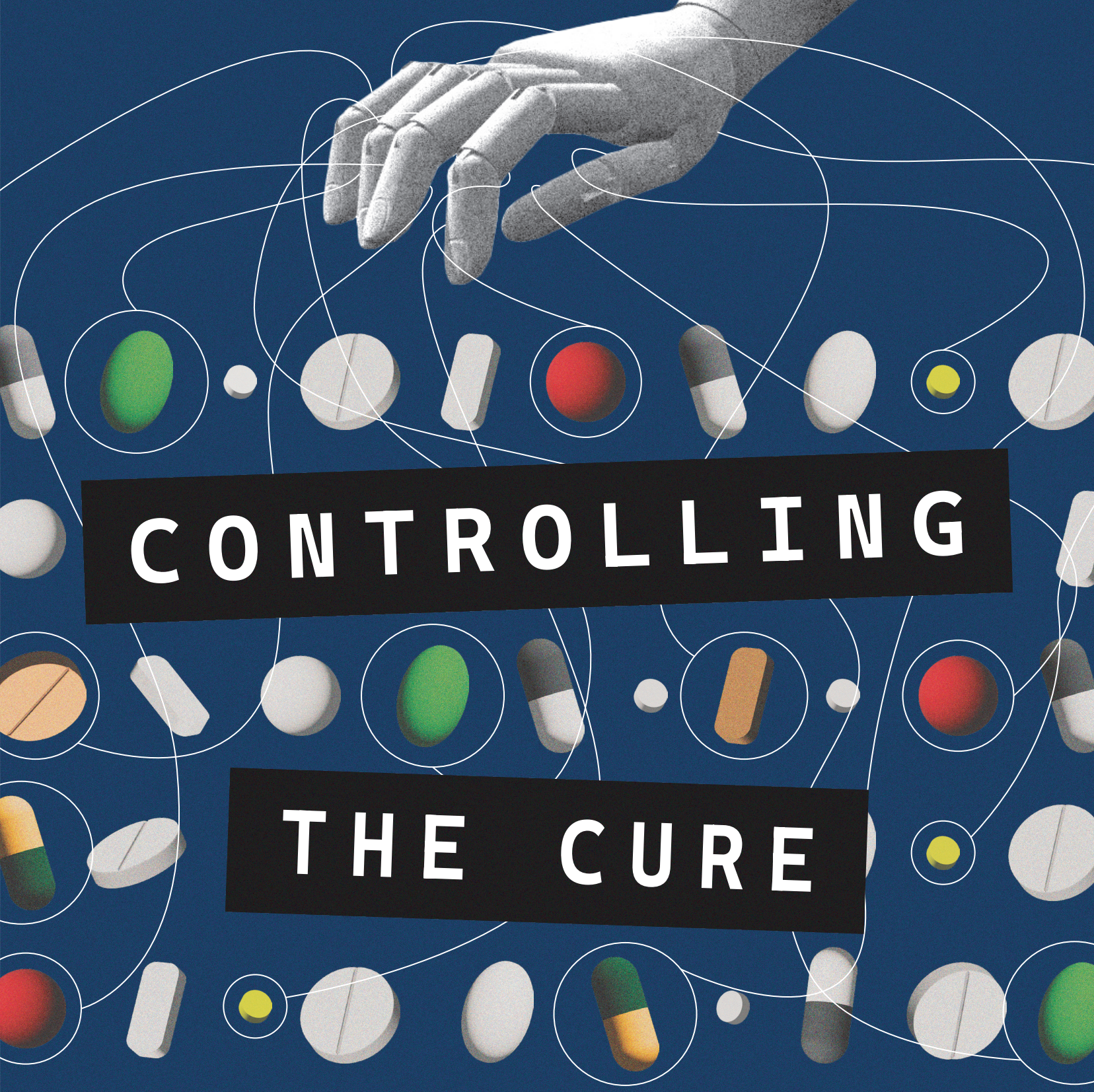

CONTROLLING THE CURE

BIG PHARMA AND PH PHARMACEUTICAL TRAP

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www.ibon.org
+63 2 8927-7060 to 61 | Fax +63 2 8929-2496
admin@ibon.org | publications@ibon.org

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ACRONYMS, ABBREVIATIONS

AC Health	Ayala Healthcare Holdings Inc.
ADCs	antibody-drug conjugates
AHP	American Home Products
AO	Administrative Order
API	active pharmaceutical ingredients
BLOM	Botika ng Lalawigan ng Oriental Mindoro
CALABARZON	Cavite, Laguna, Batangas, Rizal, Quezon (Region IV-A)
CAR	Cordillera Administrative Region
CDMO	Contract Development and Manufacturing Organization
CMO	Contract Manufacturing Organization
COPD	chronic obstructive pulmonary disease
CREATE	Corporate Recovery and Tax Incentives for Enterprises
DNA	deoxyribonucleic acid
DOH	Department of Health
DOST	Department of Science and Technology
DVT	Deep Vein Thrombosis
EO	Executive Order
FDA	Food and Drug Administration
GLP-1	glucagon-like peptide-1
GMP	Good Manufacturing Practice
GSK	GlaxoSmithKline
HAIN	Health Action Information Network
HIV	Human Immunodeficiency Virus
IB	Institute of Biology
IC	Institute of Chemistry
IND	Investigational New Drug
IP	intellectual property
IPC	Institute of Popular Culture
IPR	intellectual property rights
kg	kilogram
M&A	mergers and acquisitions
MAH	marketing authorization holder
MDRP	Maximum Drug Retail Price
Med Rep	medical representative
MNC	multinational corporation
MPR	median price ratio
MSI	Marine Science Institute
NCEs	New Chemical Entities
NCR	National Capital Region
NDA	New Drug Application
NIH	National Institutes of Health
NIMBB	National Institute of Molecular Biology and Biotechnology
OTC	over-the-counter
PCHRD	Philippine Council for Health Research and Development
Pharma-Dev Zones	Pharmaceutical and Medical Device Ecozones
PDP	Philippine Development Plan
PEZA	Philippine Economic Zone Authority
PITC	Philippine International Trading Corporation
PTC	Pharmaceutical Therapeutic Committee
R&D	research and development

RA	Republic Act
SGLT2	sodium-glucose co-transporter 2
TGP	The Generics Pharmacy
TNC	transnational corporation
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UP	University of the Philippines
USFDA	United States Food and Drug Administration
USPTO	United States Patent and Trademark Office
VAT	value-added tax
WIPO	World Intellectual Property Office
WTO	World Trade Organization

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INTRODUCTION

The global pharmaceutical industry is dominated by only a handful of multinational corporations, called Big Pharma. They operate at the intersection of public health and profit, undermining the people's right to health.

Big Pharma dominates research pipelines, patent portfolios, and global supply chains, giving it immense power to set prices far beyond production costs. Through aggressive patent evergreening, strategic litigation against generics, and heavy lobbying of regulators, these pharmaceutical giants extend monopolies that restrict competition and keep life-saving medicines unaffordable for millions.

Public funding frequently underwrites early-stage research, yet the resulting drugs are privatized and sold back to the public at exorbitant prices, socializing risk while privatizing reward. The result is a system where access to treatment depends less on medical need and more on purchasing power.

Moreover, Big Pharma's influence over clinical trials, marketing practices, and policy design raises deep ethical concerns. Selective publication of trial data, close financial ties with physicians, and the prioritization of "blockbuster" drugs over neglected diseases skew innovation toward the most profitable markets rather than the most urgent health burdens.

In low- and middle-income countries such as the Philippines, this dynamic exacerbates structural inequities, as essential medicines remain out of people's reach and local production is constrained by global intellectual property regimes. While pharmaceutical innovation has undeniably saved lives, the prevailing profit-driven model undermines the right to health by treating medicine primarily as a commodity rather than a public good. A country like the Philippines, which lacks locally produced pharmaceuticals and an established national industry, is bound to be caved in between foreign and private entities, with profit standing as priority.

MONOPOLY POWER

The modern pharmaceutical industry began in the 1800s. It grew out of small apothecaries that mixed herbal medicines by hand. By the mid-19th century, companies such as Merck in Germany (which began as a pharmacy in 1668) began producing purified chemical medicines on a larger scale. This marked the shift from traditional remedies to a science-based industry.[1]

In the late 1800s and early 1900s, major drug companies were established in both Europe and the United States, such as Pfizer (founded in 1849) and Glaxo's early predecessor in the United Kingdom (1859). Wars increased the demand for medicines like antiseptics and painkillers, helping these companies grow.

Major scientific discoveries, like insulin in 1921 and penicillin in 1928, were developed further and mass-produced through cooperation between pharmaceutical companies and governments during World War II. This opened a new era of modern drug development.

After the war, the industry expanded quickly with the rise of antibiotics, vaccines, and other life-saving medicines. The creation of national health systems (NHS), such as the United Kingdom's NHS in 1948, also provided stable markets for pharmaceutical products.

Vaccine development has indeed contributed to the substantial growth of the pharmaceutical industry. In 2021, for instance, the COVID-19 pandemic strengthened the need for research and development (R&D) and vaccine demand and production. The COVID-19 vaccine manufacturing capacity was scaled up from zero to over 11 billion doses.[2]

Race for drug dominance

Today, the global pharmaceutical industry has grown into a massive market. An estimated US$4.7 trillion market capitalization is held by just 50 companies, with 56% based in the United States, followed by Europe (34%) and Asia Pacific (10%).[3]

As of April 2026, Eli Lilly (US$828.3 billion) has consistently dominated the market, followed by Johnson & Johnson (US$566.8 billion), AbbVie (US$373.5 billion), Roche (US$337.5 billion), and AstraZeneca (US$317 billion). (See **Table 1**) Eli Lilly's dominance is driven by the explosive growth of GLP-1 receptor agonist drugs for diabetes and obesity.[4]

TABLE 1. Top 10 biotech companies by market cap, as of April 2026

RANK	COMPANY	MARKET CAPITALIZATION (in billion US$)	SHARE PRICE (in US$)	COUNTRY
1	Lilly	828.3	925.5	United States
2	Johnson&Johnson	566.8	235.2	United States
3	abbvie	373.5	211.1	United States
4	Roche	337.5	424.2	Switzerland
5	AstraZeneca	317.0	204.5	United Kingdom
6	NOVARTIS	292.8	151.7	Switzerland
7	MERCK	289.8	117.2	United States
8	ThermoFisher SCIENTIFIC	196.1	527.8	United States
9	AMGEN	190.9	354.1	United States
10	novo nordisk®	182.3	40.9	Denmark

SOURCE: *Capital Com Online Investments Ltd.*

In terms of revenue, the global pharmaceutical industry is estimated at US$1.77 trillion as of 2025 and is predicted to reach US$3.12 trillion by 2035.[5] [6] Johnson & Johnson tops the list (US$94.2 billion), followed by Roche (US$79.3 billion), Eli Lilly (US$65.2 billion), Pfizer (US$62.6 billion), and AbbVie (US$61.2 billion). (See **Table 2**) These companies drive innovation in oncology, immunology, and vaccines, with top players increasingly focused on high-growth areas like diabetes, obesity, and targeted therapies.[7]

TABLE 2. Top 10 biotech companies by market revenues, 2025 (in billion US$)

RANK	COMPANY	Q1	H1	9M	ANNUAL
1	Johnson&Johnson	21.9	45.6	69.6	94.2
2	Roche	18.7	38.3	56.8	79.3
3	Lilly	12.7	28.3	45.9	65.2
4	Pfizer	13.7	28.4	45.0	62.6
5	abbvie	13.3	28.7	44.5	61.2
6	AstraZeneca	12.9	28.0	43.2	58.7
7	MERCK	13.6	27.7	43.3	58.1
8	NOVARTIS	13.2	27.3	41.2	54.5
9	sanofi	11.2	23.0	37.5	51.6
10	novo nordisk®	12.2	24.2	35.7	49.0

SOURCE: *iPharmaCenter Consulting Services*

Johnson & Johnson tends to top overall corporate revenue because it includes consumer health and medical devices, not just pharma. If pharma-only sales are calculated, Eli Lilly continues to lead the global pharmaceutical industry, as it is almost entirely pharmaceuticals. Its revenue growth has been driven by the robust uptake of its popular GLP-1 drugs, Mounjaro for Type II diabetes, and Zepbound for obesity.[8]

However, in terms of worldwide prescription drug sales, Pfizer has led for more than two decades, though the last two years saw the end of its reign amid steep declines in demand for COVID-19 vaccines and therapies.[9] Pfizer's dive put it at number 6 in 2023, dethroned by Johnson & Johnson, though Pfizer's acquisition of oncology power Seagen for US$43 billion by the end of the year could nudge it back up the rung.[10] (See **Table 3**)

In 2024, Merck held the top position, drawing on the sales of its drug Keytruda, the world's best-selling drug, whose sales rose 18% that year. Keytruda accounts for about 46% of Merck's sales. As expected, Pfizer regained the second position, with its anticoagulant drug Eliquis, Prevnar vaccine, and Vyndaqel franchise.[11] (See **Table 4**)

Johnson & Johnson sustained its sales momentum from oncology and immunology drugs, with its top seller, Darzalex. AbbVie is successfully navigating the patent expiry of its long-time blockbuster, Humira, while its new immunology drugs Skyrizi and Rinvoq surged. AstraZeneca has successfully built out its product portfolio, especially in oncology and cardiovascular/metabolic diseases. Standout products include the SGLT2 inhibitor, Farxiga/Forxiga, and the cancer treatment, Tagrisso.[12]

While tirzepatide's unique properties have helped fuel Eli Lilly's growth, Novo Nordisk continues to maintain market dominance with nearly 55% of the total GLP-1 market share. Its diabetes medication, Ozempic, saw growth of 26% in 2024, with its US patent protection secure until 2032, while its weight loss drug, Wegovy, nearly doubled sales from 2023.

Overall, the best-selling drugs that drive up the sales of pharmaceutical companies are for the treatment of obesity, Type II diabetes, cancers, and other inflammatory diseases. (See **Table 5**) The largest regional market is North America, accounting for 53% of sales, followed by Europe (23%), China (8%), and Japan (7%).[13]

Drug development cannot be overemphasized as crucial and beneficial to public health. But giant pharmaceutical companies have captured drug development only to profit from it. They have done this by controlling R&D, patents, and intellectual property rights (IPR), and by sheer monopoly of the global supply chain.

Profiting more from inventions

Pharmaceutical companies invest in R&D to create new medicines and vaccines – from developing the active pharmaceutical ingredients (API) to bringing the drug to market. API development starts with screening thousands of chemical or biological compounds to find ones that could treat diseases or new conditions. For vaccines, this means identifying antigens that trigger the immune system to produce antibodies and protect against illness. Out of around 5,000-10,000 compounds tested, only one is usually found to be promising.[14]

TABLE 3. Top 10 pharmaceutical companies based on prescription drug sales, 2023 (in billion US$)

RANK	COMPANY	Rx SALES	R&D SPEND	TOP-SELLING DRUGS	
				BRAND	SALES
1	Johnson&Johnson	53.5	14.8	Stelara	10.9
				Darzalex	9.7
				Tremfya	3.1
2	abbvie	52.7	7.0	Humira	14.4
				Skyrizi	7.8
				Rinvoq	4.0
3	NOVARTIS	52.5	8.6	Entresto	6.0
				Cosentyx SC	5.0
				Promacta	2.3
4	MERCK	50.8	29.7	Keytruda	25.0
				Gardasil	8.9
				Januvia	2.2
5	Roche	49.1	14.7	Ocrevus	7.1
				Hemlibra	4.2
				Perjeta	4.2
6	Pfizer	48.2	10.7	Comirnaty	11.2
				Prevnar 13	6.4
				Ibrance	4.8
7	Bristol Myers Squibb	44.4	9.1	Eliquis	12.2
				Opdivo	9.0
				Revlimid	6.1
8	AstraZeneca	43.8	10.3	Farxiga	6.0
				Tagrisso	5.8
				Imfinzi	4.0
9	sanofi	40.8	7.3	Dupixent	11.6
				Fluzone	2.9
				Pentacel	2.3
10	GSK	36.8	7.2	Shingrix	4.3
				Trelegy	2.7
				Dovato	2.3

SOURCE: *Pharmaceutical Executive*

TABLE 4. Top 10 pharmaceutical companies by revenues, 2024 (in billion US$)

RANK	COMPANY	COUNTRY	REVENUES
1	MERCK	United States	64.2
2	Pfizer	United States	63.6
3	Johnson&Johnson	United States	57.1
4	abbvie	United States	56.3
5	AstraZeneca	United Kingdom	54.1
6	Roche	Switzerland	52.5
7	NOVARTIS	Switzerland	50.3
8	Bristol Myers Squibb	United States	48.3
9	Lilly	United States	45.0
10	sanofi	France	44.5

SOURCE: *Drug Discovery & Development*

TABLE 5. Top 10 drugs by revenues, 2025 (in billion US$)

RANK	BRAND	REVENUES	COMPANY	INDICATIONS
1	Keytruda	31.7	MERCK	Cancer
2	Mounjaro	23.0	Lilly	Type 2 diabetes/weight loss
3	Ozempic	20.0	novo nordisk	Type 2 diabetes/weight loss
4	Dupixent	18.5	sanofi / REGENERON	Inflammatory diseases
5	Skyrizi	17.6	abbvie	Psoriasis
6	Darzalex	14.5	Johnson&Johnson	Cancer
7	Eliquis	14.4	Bristol Myers Squibb / Pfizer	DVT/pulmonary embolism
8	Biktarvy	14.3	GILEAD	HIV replication cycle
9	Zepbound	13.5	Lilly	Weight loss
10	Wegovy	12.5	novo nordisk	Weight loss

DVT *- Deep Vein Thrombosis* ***HIV*** *- Human Immunodeficiency Virus* ***SOURCE:*** *iPharmaCenter Consulting Services*

Researchers carefully test the compound to make sure it works, is safe, and is not harmful. The testing occurs in two stages – pre-clinical and clinical – and can take 10 to 15 years for both medicines and vaccines. Pre-clinical trials have two types: in vitro – testing done in a laboratory, outside a living body; and in vivo – testing done on animals.[15]

Before starting clinical trials, a company must first apply for an Investigational New Drug (IND). This is a request for the government's drug regulator (such as the Food and Drug or FDA) for permission to test a new drug or vaccine on humans.

In clinical trials, new drugs are tested on human volunteers to evaluate their safety and effectiveness in three phases:

- **Phase I** – 20-100 volunteers; about 57% chance of success
- **Phase II** – 100-500 volunteers; about 39% chance of success
- **Phase III** –1,000 to 5,000 volunteers; about 68% chances of success[16]

After these trials, the company applies for a New Drug Application (NDA) – a request to the drug regulator for approval to sell the drug. Even then, the return on investment is uncertain, with about 1 in 3 chances of success.

The global pharmaceutical industry spends heavily on R&D. It has also consistently invented the most. Compared to other high-tech industries, it spends annually 8.1 times more than aerospace and defense; 7.2 times more than the chemicals industry; and 1.2 times more than software and computer services.[17] Its R&D work alone contributes about US$227 billion to global GDP, which is 30% of its total contribution to the world economy.[18]

Patents as monopoly tool

Patents are exclusive rights given to inventors, pharmaceutical companies, or research organizations to protect their innovations in drug development. Patents protect innovators legally, preventing others from making, using, selling, or importing their patented inventions without permission. Patents typically last for 20 years, creating a firm monopoly and supporting recovery of R&D costs.[19] That exclusivity is a major incentive for firms to invest in expensive, high-risk drug development.

While a patent is active, the company can block generic competition and usually has substantial pricing power. Firms often use follow-on patents for new formulations, dosing regimens, or new uses to extend protection and delay generic entry and competition. This is why patents are often described as a "mini monopoly" in pharma.[20]

Patents can keep drug prices high and limit access while they are in force. Once patents expire, generic competition usually drives prices down, making medicines more accessible. Until then, policymakers must balance incentives for innovation with affordability, using tools such as price controls, patent challenges, and rules that

allow generic entry. Otherwise, drug patents can become a key mechanism for market control and profiteering, shaping how much patients and health systems pay.[21]

Primary patents on 7 out of 10 of the US's top-selling drugs are set to expire this decade. But the major pharmaceutical companies are delaying this by filing or amassing hundreds of patents, called "patent thickets", a strategy to extend monopoly power. On average, there are 74 granted patents on each of the US's 10 top-selling drugs, providing major drugmakers a substantial advantage to keep generic and biosimilar competitors off the market for a long time. The drugmakers filed more than 140 patent applications on average per drug; on average, 66% of the applications were filed after the FDA approved the drug to be on the market.[22]

"Patent thicket" refers to the dozens or even hundreds of patent applications that drugmakers file with the US Patent and Trademark Office (USPTO) and the patents that are actually granted. These serve as barriers that generic and biosimilar competitors must avoid to stay in compliance with the law, deterring them in the process from entering the market for a considerable time.

Cheap medicines are out of the hands not just of the American public but of the global population, and pharmaceutical giants are free to set astronomical prices. The public ends up paying a lot more for branded medicines. To illustrate, lower-cost generic and biosimilar versions of three top-selling drugs – Humira, Eliquis, and Enbrel – were launched in Europe an average of 7.7 years earlier than their expected US entry. During this time, Americans will spend an estimated US$167 billion on branded versions of just these drugs.[23]

TRIPS for Big Pharma

The World Trade Organization's (WTO) Trade-Related Aspects of Intellectual Property Rights (TRIPS) contributes to global pharmaceutical patenting by setting minimum patent standards that all WTO members must apply, including for medicines.[24] In practice, TRIPS pushes many countries to adopt stronger and more uniform patent protection for drugs, especially product patents and longer effective exclusivity.

TRIPS requires patents for technological inventions with a minimum term of 20 years, and it applies these standards across WTO members. Before TRIPS, many developing countries had weak or no pharmaceutical product patent protection, so generic copying was easier, and patents were shorter or narrower. After TRIPS, countries had to enforce patent rights more consistently, which increased the global scope and predictability of pharmaceutical patent protection. Stronger patent protection has given drug companies a longer window of market exclusivity, which supports high prices and R&D recoupment.

TRIPS does include flexibilities such as compulsory licensing and limited exceptions, and the WTO Doha Declaration on TRIPS and Public Health clarified that TRIPS should

be interpreted in a way that supports access to medicines. In practice, however, using these safeguards can be difficult, so the default effect of TRIPS has often been to strengthen patent control in pharmaceuticals.

The TRIPS patent regime has resulted in a tremendous increase in global patenting. In 2023, innovators worldwide filed 3.55 million patent applications, double from around 1 million in 1995 at the start of the WTO to approximately 2 million by 2010.[25] The World Intellectual Property Office (WIPO) of the United Nations (UN) noted that 2023 is the 4th consecutive year of growth despite a "challenging macroeconomic environment", otherwise called a global economic stagnation.[26]

Mergers & Acquisitions

Big Pharma strengthened its monopoly further through mergers and acquisitions (M&A), transforming a fragmented landscape into a highly concentrated oligopoly dominated by a handful of players. The main drivers have been patent-life-cycle pressures, R&D productivity concerns, and the strategic pursuit of blockbuster franchises, especially in oncology and biologics.

The year 1989 saw the merger of Beecham of the United Kingdom with SmithKline Beckman of the US, and that of Bristol-Myers with its US rival Squibb – this accelerated the process of consolidation.[27] In December 1996, Ciba-Geigy was a Swiss pharmaceutical and chemical company that merged with Sandoz to form Novartis.[28] But it was the merger of Glaxo Wellcome and SmithKline Beecham in 2000 and that of Pfizer and Warner-Lambert the year before, and subsequently that of Pfizer and Pharmacia in 2022, which created giants with enormous sales and market capitalization.[29] Pfizer's acquisition of Warner-Lambert was the largest deal at US$111.8 billion, which brought in the blockbuster atorvastatin (Lipitor).[30] (See **Table 6**)

To get an idea of the size of the companies created through M&A, and the scale of business operations, it is worthy to look at GlaxoSmithKline (GSK) and Pfizer. The merger of GSK created a 110,000-workforce, R&D budget of nearly US$4 billion a year, making it the most powerful force in British science after the government. Pfizer, on the other hand, spoiled the agreed merger of American Home Products (AHP) and Warner-Lambert only hours after its announcement, by raising the original offer by 10% and paying AHP US$1.8 billion as a break-up fee – the largest ever paid. At one stroke, the merger created a company that would become one of the world's largest drug-makers.[31]

Other M&As in the early years included Hoechst, a German chemicals company, which later became a life sciences company, merging with France's Rhône-Poulenc and forming Aventis Deutschland.[32] In 2004, Sanofi-Synthélabo merged with Aventis and was renamed Sanofi-Aventis.[33] Eventually, Sanofi-Aventis was acquired by Genzyme, and simplified its name to Sanofi in May 2011.[34] Meanwhile, AbbVie is a pharma company that was spun off from Abbott in 2013.[35]

Over the 1990s–2010s, successive rounds of M&A reduced the number of global players, with several of the Big Pharma each securing roughly 8–12% of global prescription-drug sales. Recent studies (2010–2023) show that M&As take place in waves, with big spikes like 2015 (about US$314 billion in total deals) and 2016 (267 deals). However, if smaller deals are ignored, there is no clear long-term increase in the number of transactions.[36] In 2024, there were 430 announced M&A deals worth US$68.8 billion. Big Pharma will likely continue to pursue acquiring or partnering with biotech to offset losses from patent expiry, according to GlobaData's Deals Database.[37]

Market-concentration measures (like Herfindahl-Hirschman Index) show that some drug classes – such as genitourinary, anti-infectives, and ophthalmology – are now dominated by fewer companies, with M&A increasing concentration by about 10–30% in some markets. Even in more competitive areas like oncology, concentration has still increased, although new biotech products and biosimilars have partially offset consolidation.[38]

Oncology has emerged as the dominant M&A-target sector. In 2010, about 20% of pharmaceutical M&As involved oncology-focused companies. By 2021, this share had nearly doubled to around 35 percent. Key drivers include the high prices of cancer therapies, the rise of precision oncology and antibody-drug conjugates (ADCs), and the aging population backdrop.[39]

Biologics and antibody technologies have also grown sharply in prominence. Small-molecule companies remain the most common M&A targets, but biologics-focused deals have more than tripled as a share of M&A from 10% in 2010 to over 30% by 2023. Antibody-technology-driven acquisitions have risen from about 7% of deals in 2010 to roughly 22% in 2023.[40]

Using global value chains

Aside from M&A, pharmaceutical transnational corporations (TNCs) also cut costs and access specialized expertise by using global value chains. They do this by outsourcing production and development work to Contract Manufacturing Organizations (CMOs) and Contract Development and Manufacturing Organizations (CDMOs).

The global market for pharmaceutical CDMO was about US$184.9 billion in 2024. Asia Pacific had the largest share at 42.5% (US$73.6 billion).[41] The region is also the fastest-growing market, driven by lower production costs, rapid growth in biopharmaceutical research, and better compliance with global quality standards.[42] [43]

Through collaboration with contract manufacturers, Big Pharma companies escape the large capital outlays needed to establish and run their own plants while enjoying cutting-edge manufacturing capability, specialized technologies, and cheap labor of other regions and/or countries.

TABLE 6. Mergers & acquisitions in the global pharmaceutical industry, as of April 2026

RANK	YEAR	PURCHASER	TARGET	TRANSACTION TYPE	VALUE (in billion US$)
1	1999	Pfizer	Warner-Lambert	Acquisition	**111.8**
2	2000	Glaxo Wellcome plc	SmithKline Beecham	Merger (formed GlaxoSmithKline)	**76.0**
3	2019	Bristol-Myers Squibb	Celgene	Acquisition	**74.0-95.0**
3	2004	Sanofi	Aventis	Acquisition	**73.5**
4	2015	Actavis	Allergan, Inc	Acquisition	**70.5**
5	2009	Pfizer	Wyeth	Acquisition	**68.0**
6	2002	Pfizer	Pharmacia	Acquisition	**64.3**
7	2018	Takeda Pharmaceutical	Shire	Acquisition	**62.0**
8	2016	Bayer	Monsanto	Acquisition	**54.5-63.5**
9	2009	Merck & Co.	Schering-Plough	Acquisition	**47.1**
10	2009	Roche	Genentech	Acquisition	**44.0**
11	2014	Medtronic	Covidien	Acquisition	**42.3**
12	2015	Teva Pharmaceutical Industries	Actavis	Business Unit	**40.5**
13	2010	Novartis	Alcon	Acquisition	**39.3**
14	2016	Shire	Baxalta	Acquisition Unit	**32.0-35.0**
15	2016	Abbott Laboratories	St Jude Medical	Acquisition	**30.5**
16	1998	Astra AB	Zeneca	Merger (formed AstraZeneca)	**30.4**
17	2017	Johnson & Johnson	Actelion	Acquisition	**30.0**
18	1996	Ciba-Geigy	Sandoz	Merger (formed Novartis)	**29.0**
19	2006	Boston Scientific, Abbott Laboratories	Guidant	Acquisition	**27.2**
20	1999	Pharmacia & Upjohn	Monsanto	Merger	**25.2**
21	2016	Abbott Laboratories	St Jude Medical	Acquisition	**25.0-30.5**
22	2015	AbbVie	Pharmacyclics	Acquisition	**21.0**
23	2014	Actavis	Forest Laboratories	Acquisition	**20.7**
24	2011	Sanofi	Genzyme Corporation	Acquisition	**20.1**
25	2012	Johnson & Johnson	Synthes	Acquisition	**19.7**
26	2006	Bayer	Schering	Acquisition	**18.4**
27	2016	Quintiles	IMS Health	Merger (formed QuintilesIMS)	**17.6**
28	2015	Pfizer	Hospira	Acquisition	**17.0**
29	2014	Merck Group	Sigma-Aldrich	Acquisition	**17.0**

30	2001	Amgen	Immunex	Acquisition	**16.8**
31	2006	Johnson & Johnson	Pfizer Consumer Health	Business Unit	**16.6**
32	2014	Novartis	GlaxoSmithKline Oncology	Business Unit	**16.0**
33	2015	Valeant	Salix Pharmaceuticals	Acquisition	**15.8**
34	2007	AstraZeneca	MedImmune	Acquisition	**14.7**
35	2007	Schering Plough	Organon International	Acquisition	**14.5**
36	1995	Glaxo	Wellcome	Acquisition	**14.2**
37	2014	Bayer	Merck & Co Consumer Health	Business Unit	**14.2**
38	2014	Zimmer Inc.	Biomet Inc.	Acquisition	**13.4**
39	2019	Amgen	Otezla (drug programme)	Acquisition	**13.4**
40	2006	Merck Group	Serono	Acquisition	**13.2**
41	2018	GlaxoSmithKline	GlaxoSmithKline-Novartis Consumer Healthcare	Acquisition	**13.0**
42	2016	Boehringer Ingelheim	Sanofi Animal Health (Merial)	Business Unit	**12.4**
43	2017	Gilead Sciences	Kite Pharma	Acquisition	**11.9**
44	2018	Sanofi	Bioverativ	Acquisition	**11.6**
45	2011	Gilead Sciences	Pharmasset	Acquisition	**11.2**
46	2013	Amgen	Onyx Pharmaceuticals	Acquisition	**10.4**
47	2020	AbbVie	Allergan	Acquisition	**63.0**
48	2024	Novo Holdings A/S	Catalent	Acquisition	**16.5**

SOURCE: *Wikipedia, "List of largest pharmaceutical mergers and acquisitions"*

In China, a combination of skilled workers, low manufacturing costs, and simpler drug approval rules has helped the growth of CDMOs. In India, growth is driven by cheap production sites and a skilled workforce, attracting both local and global companies. The country has become a major global hub for producing APIs, generics, and biosimilars. API manufacturing, the most complex and critical part of drug development, accounts for the largest share of CDMO services at 63.7 percent. Nearly two-thirds of all APIs worldwide are produced in China and India.

PH HEALTHCARE: BIG PHARMA'S CAPTIVE MARKET

Before the Second World War, only about 20 drug companies were operational in the country – mostly Filipino-owned, preparing most of their compounds manually, using a mortar and pestle.

During the postwar period, foreign pharmaceutical companies streamed into the country, and no fewer than 10 companies had already set up shop in the decade after the war. The country has since then continued its openness and has been ruled by Big Pharma.[44] Today, 14 of the world's top 20 pharmaceutical firms have production subcontracting in the Philippines.[45]

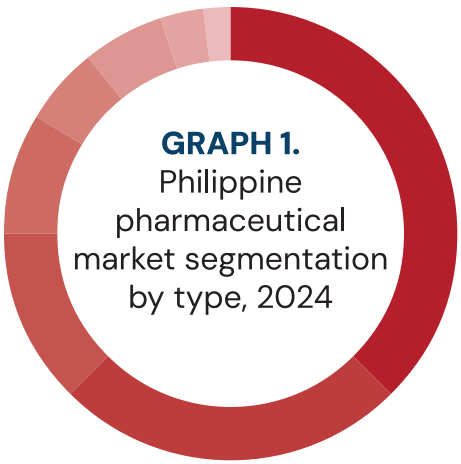
A market of foreign drug firms

The Philippine pharmaceutical industry is currently valued at US$3.36 billion, making the Philippines one of the largest pharmaceutical markets in Southeast Asia by absolute size, and is projected to grow 7.6% by 2030.[46] [47]

The market can be segmented as follows: prescription drugs, over-the-counter (OTC) drugs, generics, branded, biopharmaceuticals, vaccines, herbal medicines, and others. Prescription drugs dominate due to the increasing prevalence of chronic diseases such as diabetes, hypertension, and cancer.[48] (See **Graph 1**)

By end-user, the market can be segmented as follows: hospitals, pharmacies, clinics, home care, and others. Hospitals are the largest end-user segment due to the high volume of patients requiring medications for various treatments, including outpatient and preventive healthcare. Pharmacies also serve as the primary point of access for patients to obtain their medications.[49] (See **Graph 2**)

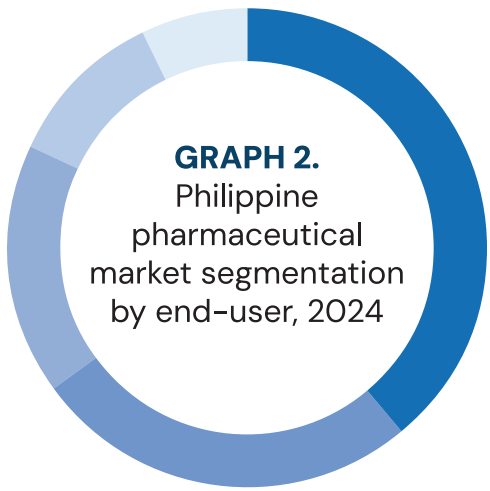
An analysis of the market based on therapeutic category shows that antiallergics have the largest share, followed by blood and blood-forming organs, and cardiovascular system. (See **Graph 3**)



GRAPH 1.
Philippine pharmaceutical market segmentation by type, 2024

- Prescription drugs
- OTC drugs
- Generic drugs
- Branded drugs
- Biopharmaceuticals
- Vaccines
- Herbal medicines
- Others

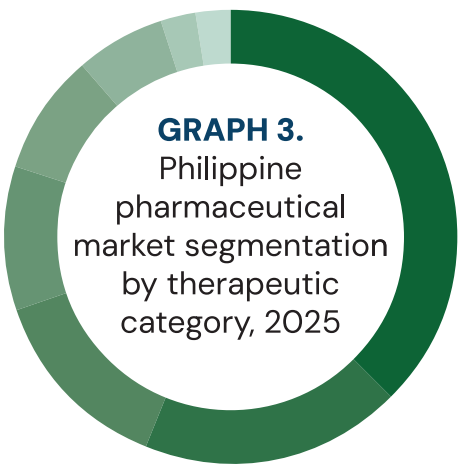
***OTC** - over-the-counter*
***SOURCE:** Ken Research Philippines pharmaceutical market report Size, Share, Growth Drivers, Trends, Opportunities & Forecast 2025–2030, October 2025*



GRAPH 2.
Philippine pharmaceutical market segmentation by end-user, 2024

- Homecare
- Others
- Hospitals
- Pharmacies
- Clinics

***SOURCE:** Ken Research Philippines pharmaceutical market report Size, Share, Growth Drivers, Trends, Opportunities & Forecast 2025–2030, October 2025*



GRAPH 3.
Philippine pharmaceutical market segmentation by therapeutic category, 2025

- Antiallergics
- Blood & blood-forming organs
- Cardiovascular system
- Dermatological
- Genito-urinary system
- Respiratory system
- Sensory organs
- Others

***SOURCE:** IMARC Services Private Limited, "Philippines Pharmaceutical Market Size, Share, Trends, and Forecast by Prescription Therapeutic Category, Therapeutic Category, and Region, 2026-2034"*

The major players in the Philippine pharmaceutical industry are the large foreign drug companies that have dominated the global industry since the Second World War. These include GlaxoSmithKline, Pfizer, Abbott Laboratories, Novartis, Roche, AstraZeneca, Sanofi Philippines, and Merck, among others.[50]

Old reports pegged the share of foreign drug firms in the Philippine pharmaceutical market at 60-75 percent.[51] [52] Recent data, however, show that multinational corporations (MNCs) account for 56.5% of sales value and dominate the prescription drugs market, accounting for 70% of it.[53] [54]

No genuine manufacturing

The Philippine pharmaceutical industry imports 98% of its APIs and finished drugs, with local production focused on secondary activities such as formulation, packaging, and toll manufacturing. There are about 435 pharmaceutical manufacturing and packaging businesses that the FDA has licensed to operate in the country. These are clustered in the National Capital Region (NCR), CALABARZON, and Central Luzon.[55]

There are four main types of 'drug manufacturers':

1. A **multinational importer** imports products from its regional production hub and gets the service of a local manufacturer for packing, repacking, and labelling. Some MNCs also use local toll manufacturers to produce their formulations, but the MNC is the marketing authorization holder (MAH).
2. **Toll manufacturers** produce for a trader using the trader's own formulation, while the trader is the MAH and is responsible for registration requirements.
3. A **manufacturer-formulator** formulates its own product, procures its own materials, conducts R&D for formulation, and manufactures (including packing and labeling) for itself and for other partner traders. A manufacturer-formulator is a locally owned firm that usually conducts or invests in pre-production R&D, has its products undergo tests such as bioequivalence/bioavailability tests and/or bio-waiver tests, and applies for drug registration.
4. An **importer-repacker** may engage in the importation of medicines for registration or may import finished products in bulk and conduct re-packing and re-labelling.[56] [57]

With the activities and functions overlapping, some estimates have placed the number of genuine manufacturers at fewer than a hundred of the FDA-licensed firms. Another way to estimate this is to count the number of firms that hold GMP certification. Good Manufacturing Practice (GMP) covers all production aspects, including raw materials, personnel hygiene, equipment, facilities, documentation, and quality control to minimize risks such as contamination or errors. In the Philippines, only 59 of 435 FDA-licensed firms hold GMP certification, which limits advanced manufacturing.[58]

Of the 11 manufacturers of drugs and medicines in the top 1,000 corporations in the country, seven are MNCs. These are Abbott Laboratories, Wyeth Philippines, Boehringer Ingelheim, GlaxoSmithKline, Bayer, Novartis, and Pfizer. These seven companies account for 54% of the Php147.2 billion total revenues of the 11 manufacturers. The top spot is occupied by the local leader, Unilab. (See **Table 7**)

Likewise, there are 11 pharmaceutical wholesalers among the top 1,000 corporations in the country. Five of them are MNCs, namely Zuellig Pharma Corp., Metro Drug Inc., AstraZeneca Pharmaceuticals, Merck Sharp & Dohme, and Sanofi-Aventis. Zuellig and Metro Drug, a subsidiary of Zuellig, account for 72% of the revenues of the top wholesalers. (See **Table 8**)

TABLE 7. Gross revenues of drugs and medicines manufacturers among the top 1,000 corporations in the Philippines, 2024 (in million Php)

COMPANY	GROSS REVENUE (in million Php)
UNILAB, Inc.	**53,295**
Abbott Laboratories	**23,259**
Wyeth Philippines, Inc.	**19,117**
Boehringer Ingelheim (Philippines), Inc.	**9,888**
GlaxoSmithKline Philippines, Inc.	**7,912**
Bayer Philippines, Inc.	**6,548**
Novartis Healthcare Philippines, Inc.	**6,492**
Pfizer, Inc.	**6,482**
Ritemed Phils., Inc.	**5,413**
Euro-Med Laboratories Phil., Inc.	**4,398**
ADP Pharma Corp.	**4,363**
TOTAL	**147,165**

NOTE: *Details may not add to total due to rounding off*
SOURCE: *BusinessWorld Top 1000 Corporations in the Philippines (Vol. 39)*

TABLE 8. Gross revenues of wholesalers of medicinal and pharmaceutical prducts among the top 1,000 corporations in the Philippines, 2024 (in million Php)

COMPANY	GROSS REVENUE (in million Php)
Zuellig Pharma Corp.	**83,793**
Metro Drug, Inc.	**39,043**
Globo Asiatico Enterprises, Inc.	**8,904**
AstraZeneca Pharmaceuticals (Phils), Inc.	**5,703**
Merck Sharp & Dohme (I.A.) LLC	**5,621**
Dyna Drug Corp.	**5,530**
Natrapharm, Inc.	**5,288**
Getz Bros. Philippines, Inc.	**4,924**
Corbridge Group Phils., Inc.	**4,251**
Galderma Philippines, Inc.	**4,089**
sanofi-aventis Philippines, Inc.	**4,054**
TOTAL	**171,200**

NOTE: *Details may not add to total due to rounding off*
SOURCE: *BusinessWorld Top 1000 Corporations in the Philippines (Vol. 39)*

Most of the MNCs are drug traders. For instance, Pfizer and GSK import 76% of products on average and use local tolling. Like about 30 other MNCs, they hire the manufacturing services of Interphil, a big toll manufacturer that is a locally-owned subsidiary of the foreign company, Manchester Holdings. Pfizer subcontracts 100% of its local production, and Wyeth 91%, to Interphil. Other toll manufacturers that MNCs use are Hizon Laboratories, Swiss Pharma, and Euro-Med Laboratories.[59] Meanwhile, Zuellig handles most of the distribution of MNCs' drug products.

On the other hand, the local companies can be categorized into manufacturer-traders and traders. Unilab and Pascual Laboratories, for instance, are manufacturer-traders. However, they focus on generics rather than APIs. RiteMed is Unilab's producer of generics. On the other hand, Natrapharm, Medhaus Pharma, GX International, Prohealth Pharma, Cathay Drug, and others are traders. The traders subcontract production to local toll manufacturers, and at the same time, import finished products and distribute them to the local market either through their own distribution units or affiliates.[60]

Local CMOs/CDMOs are growing as companies outsource the production of generics and biologics, offering lower-cost, GMP-compliant manufacturing. Firms are investing in formulation and packaging, supported by incentives, but still face challenges such as reliance on imported inputs and competition from neighboring countries. Most complex API production is still outsourced abroad, while local firms handle about 23% of multinational needs through contractors like Interphil.[61]

Overall, the Philippines remains in a low-to-mid tier position in the global pharmaceutical value chain, focusing on distribution, repackaging, and generics rather than API production or R&D. It is largely import-dependent, with some growing role in secondary manufacturing for export, but limited capabilities continue to constrain its advancement. On top of this, foreign entities in the country own up to 99% of the paid-up capital in pharmaceutical establishments that manufacture, import, and distribute medicines, making a nationwide manufacturing hub for their local and global business.[62]

High price of import dependence

The current supply of pharmaceuticals in the country is 98% imported. The figure may even be 100%, considering that so-called locally manufactured drugs are merely packed, repacked, or labelled. APIs used in the manufacturing and/or formulation of pharmaceuticals are all imported; the only material locally procured is sugar, which is used as an additive in the formulations and packaging materials.

Overall, the total pharmaceutical imports were about US$2.36 billion in 2025. India accounted for the largest share at US$442 million, Germany US$241 million, the US US$190 million, France US$167 million, and China US$146 million.[63]

Import dependence has serious consequences for pricing, especially since Big Pharma exercises pricing power. Key players in the local industry must finance the procurement prices of their imported materials. Based on a report by the Philippine Pharmaceutical Manufacturers Association, for example, the purchasing costs of Amlodipine can go from Php14,153 per kilogram (kg) for small quantities to Php7,215 per kg for larger orders.[64] This is roughly half the price for a 10-kg purchase. Local manufacturers and/or traders cannot afford the bulk purchasing of APIs. In fact, only a few products manufactured locally have economies of scale.

Aside from this, smaller firms often struggle to finance regulatory requirements, such as bioequivalence testing for generic drugs, which involve high costs. Thus, they are just bound to produce lower volumes of pharmaceuticals, resulting in higher production costs.

The power of the Med Rep

Local and smaller companies are also inferior to MNCs' marketing and distribution capacity, constraining them to supply medicines to major drugstores and hospitals. Prescription drugs account for about 70% of the total MNC pharmaceutical market, while the remaining share is attributed to OTC products. Hospitals and health professionals in the country, who have the crucial role in prescribing medicines to patients, have also been captivated by Big Pharma.[65]

In private hospitals, the Pharmaceutical Therapeutic Committee (PTC) identifies the medicines that will be included in their formulary. In making procurement decisions, PTC members, including the hospital's chairman, medical director, supply chain manager/purchaser, doctors, and pharmacist, usually rely on the information provided by companies through a medical representative (Med Rep). Thus, the marketing strategies and capacity of the manufacturers through their Med Reps exert a great deal of influence on the approval of the products for the formulary.

This could be detrimental to small firms, which lack marketing capacity, i.e. cannot afford to pay for the services of Med Reps. Furthermore, registered generic products, which may be more affordable, cannot penetrate private hospitals if not promoted or if the company does not have the marketing capacity, which leads to limited product choices for patients.

Only after the approval of the medicine in the formulary will the PTC negotiate with distributors, but mainly with Zuellig Pharma and Metro Drug, the top distributors of pharmaceuticals in the country.

Even in public hospitals, the government's medicine purchases are greatly influenced by Big Pharma. Data from the Department of Health (DOH) also shows that government bidding is highly participated in by Zuellig, Metro Drug, and Pfizer, and other foreign firms. MNCs supply 79% of government-procured medicines.[66]

Failings of laws on generics and cheaper medicines

The Philippine government imports generic drugs primarily through parallel importation programs to ensure affordability and supply, authorized under the Generics Act of 1988 (Republic Act (RA) 6675) and the Cheaper Medicines Act of 2008 (RA 9502).[67] [68] Parallel imports allow government agencies like the DOH to source cheaper generics from countries like India and Pakistan, bypassing patents for public health needs after FDA registration.[69]

The Generics Act of 1988 was issued to promote, require, and ensure the production of drugs and medicines identified by their generic names, which offer a price much lower than patented drugs mainly produced by big MNCs. The Cheaper Medicines Act of 2008 was issued to reduce the cost of medicines and to strengthen the production, distribution, use, and social acceptance of generic medicines. It was designed to increase access to affordable, quality medicines through generics promotion, parallel importation, and public dispensing outlets.[70]

By 2025, generic medicines constituted a large share of the volume in the domestic market – 76% in earlier years and projected to reach 54% of total market sales by 2030.[71] [72] This implies continued strong import demand for off-patent generics sourced from India, China, and other low-cost manufacturers.

The Cheaper Medicines Act lowered prices for some medicines, but there have been implementation gaps, such as weak enforcement, limited funding, supply-chain problems, low public trust in generics, and poor monitoring, which have substantially blunted its impact.[73]

The Philippine government has also had initiatives to lower the prices of 50 essential medicines or to track the top 50 pharmaceutical products or companies for policy action. This is called "Pharma 50". This, however, had been simply pushed through Executive Orders (EOs) by the president, such as the mandatory 50% price cuts for 21 essential medicines in 2009 under the Arroyo administration (EO 821).[74] Other EOs include:

- **EO 104 (2019)** – DOH proposed a Maximum Drug Retail Price (MDRP) scheme and an initial list of about 120 medicines for recommended price reductions of 56%[75]
- **EO 155: To implement the MDRP in phased rounds** – the first round to cover 87 drug molecules (133 formulations), and subsequently expand coverage, adding 34 molecules (71 formulations), so that by late 2021-2022, at least 120 drug molecules would be included[76]

The DOH also issued Administrative Orders (AOs) and implementing guidelines that specified how MDRP would be applied in retail and wholesale points, including hospital pharmacies, drugstores, and other outlets, and provided transition periods for existing inventories. AOs also expanded mandatory caps to cover essential medicines for chronic and high-cost conditions, such as hypertension, diabetes, asthma, chronic obstructive pulmonary disease (COPD), renal disease, and some cancers, among others.[77]

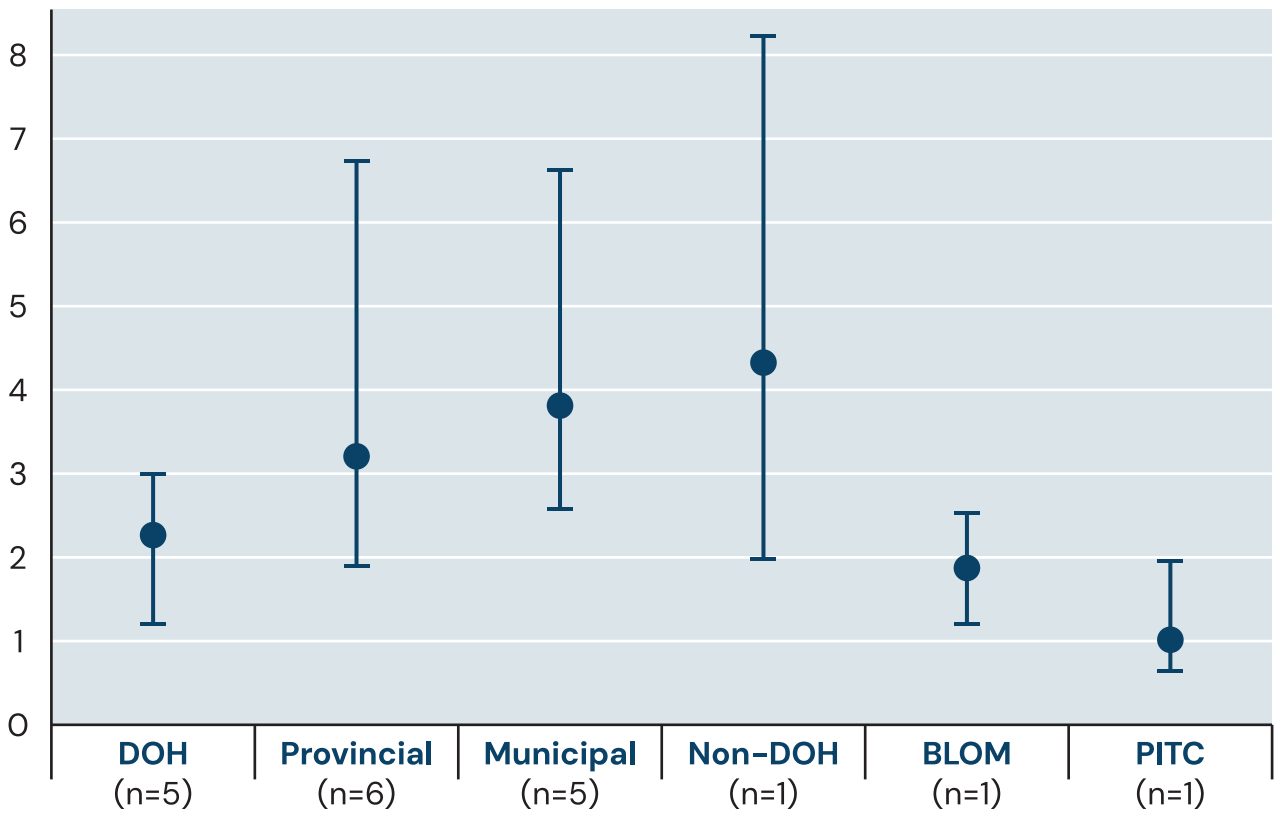
Since generics remain imported, these efforts did not translate to cheaper medicines. Public procurement prices are still higher than the international price reference. Combined public procurement operations at DOH-retained, provincial, and municipal hospitals procure generic medicines at 2.9 times the international reference price. When originator brands are procured, they are on average at 15.7 times international reference prices. (See **Table 9** and **Graph 4**) These laws will remain toothless as long as Big Pharma lords over the local industry.

TABLE 9. Number of times more expensive: public sector procurement prices compared to international reference prices

	ORIGINATOR BRAND	LOWEST PRICED GENERIC
Median MPR	15.7	2.9
(interquantile range)	*(4.9 - 33.3)*	*(1.9 - 5.3)*
Minimum	0.9	0.9
Maximum	79.3	40.8
Number of listed medicines	**33**	**39**

***MPR** – median price ratio*
***SOURCE:** World Health Organization and Health Action International, "Public procurement prices of medicines in the Philippines", 2008*

GRAPH 4. Number of times more expensive: generic medicine procurement prices compared to international references prices



***BLOM** – Botika ng Lalawigan of Oriental Mindoro* ***DOH** – Department of Health*
***MPR** – median price ratio* ***PITC** – PITC Pharma, Inc.*
***SOURCE:** World Health Organization and Health Action International, "Public procurement prices of medicines in the Philippines", 2008*

THE DRUGSTORE OLIGARCHY

Hospitals are the largest end-users of medicines, but a huge percentage of local sales goes to retail outlets. Of the Php153.5 billion total sales in 2024, 90% was supplied through retail outlets such as big drugstore chains, while only 10% went through hospitals.[78]

Drug retailers are owned and controlled by the country's economic oligarchs. The 10 pharmaceutical retailers among the top 1,000 corporations are owned and affiliated with only three oligarch families. They are Que-Azcona, Sy and Gokongwei, having a total of Php365.5 billion in gross revenues. (See **Table 10**)

Mercury Drug Corporation, the leading health and beauty chain in the country with 1,200 branches nationwide, generated gross revenues of Php203.98 billion, top among drug retailers and 7th overall among the top 1,000 corporations.

The total pharmaceutical sales through retail drugstores is estimated to be around Php278 billion as of September 2023, indicating that Mercury Drug may account for 75-85% of the retail drugstore market.[79] [80] Mercury Drug is owned by the Que-Azcona family, 6th in the Forbes list of Filipino billionaires in 2025.[81]

To compete more effectively in the retail market, there is an observable trend of consolidation among retailers. Big corporations have been merging and/or acquiring other firms. New players penetrate the drug retail market by partnering with retail giants and big corporations like SM Prime Holdings (Sy family), Robinsons (Gokongwei family), and AC Health (Ayala).

The Generics Pharmacy (TGP) was founded in 2001 by the Liuson Family, who have been involved in the pharmaceutical industry since 1959, to supply cheaper medicines. In 2016, the Robinsons Retail Group acquired a 51% stake in TGP. It is now recognized as the country's largest and fastest-growing generics drugstore chain with over 1,800 stores nationwide.[82]

Aside from TGP, Robinsons also owns South Star Drug. Before its acquisition in 2012, South Star Drug was already a growing company as a Chinese herbal pharmacy in 1937.[83] Today, there are around 400 South Star Drug stores, placing Robinsons' retail drug network at nearly 2,200 stores nationwide, making it the largest.[84]

Meanwhile, the Ayalas acquired 50% of Generika Drugstore through Ayala Healthcare Holdings Inc. (AC Health) in 2015.[85] Currently, Generika Drugstore has 750 stores nationwide and is poised to become bigger in the pharmaceutical retail space.[86]

TABLE 10. Gross revenues of retailers of drugs and pharmaceutical goods among the top 1,000 corporations in the Philippines, 2024 (in million Php)

COMPANY	GROSS REVENUE (in million Php)	OWNERSHIP/ AFFILIATION
Mercury Drug Corp.	**203,976**	Que-Azcona
Watsons Personal Care Stores (Philippines), Inc.	**81,941**	Sy
South Star Drug, Inc.	**19,404**	Gokongwei
Central Luzon Drug Corp.	**12,970**	Que-Azcona
Rose Pharmacy, Inc.	**11,528**	Gokongwei
Southern Luzon Drug Corp.	**9,251**	Que-Azcona
Northern Luzon Drug Corp.	**8,610**	Que-Azcona
Familyhealth & Beauty Corp.	**7,948**	Sy
TGP Pharma, Inc.	**5,606**	Gokongwei
Bicolandia Drug Corp.	**4,225**	Que-Azcona
TOTAL	**365,459**	

SOURCE: *BusinessWorld Top 1000 Corporations in the Philippines (Vol. 39)*

Lastly, SM Prime Holdings also entered the pharmaceutical retailing with its partnership with the Hong Kong-based A.S. Watsons in 2002.[87] Now, Watsons has more than 1,200 stores and operates largely in SM malls nationwide.[88]

In a nutshell, pharmaceutical establishments, including retailers, are owned by only a few groups or entities. If establishments that have similar owners are pooled, it would turn out that some 31 pharmaceutical establishments would consolidate into only 5 companies.[89]

These companies have also started to manufacture their own brand of generic medicine to further increase their competitive advantage in the market. For instance, Watsons has Watsons Generics, TGP has its own line of generic medicines, and Mercury Drug has Rhea Generics.

Medicines in PH are more expensive

The prices of medicines in the Philippines are higher compared to international reference prices. The Health Action Information Network (HAIN) surveyed 27 private and 21 public outlets to compare the prices of selected pharmaceutical products.

The survey revealed that prices of medicines in both the public and private outlets were higher compared to international reference prices, for both generic and originator brand medicines.[90] (See **Tables 11** and **12**)

In private outlets, the lowest-priced generics were almost eight times more expensive than international reference prices. The highest-priced generics were about 15 times more expensive, while originator brands were almost 30 times more expensive. Of the originator brand products, Diclofenac has the biggest difference, at over 100 times the international reference price.

TABLE 11. Number of times more expensive: prices in public sector compared to international reference prices

	LOWEST PRICED GENERIC
Median MPR	3.66
25th percentile	2.74
75th percentile	7.57
Minimum	1.30
Maximum	23.46
Number of medicines	**16**

***MPR** – median price ratio*
***SOURCE:** Health Action Information Network, "A Survey on Medicine Prices and Availability in the Philippines", 2009*

Meanwhile, in the public sector, the lowest-priced products were generally sold at more than three times the international reference prices. Very high-priced generics, with an median price ratio (MPR) over five, include Captopril, Diclofenac, Glibenclamide, Ibuprofen, Metronidazole, and Simvastatin. The MPR interquartile of generic medicines sold in the public outlets could go from the minimum of 1.30 (Ceftriaxone injection) to the maximum of 23.46 (Diclofenac) times higher than international reference prices.

Public sector prices were generally lower than private sector prices, but the research noted that the availability of medicines in public facilities was poor.

TABLE 12. Number of times more expensive: prices in private pharmacies compared to international reference prices

	ORIGINATOR BRAND	HIGHEST PRICED GENERIC	LOWEST PRICED GENERIC
Median MPR	29.32	14.94	7.95
25th percentile	13.02	10.07	3.56
75th percentile	40.01	23.03	13.27
Minimum	4.31	5.98	2.59
Maximum	105.32	57.00	27.78
Number of medicines	**21**	**12**	**23**

***MPR** – median price ratio*
***SOURCE:** Health Action Information Network, "A Survey on Medicine Prices and Availability in the Philippines", 2009*

Bloated prices

The Filipino people have been carrying the burden of being charged a price bloated by the mark-ups made along the supply chain.

Foreign pharmaceutical companies set prices of imported drugs differently in each country. The first mark-up occurs in the transaction between the company's head office and the local Philippine office. This is followed by the estimates of at least 20% from the cost-insurance-freight price, due to import tariffs, finance charges, quality control testing fees, national corporate taxes, and transport costs.[91] [92] (See **Table 13**)

TABLE 13. Minimum add-on costs and mark-ups for imported drugs

	ADD-ON COST/MARK-UP	HYPOTHETICAL CASE
Price of imported drug: cost-insurance-freight price	**N/A**	Php8.00
Import tariffs, finance charges, quality control testing fees, national corporate taxes, transport costs	**20%**	Php9.60
Local offices of foreign pharmaceutical companies	**4.5% to 12.5%**	Php10.00 to 10.80
Distributors/wholesalers	**5% to 13%**	Php10.50 to 12.20
Retailers	**5% to 13%**	Php11.00 to 13.70
Value-Added Tax	**12%**	Php12.30 to 15.00

SOURCE OF BASIC DATA: *Azada-Palacios, Rowena Anthea and Antonette Palma-Angeles, Ph D, "Medicine Prices, Price Controls and the Philippines Pharmaceutical Industry", Ateneo Graduate School of Business Occasional Paper Series, No. 4, 2015*

Then, the entire wholesale mark-up is set at 17.5% at the very least. In the case of originator drugs, local offices of foreign companies have a mark-up of at least 4.5% to 12.5%, and the distributors and wholesalers will mark this up further by 5 to 13 percent. But this is not where it ends. There are also retail mark-ups for originator drugs that are estimated to be anywhere between 5 and 13 percent. However, Institute of Popular Culture (IPC) estimates are much higher at 20 percent.

Finally, an additional 12% value-added tax (VAT) is charged to the consumer for the majority of medicines. The FDA periodic updates of VAT-exempt list strictly focus on medicines for non-communicable diseases, such as diabetes, high cholesterol, hypertension, cancer, mental illness, tuberculosis, and kidney diseases. There are 2,263 VAT-exempt medicines for such diseases. But this accounts for only 5% of the 50,000 recorded government-procured medicines as of 2019. Still over-the-counter products like paracetamol, vitamins and mineral supplements, cough and cold medicines, antibiotics, antacids and many others remain taxable.[93] [94]

Meanwhile, for locally produced generic drugs, the range of mark-ups is much higher. There is an estimate of distributor mark-up that ranges from 5% to 355%, and retailers' mark-up from 18 to 117 percent. This does not include the much higher production cost for locally manufactured pharmaceuticals.

Beyond the poor's reach

Furthermore, the HAIN survey calculated affordability as the number of days a minimum wage earner (Php645/day) would have to pay for a standard treatment course based on the median price of the medicine. Medications for a few leading illnesses and morbidity in the Philippines that are VAT-exempt were selected, such as Glibenclamide (diabetes), Amlodipine and Losartan (hypertension), and Amoxicillin (adult respiratory infection). For an acute condition, the cost of a full course of therapy was calculated, and for a chronic condition, one month's worth of treatment was used.

In general, all the VAT-exempt treatments are affordable in public and private outlets, as regimens cost about a day's worth of wages or less. It should be noted, however, that in actual situations of illness, patients will have to contend not only with paying for medicines but also for consultation fees and diagnostic tests. And for an illness requiring multiple medicines, comorbidity, or in a family with more than one ill family member, the compounded cost of treatment can make even the least costly regimens unaffordable.

Furthermore, many Filipinos earn less than the minimum wage. Treatments that appear affordable may burden most of the poor and low-income families who make up 60-75% of the population and push them to catastrophic spending on health. Currently, the Philippines is among the countries with the highest out-of-pocket health expenditures in the region, making up 42.7% of the current health expenditure in 2024.[95]

NEOLIBERALISM, A BITTER PILL

The Philippine government is the catalyst of Big Pharma's monopoly in the country, with its neoliberal agenda on medicines. It opens the economy and further strengthens the country to be a Big Pharma manufacturing hub through the Ecozone Transformation Roadmap of the Philippine Development Plan (PDP) 2023-2028. This gave the Philippine Economic Zone Authority (PEZA) and FDA the mandate to establish Pharmaceutical and Medical Device Ecozones (Pharma-Dev Zones), which will become specialized hubs to attract local and foreign companies and investors in medical and drug manufacturing, including R&D, trials, and clinical testing. There are 26 Pharma-Dev Zones as of December 2023.[96]

Coinciding with this, the government has also been encouraging foreign pharmaceutical companies to establish manufacturing facilities through the Corporate Recovery and Tax Incentives for Enterprises (CREATE) law, which gives tax incentives to pharmaceutical firms with facilities in the country.

Rather than impose protectionism and support local and small companies, some negligent regulations like IPR filings by foreign corporations through the Intellectual Property Office of the Philippines, even though Filipinos are the only ones eligible to file, have become a way to protect foreign innovation in the country. Philippine intellectual property (IP) laws and regulations do not restrict foreign investors intending to file for IPR as long as there is a local representative who can file on their behalf.

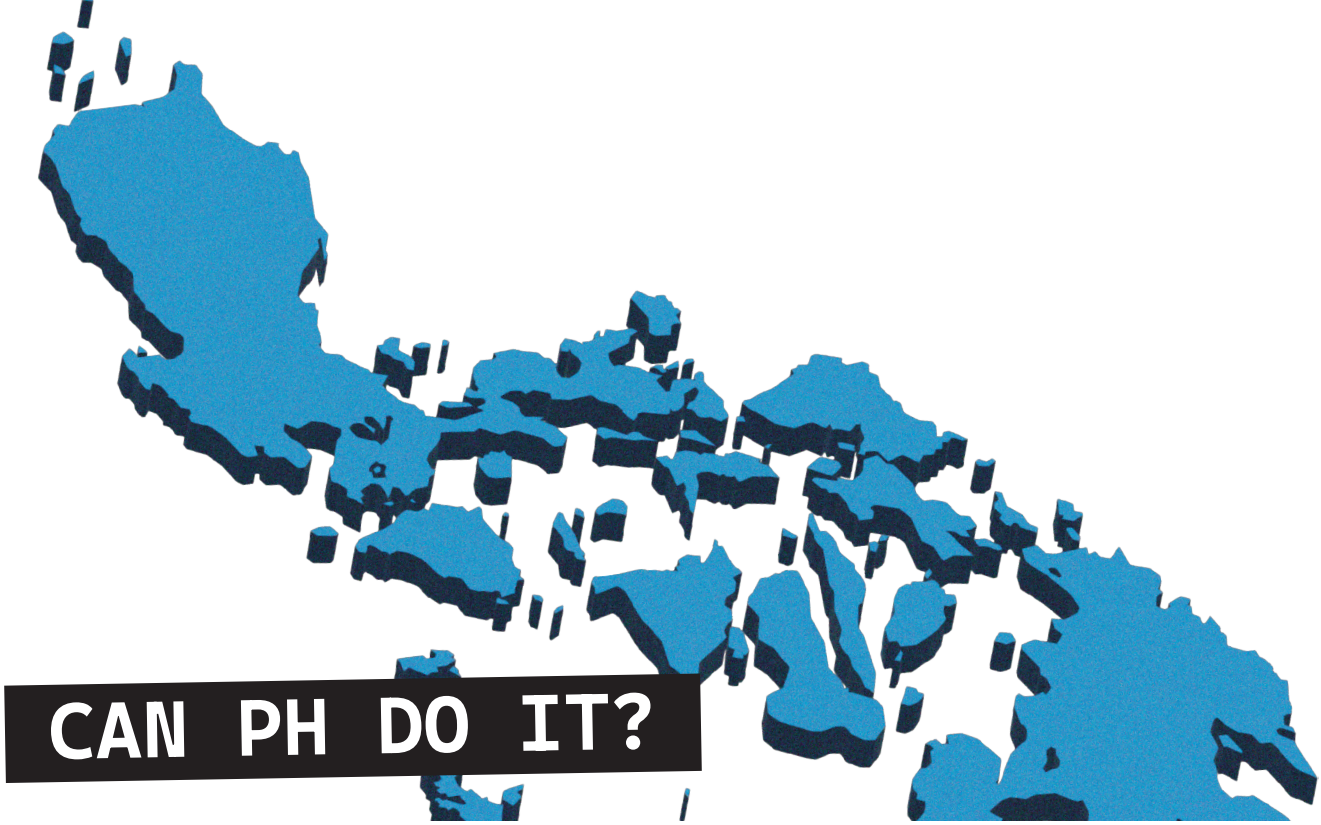
Applications for a patent grant expanded by 2.9% to 4,544 from 4,418 in 2023, with 24.8% being from pharmaceuticals with 2,600 applications. Non-resident applications for the patent grant accounted for 84 percent.[97] Meanwhile, the Philippine government and the foreign pharmaceutical investors feign concern for the rising prices of medicines that are driven by their continued neoliberal agenda.

On top of the Generic Act of 1988 and the Cheaper Medicines Act of 2008, the Universal Health Care Act (RA 11223) was enacted in 2019 to enhance health financing and to improve healthcare access and financial protections against out-of-pocket expenses. But significant out-of-pocket payments have even increased since these laws' enactment.

Between 2000 and 2012, out-of-pocket health spending increased by 150% in real terms. This trend continued after 2012, as health expenditures rose, reflecting growing healthcare costs and increased usage of health services. In 2021, out-of-pocket spending reached about Php451 billion, constituting 41.5% of total health expenditures. Spending on medications has been the major driver of out-of-pocket health expenses, accounting for nearly two-thirds of health spending. This particularly impacts poorer households more, where the figure rises to three-fourths.[98] [99]

The incidence of catastrophic health expenditures, which is defined as spending that exceeds a certain percentage of household income, has also increased. Catastrophic payments nearly tripled from 2.5% in 2000 to 7.7% in 2012, indicating a growing financial burden on Filipinos due to health-related costs. In 2012, out-of-pocket health expenses were pushing an estimated 1.5 million people into poverty. Out-of-pocket health spending further increased to 42.7% of total health expenditures in 2024.

Out-of-pocket health spending in the Philippines has demonstrated an upward trend, making it a pressing concern for healthcare access and financial security for many Filipino families. Local pharmaceuticals is a critical industry that should not be put in the hands of foreign and private entities, but the government has opted for neoliberalism in the sector. Instead, the government should focus on investing in health and establishing a nationalized pharmaceutical industry that guarantees a safe, sufficient, and affordable medicine supply for Filipinos.



CAN PH DO IT?

The discovery and production of drugs derived from natural resources has been proven possible through emerging initiatives over the years. In fact, 58% of the New Chemical Entities (NCEs) approvals by the United States Food and Drug Administration (USFDA) belonged to the small molecule class of drugs that can be derived from natural products.[100] [101]

The Philippines has a huge potential in establishing a national pharmaceutical industry from its rich biodiversity, with the availability of land, natural conditions, the country's location, and diverse natural resources and species. These conditions make it favorable for the discovery of novel compounds.

A few years back, the National Integrated Research Program on Medicinal Plants of the Department of Science and Technology (DOST)-Philippine Council for Health Research and Development (PCHRD) successfully developed medicines from *lagundi* and *sambong* plants.[102]

As of the current available data, there are 10 Philippine medicinal plant species approved for therapeutic uses by the DOH and FDA. These are:

1. *Lagundi* (Vitexnegundo) for cough and asthma
2. *Sambong* (Blumeabalsamifera L.) as an anti-urolithiasis
3. *Ampalaya* (Momordicacharantia L.) for lowering blood sugar and as anti-diabetes
4. Garlic (Allium sativum) as anti-cholesterol
5. Guava (Psidiumguajava) for oral/skin antiseptic
6. *Tsaang-gubat* (Carmona cetusa) as mouthwash
7. *Yerba-Buena* (Menthaarvensis) as an analgesic or anti-pyretic
8. *Niyog-niyogan* (Quisaualisindica) as anthelmintic
9. *Acapulco* (Cassia alata) as an antifungal,
10. *Ulasimang-bato* (Peperomiapellucida) as anti-hyperuricemia

The DOST further pushes for a comprehensive drug discovery and development program to respond to the growing health needs of the Filipinos and to harness the potential of Philippine biodiversity. The DOST can make opportunities for extensive science and technology interventions, particularly through the Tuklas Lunas Program, a drug discovery program harnessing the local endemic resources. The DOST pushes for the development of standardized herbal drugs, cultural management/propagation of organisms that have reached at least pre-clinical development, discovery of new drugs from local natural sources for development up to the preclinical stage, and development and/or validation of standard processes and protocols for various stages of drug discovery and development.[103]

As part of the Tuklas Lunas Program, the PCHRD partners with institutions to establish Tuklas Lunas Centers in the regions. They study diverse resources peculiar and abundant to different parts of the country, and their potential for drug research. To date, the program has supported and partnered with 29 institutions nationwide for the implementation of projects that entail various stages of drug discovery and development.[104] (See **Map**)

Researchers, particularly from the University of the Philippines (UP) Manila, have been developing herbal tablets derived from different medicinal plants in the country. Under the Tuklas Lunas Program, researchers led by College of Pharmacy Associate Professor Bienvenido Balotro have developed a standardized herbal tablet for diabetes management. Aside from this, researchers from the Institute of Herbal Medicine of the National Institutes of Health (NIH) have developed an *ulasimang bato* (Peperomia pellucida) tablet as an alternative treatment for gout and hyperuricemia.

Since its establishment, the Tuklas Lunas Program has already developed 11 products that are in the commercial stage, discovered 21 new active ingredients, and is undergoing clinical trials for two potential treatments.[105]

The country's rich biodiversity and having competent local scientists and researchers prove the viability of producing local pharmaceutical products. Yet, sadly, the national government only intensifies misprioritization of the national budget, allocating limited budgets for health, science, and technology. These potentials and the drugs being discovered or developed are just being turned over to private companies for commercialization.

MEDICINE FOR PEOPLE, NOT PROFIT

The Philippine pharmaceutical industry remains heavily dominated by foreign multinational corporations, leaving the country dependent on imported medicines, imported raw materials, and foreign-controlled supply chains. While medicines are essential to public health, the structure of the industry shows how access to healthcare has increasingly been shaped by profit-driven global pharmaceutical giants rather than by national industrial and health priorities.

Big Pharma continues to control large segments of the local market, especially in high-value branded medicines. The global pharmaceutical firms have become even more concentrated internationally, strengthening their control over patents, R&D, production, and distribution. The Philippines is captive to this control, as local manufacturing remains weak and dependent on imported inputs. Meanwhile, the local economic oligarchs are raking in super-profits from this weakness by concentrating on retailing, adding to Big Pharma's monopoly pricing.

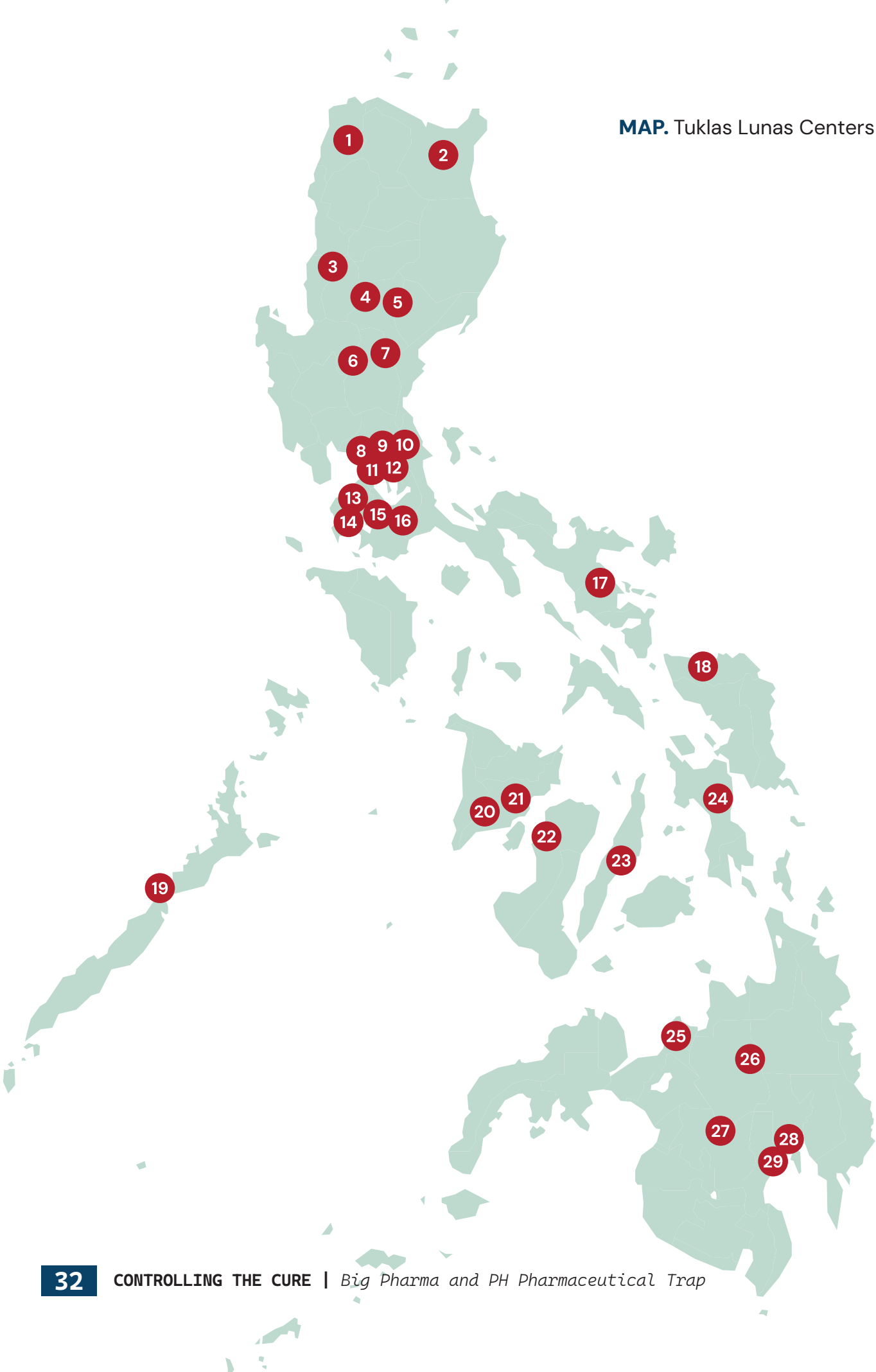
Drug prices in the Philippines have long been among the highest in Asia despite policies promoting generics and cheaper medicines. The Philippine government's adherence to neoliberal policies, including Intellectual property rules, trade liberalization, and investment incentives, has only favored foreign multinational corporations.

Neoliberalism has failed to build a strong domestic pharmaceutical base and instead has reinforced dependence on foreign capital and imports. It has limited the country's ability to pursue genuine pharmaceutical industrialization. Public health needs are subordinated to market priorities, where profitability, not accessibility, determines what medicines are produced and distributed.

Strengthening the pharmaceutical industry demands a national industrial policy that builds domestic API production, supports local R&D and local scientists, expands public manufacturing capacity, and treats medicines as a public good rather than merely a commodity. Without this, the Philippines will remain trapped as a dependent market for global pharmaceutical giants instead of developing a self-reliant healthcare system and industry.

The country has a rich biodiversity for medical discovery and development. It has competent and intelligent Filipino researchers and scientists. The viability of establishing a national pharmaceutical industry is clear, but it must be pushed by the kind of government that prioritizes people over profit.

MAP. Tuklas Lunas Centers



1 **MARIANO MARCOS UNIVERSITY**
Development of anti-inflammatory herbal products from lluko plants

2 **CAGAYAN STATE UNIVERSITY**
Anti-pain, anti-infective activity of plants from Region II

3 **BENGUET STATE UNIVERSITY**
Isolation, purification of anti-diabetic bioactive hits from plants from CAR

4 **UP BAGUIO**
Isolation, purification of anti-infective bioactive hits from plants. fungi from CAR

5 **SAINT LOUIS UNIVERSITY**
Resistance modifying agents from microbiota and plants of Benguet

6 **CENTRAL LUZON STATE UNIVERSITY**
Development of functional food from mushrooms; Screening for anti-pain, anti-hypertensive, anti-diabetic properties of Philippine mushrooms

7 **LEONIE AGRIE CORPORATION**
Screening plants from Sierra Madre for hypertension, diabetes, pain, inflammation, gout, immunodulation, cancer

8 **UP DILIMAN**
Enzyme-based bioassay facility (IC); Orthogonal assays facility (NIMBB); Biorepository facility for extracts (IB); Structure ID, bioactive hits isolation for hypertension, pain, diabetes, inflamation, immunodeficiency disorders, colon cancer (IB, IC); Synthesis of bioactive hits (IC); Development of anti-cancer, anti-infective leads from marine organisms (MSI)

9 **ATENEO DE MANILA UNIVERSITY**
Chemical profiling, standardization of medicinal plants

10 **PASCUAL LAB, INC.**
Formulation, standardization of selected plants from gout

11 **UP MANILA**
Isolation, purification of anti-infective, anti-cancer (breast) bioactive hits from plants; Formulation, pre-clinical, clinical studies of selected herbal drugs candidates

12 **UNIVERSITY OF SANTO TOMAS**
DNA barcoding of medicinal plants; Synthesis of anti-inflammatory compounds

13 **DE LA SALLE UNIVERSITY HEALTH SCIENCE INSTITUTES**
Development of anti-dengue herbal drugs

14 **PHARMALYTICS, INC.**
Formulation of selected plants for hypertension

15 **SYNNOVATE PHARMA CORPORATION**
Studies, correlation analyses of chemical composition, bioactivity of 3 Plant

16 **UP LOS BAÑOS**
Live garden for medicinal plants; Biorepository for seeds; Medium-sized animal facility

17 **BICOL UNIVERSITY**
Tuklas Lunas from endemic/indigenous plants in Bicol with bioactivity against diabetes, obesity, hypertension

18 **UNIVERSITY OF EASTERN PHILIPPINES**
Screening of plants from Northern Samar for hypertension, diabetes, pain, inflammation, gout, immunodulation, cancer

19 **PALAWAN STATE UNIVERSITY**
Screening of plants from Palawan for hypertension, diabetes, pain, inflammation, gout, immunodulation, cancer

20 **UP VISAYAS**
Screening of plants from Panay Island for hypertension, diabetes, pain, inflammation, gout, immunodulation, cancer

21 **UNIVERSITY OF SAN AGUSTIN**
Discovery of anti-infective leads from marine sediment actinomycetes

22 **HERBANEXT LAB, INC.**
Formulation, standardization of selected medicinal plants from Negros

23 **UNIVERSITY OF SAN CARLOS**
Discovery of cardiometabolic bioactives from plants in Central Visayas

24 **VISAYAS STATE UNIVERSITY**
Discovery, development of herbal drugs for diabetes from plants from Leyte

25 **MINDANAO STATE UNIVERSITY-ILIGAN INSTITUTE OF TECHNOLOGY**
Discovery of anti-cancer leads from sponges in Mindanao

26 **CENTRAL MINDANAO UNIVERSITY**
Development of functional food from ferns; Discovery, development of anti-inflammatory herbal products from ferns

27 **UNIVERSITY OF SOUTHERN MINDANAO**
Screening of local plants for anti-cancer activity

28 **UNIVERSITY OF IMMACULATE CONCEPTION**
Discovery, development of excipients from selected Philippine plants

29 **UP MINDANAO**
Isolation, purification of anti-cancer (lung) bioactive hits from plants in Davao

CAR *– Cordillera Administrative Region* ***DNA*** *– deoxyribonucleic acid* ***IB*** *– Institute of Biology* ***IC*** *– Institute of Chemistry*
MSI *– Marine Science Institute* ***NIMBB*** *– National Institute of Molecular Biology and Biotechnology*
SOURCE: *Philippine Council for Health Research and Development*

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