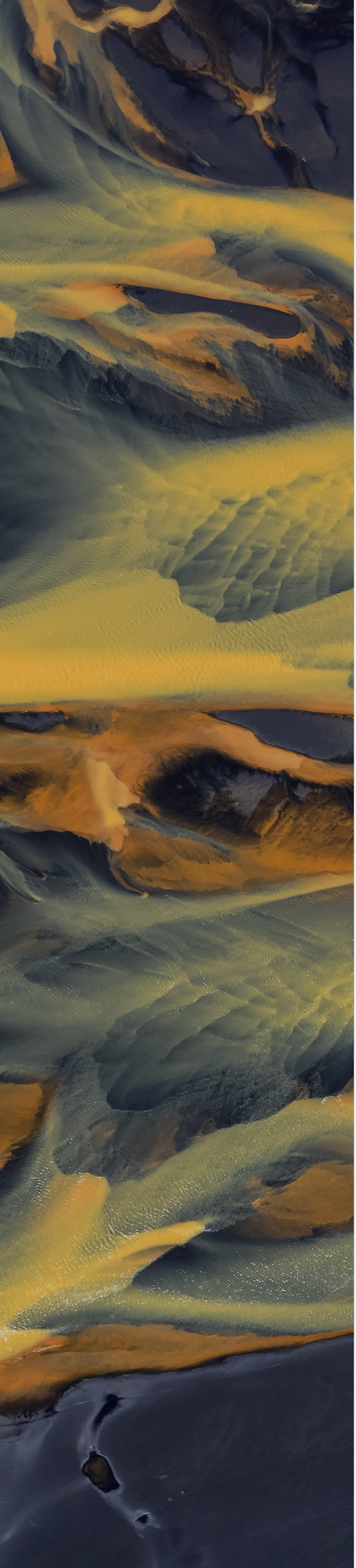


ZS Impact Institute™

Biopharma Outlook 2035

The resilience of global biopharma: Growth, innovation and the forces testing both

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About this survey

The ZS Impact Institute conducted an online survey of 305 biopharma executives and external industry experts from September 15 to October 15, 2026. The sample includes 226 industry executives, nearly all at VP level or above, and 79 external experts, including policy specialists, industry analysts and biotech investors. Respondents are based in the U.S., Europe, China, Japan and other Asia-Pacific markets. The findings are also informed by 15 in-depth phone interviews with survey respondents, counted within the 305.

ZS Impact Institute

About the Institute

The ZS Impact Institute delivers data-driven foresight and decision-ready guidance for leaders navigating disruption. By combining proprietary research with real-world experience, the Institute helps executives understand what's changing, why it matters and what to do next, so they can turn ideas into results that improve life and how we live it.



About ZS

ZS is a management consulting and technology firm that partners with companies to improve life and how we live it. We transform ideas into impact by bringing together data, science, technology and human ingenuity to deliver better outcomes for all. Founded in 1983, ZS has more than 15,000 employees in over 40 offices worldwide. To learn more, visit www.zs.com or follow us on LinkedIn.

Executive summary

Facing the combined pressure of growing geopolitical risk, regulatory fragmentation and the prospect of durable U.S. drug pricing constraints, biopharma leaders nevertheless expect the industry of 2035 to look much like today's: Growing steadily and with access to a plentiful supply of innovative therapies to fuel that growth.

Briefly, our research reveals two sets of expectations that don't add up:

On growth

89%

expect inflation-adjusted growth in branded revenue, despite 80% also expecting Most Favored Nation-style (MFN) U.S. pricing policies to remain significant through 2035.



Respondents expect more treated patients to offset lower prices, while launching in fewer markets.

For this to hold, treatment volume would have to grow faster than prices fall—and with fewer markets to build it in.

On innovation



Respondents expect the externally sourced share of pipelines to keep rising, from 60% to 68% by 2035, yet expect biotechs to face a higher evidence bar to raise money.

57%

expect China-origin innovation to be essential or dominant by 2035, even while 48% expect policy and reimbursement risks to materially limit licensing of China-origin assets.[1]

The industry expects to buy more innovation from sources that it expects will become harder to access.

Together, these expectations describe an industry counting on historical growth patterns, even as it agrees the routes to that growth are narrowing.

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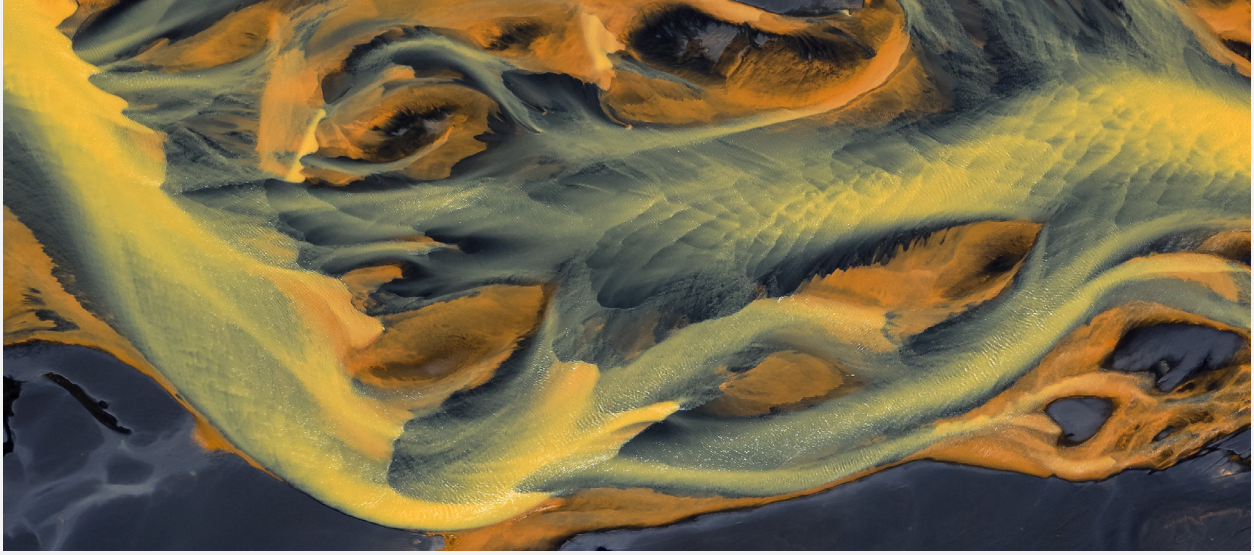
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Facing durable U.S. pricing constraints, biopharma leaders expect to drive real growth through 2035 without fundamentally changing how they generate revenue. At the same time, they're counting on continued access to innovation, even as they make choices that simultaneously deepen their reliance on an innovation source (China) that could narrow and weaken a Western biotech system they depend on to supply new assets.

For decades, three conditions powered pharma's business model: A U.S. price premium, launches in other countries that didn't imperil that premium and a Western biotech system that turned early science into assets pharma could buy. Despite periodic scares, the industry has never seriously had to plan for a shrinking profit pool. Today, four forces simultaneously threaten the model:

- U.S. drug-pricing measures, including Medicare negotiation under the Inflation Reduction Act (IRA) and the administration's evolving MFN framework, that increase pressure on U.S. prices
- Regulatory fragmentation that makes broad launches harder and costlier
- Tariffs that strain supply chains and manufacturing footprints built to serve the world from a few efficient sites
- Limits on cross-border biotech investment that constrain where capital can flow

Whatever form individual policies ultimately take, the implication holds: Choices about where to source innovation, where to manufacture, where to launch and how to price, once made largely in isolation, increasingly must be made together.

Leaders expect incremental fixes to cushion the industry, but those fixes erode what they're meant to protect

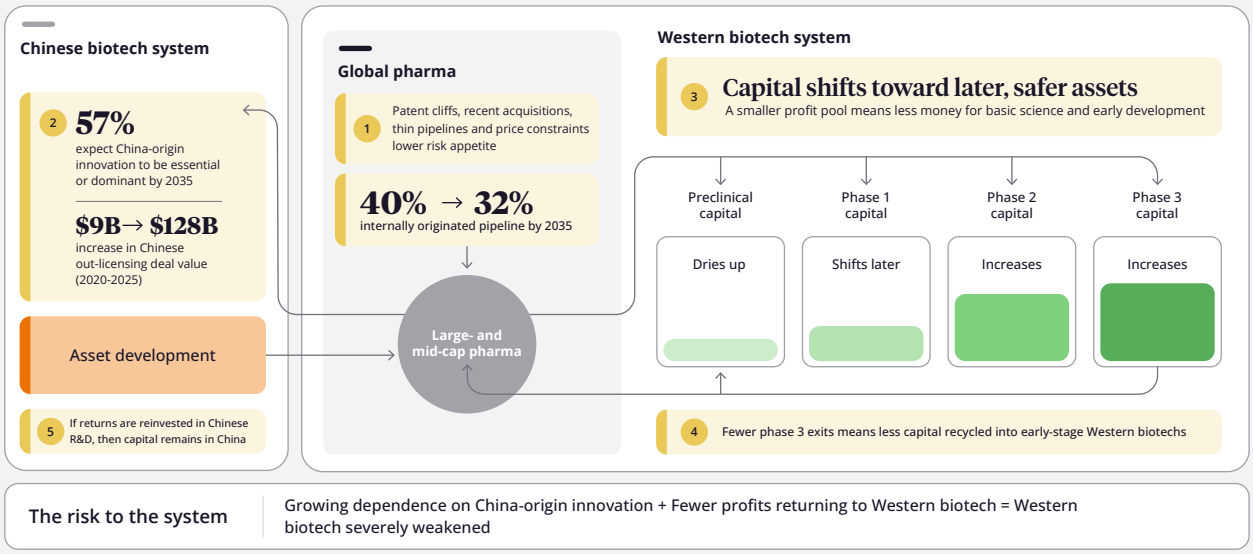
The ZS Impact Institute surveyed 305 biopharma executives, investors, analysts and policy experts in September and October 2026 to understand how they expect the industry to hold up under these pressures.

Their answers reveal an industry that's planning to make incremental, isolated fixes. These include increasing treatment volume to offset lower prices, even as launch footprints narrow, and expecting to purchase more of its pipeline from sources that may become harder to fund or reach. Each fix is rational on its own. Together, they leave the industry increasingly exposed to the pressures it is trying to absorb.

FIGURE 1

Biopharma's responses to pricing pressure narrow future innovation, imperiling tomorrow's growth

Modeled scenario: Value flows to China and Western early-stage biotech funding dries up



Note that the loop in this modeled scenario represents ZS's interpretation of how these findings reinforce one another; the survey does not show that this cycle is already underway or inevitable. Out-licensing values are announced total deal value, including milestone payments.

Sources: ZS Impact Institute, November 2026; PharmCube, accessed December 25, 2025; ZS analysis.

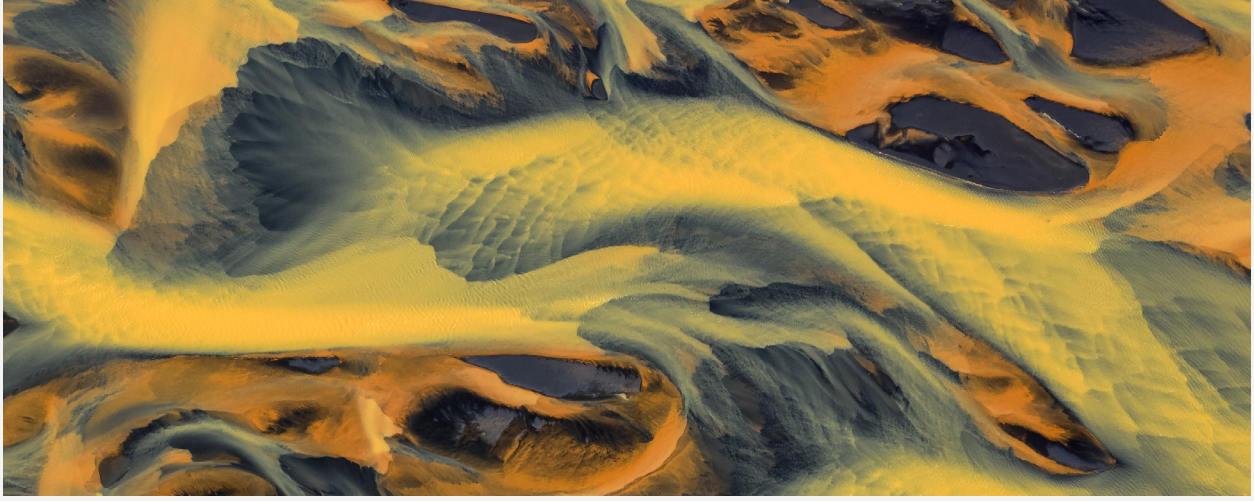
Each fix is rational on its own. Together, they leave the industry increasingly exposed to the pressures it is trying to absorb.

Followed through, the loop in Figure 1 could yield a Western biotech system with less funding and fewer early assets for pharma to buy, along with a growing reliance on China-sourced innovation. If policies limit access to this innovation pool, pharma could find itself short of new medicines from both sources.

Biopharma leaders must disrupt their current model now

Leaders appear to believe price cuts will remain modest and access to China-sourced innovation will hold. That may prove right, but plans built on the assumption should be tested against a world where it doesn't. Leaders should be planning three moves now:

1. **Adopt a multipronged strategy to grow treatment volume**
   Rebalance portfolios away from lower-volume, higher-priced therapies by shifting R&D investment toward more prevalent, less price-exposed conditions. And grow treatment volume by assessing the treatable-but-untreated population brand by brand, recovering prescriptions that are written but never filled and weighing lawful launch sequencing against the ex-U.S. volume given up.



Innovation feeds growth, and growth funds the next round of innovation.

2. **Derisk the shift in innovation sourcing**
   Leaders need a sourcing strategy that holds up if access to innovation in China narrows, particularly because policies continue to evolve. Leaders also need to weigh what the shift toward China means for the capital behind future innovation, starting with research and discovery. If more of that capital flows to China, where it may not easily be redeployed into the global system, the system that has funded growth for decades may not keep doing so.

3. **Reimagine the business model**
   It's time for leaders and boards to ask if pharma's business model of the past several decades can survive a world where the price of drugs faces consistent downward pressure. Alternative models such as treatment-as-a-service, long considered unrealistic, may become the industry's most viable path forward.

Innovation feeds growth, and growth funds the next round of innovation. Because each depends on the other being healthy, pharma leaders must pursue these three moves together. Planning for one without the other two is unlikely to address the scale of these industry pressures.

Biopharma leaders see pressures but expect today's economics to hold through 2035

Biopharma leaders expect real growth to continue, the U.S. to remain the industry's profit engine and access to innovation to withstand tighter capital and geopolitical scrutiny. They acknowledge the staying power of the changes in U.S. pricing policy, trade policy and global regulatory fragmentation, but don't expect them to curtail growth or access to innovation.

When asked to imagine their industry in 2035, biopharma leaders in our survey described an industry that remains global, growing, innovative and anchored in the U.S.

Belief 1

Revenue growth continues

89%

expect inflation-adjusted branded revenue to continue growing through 2035. This belief holds wherever respondents sit across functions: More than 80% of respondents in R&D, business development, manufacturing, commercial and corporate functions expect real growth—as do roughly the same share from large- and mid-cap pharma and small biotech, regardless of function.

Belief 2

Today's basic economic architecture remains intact

59%

expect the U.S. to remain the industry's profit engine. Meanwhile, they expect the U.S. and European shares of global branded revenue to decline only modestly.

Belief 3

Capital becomes more selective, but innovation continues

79%

expect biotechs to need stronger clinical and commercial evidence to raise money, and most expect venture investors to back fewer companies.

Belief 4

Access to innovation remains open

ONLY # 25%

expect innovation to slow, even if capital tightens by 2035.

Despite recognizing the forces bearing down on the industry, the pharma leaders and observers we surveyed don't anticipate major changes to how the industry sources innovation or how it makes money.

"Without high U.S. prices, pharmaceutical companies are not going to be what they have been."

—Former CEO, mid-size pharma

Biopharma leaders are wagering U.S. price cuts will be modest, without a plan for what happens if they're not

Industry leaders expect branded revenue to grow despite mounting pressure on U.S. pricing. Most envision maintaining revenues by offsetting lower prices with higher treatment volume, even as they expect to launch in fewer markets in response to MFN pricing policies.

For decades, biopharma depended on a powerful economic asymmetry: U.S. prices drove most industry revenue and profitability, while launches in other markets added incremental revenue and profit without putting those prices at risk. In 2022, the U.S. generated about half of worldwide prescription-drug revenue from just 13% of the volume.[2]

Although limited federal and state programs have constrained U.S. prices in some channels, the possibility of more widespread U.S. price controls loomed without fully materializing. This has allowed the industry to avoid seriously planning for a shrinking U.S. profit pool.

That changed in 2022, when the IRA created a new statutory Medicare negotiation framework covering its highest-spend drugs. Because the IRA covers only products approaching the end of their patent lives and prices paid by government insurance programs, the IRA's direct reach has been comparatively narrow. But it served as a bellwether for what would follow: The administration's evolving MFN framework has since added further pressure. And polling suggests U.S. healthcare consumers support more regulation of drug prices.[3]

42%

RANK U.S. DRUG-PRICING POLICY AS THE TOP FORCE SHAPING PRIORITIES AND INVESTMENT

Biopharma leaders acknowledge the threat of U.S. price pressure while expecting to mitigate it with more patients

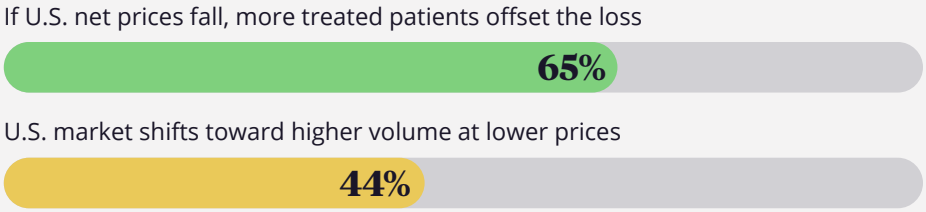
When asked what's shaping the biopharma industry's strategic priorities and investment today, 42% of respondents ranked U.S. drug-pricing policy first, and 80% say they expect MFN-style pressure to remain moderately or very significant through 2035.

Even under these conditions, 89% of survey respondents expect revenue from innovative branded drugs to keep growing and for the U.S. share to slip only modestly, from 51% to 46%. A market can lose pricing power and remain the largest, but lower prices in the industry's most profitable market would shrink total revenue unless the industry can grow volume to offset falling prices.

When asked to assume U.S. prices fall (Figure 2), most respondents (65%) say they expect more treated patients to offset the loss. When asked whether the industry will actually change what it develops and sells to serve more patients at lower prices, fewer (44%) say they expect it will. And confidence is weakest among those responsible for increasing demand, with commercial leaders even less apt to say a U.S. shift is likely.[4]

FIGURE 2

Respondents expect treatment volume to offset lower prices but aren't building a model that would support this scenario



Source: ZS Impact Institute, fielded September 15-October 15, 2026. The base varies by question: U.S. revenue outlook asked of commercial, corporate strategy, pricing-policy and analyst respondents only (n=101); future states asked of a broader group, excluding "not enough familiarity" responses (n=242). Q. If U.S. net prices decline because of MFN, IRA or other policy pressures, which outcome is most likely for U.S. branded-pharmaceutical revenue in 2035 relative to today? Q. How likely are any of the potential future states to occur by 2035?

44%

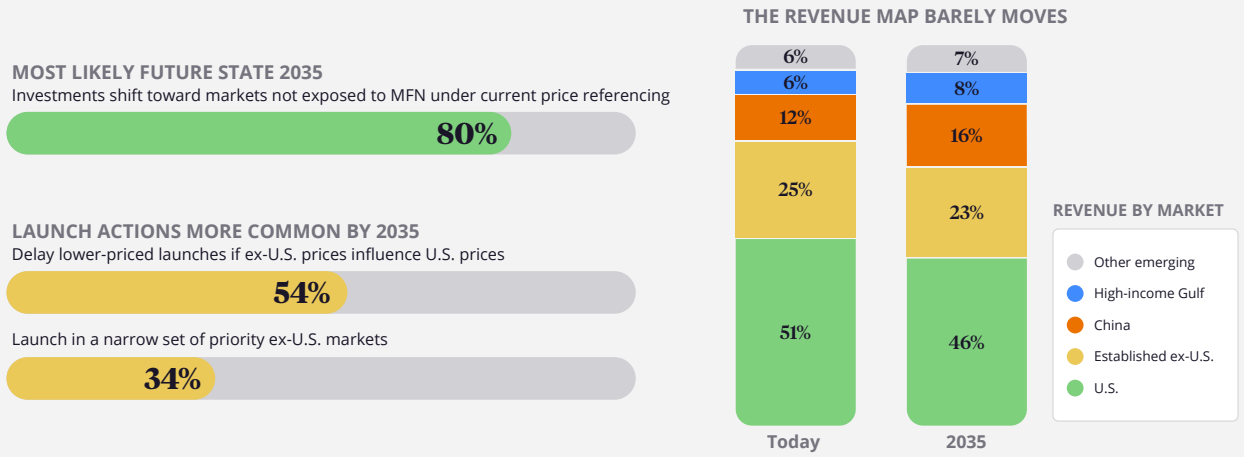
EXPECT THE U.S. TO SHIFT TO HIGHER VOLUME AT LOWER PRICES

The responses imply either that the leaders we surveyed don't believe U.S. prices will actually fall or that, if prices do fall, they'll make up the difference through a combination of higher treatment volume and higher prices abroad. Both assumptions appear shaky when combined with other expectations the survey reveals:

- Fewer than half (48%) expect Europe, Japan or other established ex-U.S. markets—all with aging populations and strained national budgets—to accept higher prices.
- Eighty percent expect to shift commercial investment away from markets exposed to MFN-like price referencing. This makes it hard to grow ex-U.S. revenue, because non-price-referenced markets can't provide enough volume to offset a smaller launch footprint.

FIGURE 3

Respondents expect companies to protect U.S. prices by launching in fewer markets, without dramatically altering their global revenue mix



Source: ZS Impact Institute, fielded September 15-October 15, 2026. Base varies by question: future states (n=237); launch and market-access actions asked of commercial, corporate and ex-U.S. regional business leaders, pricing-policy experts and analysts only (n=110); global revenue mix map (n=82). Q. How likely are any of the potential future states to occur by 2035? Q. If ex-U.S. prices increasingly influence U.S. pricing, which launch and market-access actions are most likely to become more common by 2035? Q. How do you expect the global revenue mix across the U.S. and other key market groups to change by 2035? The revenue-mix segments are mean allocations and sum to 100%.

Set side by side, leaders' expectations demand a lot from the equation.

Set side by side, leaders' expectations demand a lot from the equation. Global revenue = U.S. price × U.S. volume + ex-U.S. price × ex-U.S. volume. Respondents expect U.S. prices to fall, while fewer than half expect ex-U.S. prices to rise. Selective launches point to ex-U.S. volume that holds steady at best. These expectations only work together if U.S. price cuts remain modest.

The higher the share of U.S. sales exposed to MFN-style pricing, the more volume it will take to make up the difference

We modeled hypothetical 2035 scenarios in which MFN-style pricing applies to one of the following: half of Medicare volume, all Medicare volume or all U.S. sales for the top 10 U.S.-selling drugs. Scenarios are illustrative and do not reflect current policy, but they spotlight how much treatment volume would need to increase to offset lower U.S. prices (Figure 4).

If price referencing stays within Medicare, replacing the lost sales would require 7% to 15% more U.S. volume according to our modeled scenario. If it extends to every payer, it would require roughly 146% more baseline volume under our illustrative scenario.

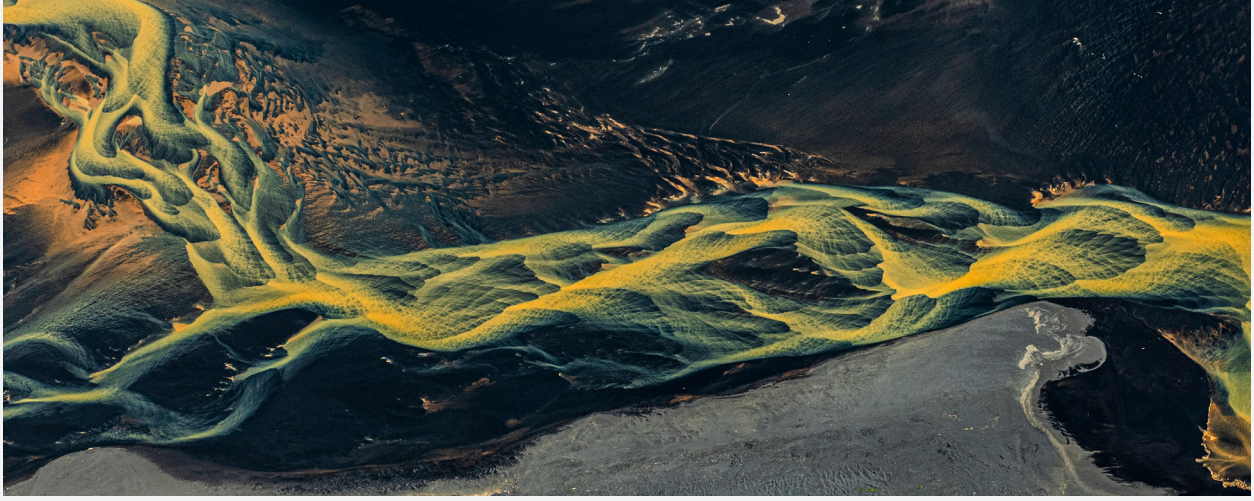


FIGURE 4

The more U.S. sales MFN-style pricing covers, the more volume it would take to replace them



Sources: ZS analysis; Evaluate Pharma (Oct 2026); NAVLIN (Oct 2026); Bloomberg (2026 YTD through Sept); World Bank 2025 GDP per capita at PPP (international $, 2025). Scope: Top 10 NME/NDA drugs by projected 2033 U.S. sales, limited to products with patent expiry after 2031, excluding obesity therapies (Skyrizi, Rinvoq, Dupixent, Vyvgart, Enhertu, Idafang, Winrevair, Imeroprubart, Alyftrek and Bimzelx).[5]

If U.S. drug prices come down meaningfully, leaders would need to deliver unprecedented growth to offset their revenue losses. Respondents favor the first route (more U.S. volume), but the second (more growth abroad) narrows as launches become more selective. This leaves their bets concentrated in the one market where policy is pushing prices down.

Both routes also assume the same thing: a steady supply of new medicines to sell.

The industry is shifting to later-stage and China-origin assets while future access to both Western and China-linked innovation remains uncertain

The question is where future innovation will come from and who pays for the early work that creates it.

Leaders expect continued access to innovation, they expect to secure it by buying later-stage assets externally, and they expect to source more assets from Chinese companies. That approach could thin the Western biotech base of assets they may later depend on, while betting that access to assets in China stays open.

The pressures on both pharma and the venture investors who feed its pipelines point the same way: Patent expirations are exposing revenue gaps, pipelines are thin, and the bar for funding is rising. All of this favors later-stage, better-validated assets over the earliest, riskiest work. The question is where future innovation will come from and who pays for the early work that creates it.

Capital is moving to later-stage assets, and pharma doesn't expect to fill the gap upstream

Industry sentiment turned positive in the third quarter for the first time since the slump, according to Endpoints Signal's proprietary measure of biopharma's current sentiment and future expectations.[6] But this recovery is K-shaped: Later-stage companies have been able to more readily raise capital, while funding for research through preclinical work has fallen over the last several years, including government, private and public funding sources.

42%

EXPECT U.S. GOVERNMENT EARLY-STAGE FUNDING TO RECOVER TO ITS PRE-2025 LEVELS BY 2035

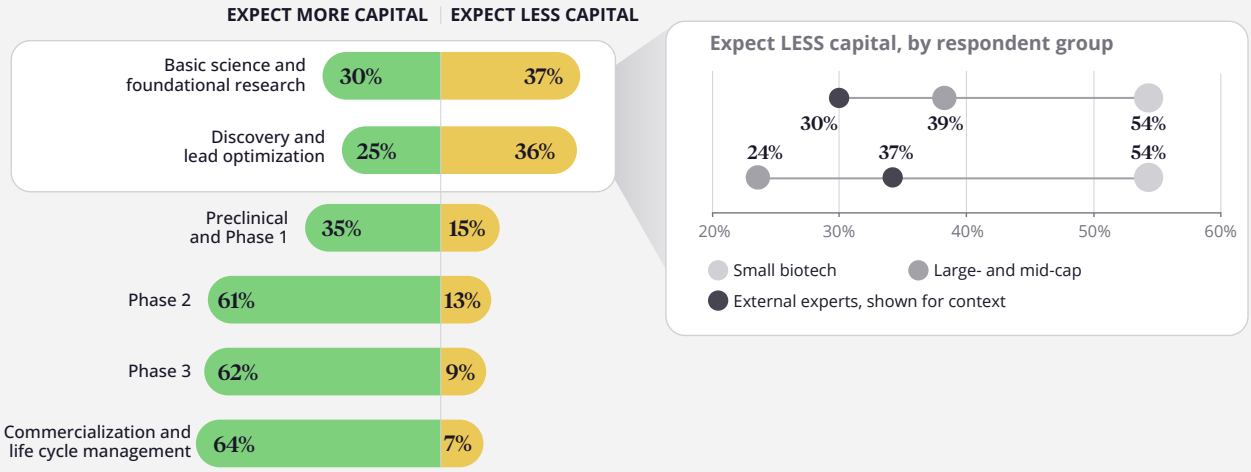
Respondents expect this split to deepen. On balance, they expect capital to move toward later stages and away from the earliest. By 2035, roughly six in 10 expect more capital at phase 2, phase 3 and commercialization, while basic science and discovery are the only stages where more respondents expect available capital to decline. Small biotechs, which do much of that early work, feel it most (Figure 5).

Several forces push capital toward safer harbors. As margins tighten, the long, risky work of early discovery is the first to lose backing. Public research funding, long the backstop that absorbed early risk, is under pressure: The U.S. National Institutes of Health terminated 2,291 grants in 2025[7] and is funding fewer projects in 2026 than the year before. Only 42% of respondents expect U.S. government early-stage funding to recover to its pre-2025 levels by 2035.[8]

After a weak exit market, venture investors face pressure to return capital sooner[9] and are favoring derisked assets, even as AI and other sectors compete for the same pool of money.[10]

FIGURE 5

Capital is moving downstream, and the squeeze is sharpest for the small biotechs doing the earliest work



Source: ZS Impact Institute, fielded September 15-October 15, 2026. The base: R&D and business development leaders, plus external experts (n=147). The right panel splits the same respondents into large- and mid-cap (n=49), small biotech (n=28, directional) and external experts (n=70). Q. By 2035, relative to today, how do you expect total capital availability to change at each stage of the biopharma innovation life cycle?

57%

EXPECT CHINA-ORIGIN INNOVATION TO BE ESSENTIAL OR DOMINANT BY 2035

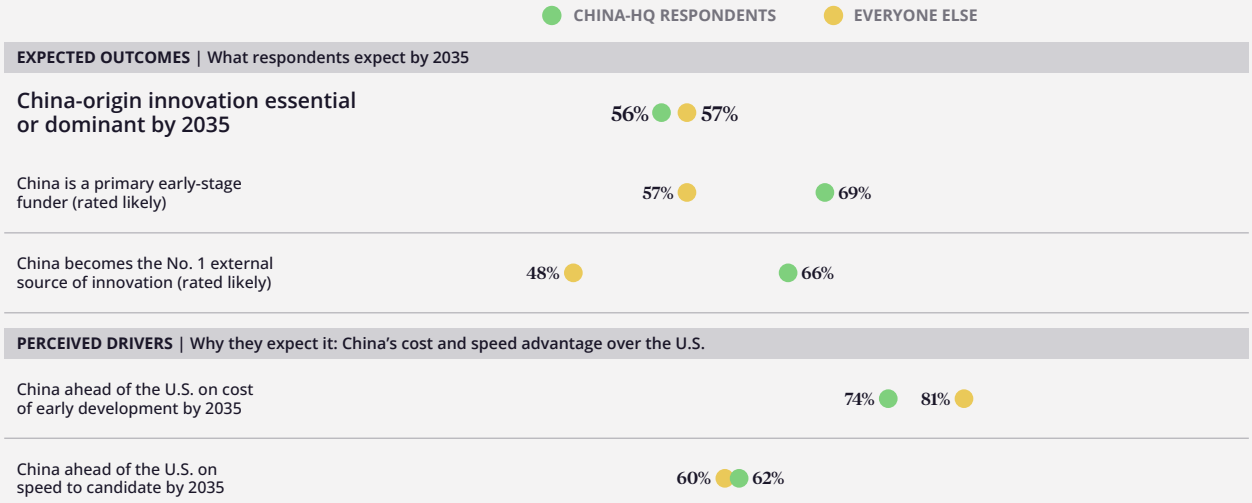
A decline in capital for the earliest work would matter less if pharma were building more of its pipeline itself, but it isn't. And the pharma leaders we surveyed expect to build even less of it going forward, with respondents projecting the internally originated share of developed assets to drop from 40% of total pipelines to 32% by 2035.[11]

With pharma and venture capital constrained, respondents expect China-origin innovation to fill the gap

Nearly six in 10 (57%) expect China-origin innovation to be essential or dominant to competitive pipelines by 2035 (Figure 6), and deal flow is already rapidly moving in that direction: Announced out-licensing by Chinese biotechs, including milestones, rose from about $9 billion in 2020 to about $128 billion in 2025.[12] Part of the draw is cost and speed, with respondents expecting China to be ahead of the U.S. on the cost of early development (80%) and speed to candidate (60%) by 2035.

FIGURE 6

Respondents in and outside China generally expect the importance of China-origin innovation to grow



Source: ZS Impact Institute, fielded September 15-October 15, 2026. Base varies by question: role of China-origin innovation (n=305); innovation funding and financing (n=274); innovation discovery, development and sourcing (n=250); U.S.-China comparison (n=305). China-HQ respondents (n=39, directional) are all pharma insiders, while all other respondents include both insiders and external experts, so the two groups are not like-for-like.

Expected outcomes: Q. By 2035, what role do you expect China-origin innovation to play in global pharmaceutical companies' pipelines? Q. How likely is each potential future state for how pharmaceutical innovation is funded and financed to occur by 2035? Perceived drivers: Q. How likely is each potential future state for how and where pharmaceutical innovation is discovered, developed and sourced to occur by 2035? Q. By 2035, how do you expect the U.S. and China to compare on each innovation dimension shown?

"The advantages of sourcing the innovation quickly and advancing it and developing it globally outweigh the risks of working with China."

—VP, Clinical R&D

Beyond cost and speed, future pipeline expectations also reflect China's growing strength in specific areas of drug development. According to Goldman Sachs, in the two and a half years to late 2025, Chinese biopharma accounted for roughly 70% of global antibody-drug conjugate development and about 60% of bispecific antibody development.[13]

For companies with thin pipelines, looming patent cliffs and money to spend, the advantages China-origin innovation offers are hard to ignore. Those advantages include speed from target identification to clinical candidate and cost of early clinical development (Figure 6), in areas where the science is competitive and at a moment when capital rewards evidence.[14]

Expected reliance on China-origin innovation is rising faster than confidence in access

Nearly half of respondents (48%) expect policy and reimbursement pressures to lead Western pharma to limit licensing of China-origin assets.[15] Across four policy scenarios the survey tested with a subset of respondents—from limits on sensitive-data transfers to controls on investment and licensing to restrictions on China-only clinical data in U.S. approvals—fewer than one in five said they expect companies to "largely avoid" China-linked sourcing.[16]

Taken together, the responses suggest that many participants expect China-linked sourcing to remain available, although access could narrow under the policy scenarios tested. That bet is now being tested. On October 22, 2026, the U.S. Treasury proposed adding biotechnology to the U.S. outbound-investment program. (Under current rules, which remain in force while the U.S. Treasury completes the rulemaking, the program does not cover biotechnology.)

48%

EXPECT POLICY AND REIMBURSEMENT PRESSURE TO LIMIT LICENSING OF CHINA-ORIGIN ASSETS

The current proposal, which would implement the COINS Act and is open for comment through December 7, 2026, would prohibit certain U.S. investments in specified Chinese biotechnology activities, such as equity investments, equity-like debt and qualifying joint ventures; traditional licensing would not be a covered transaction. Separately, two pending bills would extend Treasury review to licensing, but neither has been enacted.[17]

Where today's money goes shapes where tomorrow's innovation is created

The Western biotech system runs on a loop (Figure 1): Venture investors fund early companies, pharma acquires or licenses the winners, and investors recycle those returns into the next generation of companies. ZS analysis and illustrative modeling suggest that a sustained shift in licensing spend toward China-origin assets could reduce capital returning to some U.S. and European biotech investors if aggregate investment budgets don't expand.

Our analysis suggests that the pressures that make outside assets attractive (patent expirations, thin pipelines, a smaller profit pool) are the same ones thinning early-stage funding in the West. This makes the pull toward China stronger as the Western base weakens. If access to Chinese innovation then narrows, the industry could find a Western biotech system with less funding and fewer early assets—and little to fall back on. Pharma would be short of new medicines from both sources, just as its growth plans depend on them most.

Sourcing innovation and driving growth can look like separate challenges. The companies best placed for the next decade will treat them as one.

3 choices biopharma leaders must make to disrupt the model before they're forced to

Sourcing innovation and driving growth can look like separate challenges. The companies best placed for the next decade will treat them as one.

Uncertainty about how far U.S. prices will fall and whether access to China will hold doesn't justify waiting to act. Leaders should sequence their responses by committing now to moves that pay off in any scenario, preparing options that depend on how events unfold and deciding today which signals would trigger changing the model itself.

FIGURE 7

Growth and innovation call for the same kinds of action, sorted by when to act

	Start now Worth doing under any scenario	Prepare now, act on signals Best done before it's needed	Change the model Bolder shifts if cuts run deep
Position for growth	• Stress test plans against deep U.S. price cuts • Assess where volume can realistically offset price • Evaluate lawful launch sequencing and contracting across markets	• Decide in advance which policy signals would trigger a shift in launch plans or spending	• Move beyond unit price with outcomes accountability and disease-management arrangements, backed by broader patient access and tools to measure results
Secure access to innovation	• Shift R&D toward more prevalent conditions that are less reliant on high prices and where the level of innovation justifies the value • Map China dependencies across intellectual property, trials, licensing and equity deals	• Build resilient plans for narrower access to China	• Coinvest in early science with peers and public funders • Use simulation and model-informed development to test trial designs, and engage regulators on appropriate evidentiary uses

Source: ZS analysis. Actions reflect ZS perspective and are options to test, not survey findings.

Leadership decisions that thin the supply of new medicines or ignore where future volume will come from work against each other. Revenue can only offset lower prices when pharma companies have more to sell and more patients to reach, so every decision must be tested against both problems.

Leaders should start here

1 Plan for lower U.S. prices and know where volume can realistically replace price

If U.S. prices were to fall by 10%, some companies' portfolios might be able to absorb the loss through incremental fixes that improve diagnosis, initiation and adherence. Significantly deeper cuts would outstrip what those fixes can deliver (Figure 4), almost certainly requiring volume on a different scale.

Protecting the U.S. price by launching in fewer markets gives up volume abroad that could otherwise cushion lower U.S. revenues.

That volume can come from four places: more products, more markets, more patients per launch and longer time on therapy. The first depends on the innovation engine. All four require investment, so what matters is which can be delivered at a lower cost.

Volume isn't available everywhere. Where nearly every eligible patient is already treated, as in cystic fibrosis in the U.S., a price cut can't be offset. Where the gap between treatable and treated patients is wide, as in underdiagnosed rare autoimmune conditions, volume has somewhere to come from. Capturing it depends on investing in diagnosis and patient identification.

Each route has a cost. Protecting the U.S. price by launching in fewer markets gives up volume abroad that could otherwise cushion lower U.S. revenues. Chasing that volume also comes at a cost, because today's ex-U.S. footprint already includes costs that systematically deliver lower profit than in the U.S. The aim is cost-efficient reach, not more launches at any cost.

Planning for lower U.S. prices comes down to:

- **Finding the untapped volume.** Compare treatable and treated patients for each major brand and pipeline asset to see where volume can offset price and where it can't. Then develop strategies to close the gap between prescriptions written and prescriptions filled, using automation and AI to lower the cost of reaching those patients.
- **Planning for every plausible policy scenario.** Decide now which policy signals would trigger a shift in launch plans or spending so the response is deliberate rather than reactive.
- **Protecting the prices you can.** Evaluate lawful launch sequencing, indications, presentations and contracting strategies across markets, subject to regulatory approvals, patient access, pricing and reporting obligations, and local competition law. We're already seeing manufacturers forgo some European launches; we may also see them delay ex-U.S. launches until therapies enter the IRA negotiation window, using that ex-U.S. revenue to offset IRA-driven revenue gaps and generate revenue and access before patents expire.

2 Derisk innovation sourcing, raise the odds of success and connect today's development strategy to tomorrow's growth goals

Buying later-stage assets lowers risk for each company. Deployed across the industry, it creates new risks.

Buying later-stage assets lowers risk for each company. Deployed across the industry, it creates new risks: Fewer early assets to buy down the road, more competition for the same derisked assets and dependence on innovation sources whose access could narrow.

Leaders can reduce that exposure by addressing where innovation comes from, how likely it is to succeed and whether the portfolio can generate growth at lower prices:

- Shift R&D dollars toward more prevalent conditions that are less reliant on high prices. This shouldn't represent a retreat from rare disease but rather a rebalancing after two decades weighted toward lower-volume, higher-priced therapies.
- Map China dependencies across intellectual property, trials, licensing and equity deals, and build resilient plans. Weigh, too, the combined effect of industry capital flowing into China, where practical barriers may keep it from being redeployed into the global system.
- Co-invest with industry peers and public funders to backfill the decline in basic research and preclinical funding, a gap no single company can close and one that narrows the pipeline of new therapies reaching patients.
- Build simulation into trial design using digital twins, virtual patient cohorts and model-informed development to test designs before enrolling patients—and work with regulators to accept simulated evidence. ZS modeling suggests in silico methods could lift a typical asset's probability of success by up to 2.5x, if models mature and regulatory acceptance grows.

3 Test business models built on patient outcomes, not a single price per product

A product sold by the unit is easy to compare, negotiate and reference against other countries' prices.

The unit price sits at the core of today's model, but a product sold by the unit is easy to compare, negotiate and reference against other countries' prices. It invites public criticism; exposes pharma to payer negotiation and reference pricing, such as MFN; and reduces the value of an innovation to a cost line.

Hospitals, insurers and pharmacy benefit managers have reshaped their business models. Pharma has tried versions of alternative models before, with mixed results. Part of the reason is that sustained, healthy margins have given the industry little reason to pursue more fundamental changes. That cushion may be at risk of thinning, as governments and other payers push harder on price and patent expirations erode revenue from established products.

But changing how a drug is priced won't grow revenue on its own. After all, paying only for results on today's narrow access just means less revenue. Two models are worth testing, and both depend on treating far more patients than today, which will take years to build:

- **Outcomes accountability.** Take accountability for patient outcomes, not just a price tied to them. That means agreeing up-front on what a good outcome is worth, investing in the engagement and services—such as diagnosis, adherence support and care coordination—that get and keep eligible patients on therapy and accepting that revenue rises or falls with patient outcomes. Outcomes-based pricing can only work when paired with access for every eligible patient and the capacity to treat them. Narrow access plus outcomes pricing translates to lower revenue. And health systems today aren't positioned to treat every eligible patient at today's best practice—so pharma will have to help build capacity.
- **Disease-management arrangements.** These set a fixed price for treating a condition with a definable patient population over a set period, regardless of which product is used—much as software moved from licenses to subscriptions. Leaders should pursue disease-area arrangements only where they have depth across a therapy area and real patient volume and deprioritize areas where they are shallow.

The data captures leaders at a turning point: early enough to choose their response, but late enough that waiting risks letting events choose it for them.

None of these approaches can be switched on quickly. Few companies have the contracting and data capabilities to run programs like these at scale today, and any pilot would require case-specific legal and compliance reviews, including Medicaid Best Price and Average Manufacturer Price or other government price reporting, Anti-Kickback Statute and False Claims Act risk, privacy and data use, promotional rules, state law, payer-contracting and competition issues. Even a model that clears those reviews will need to deliver net-new value. Payers will not move off today's arrangements for a repackaged price.

Pharma leaders that don't act now risk events forcing their hand

Persistent pricing pressure, growing reliance on China for new assets, a shrinking pool of capital for early science—the warning signs are all present. Yet growth has lasted so long that most leaders in our survey expect it to continue without fundamentally changing how they operate. The data captures leaders at a turning point: early enough to choose their response, but late enough that waiting risks letting events choose it for them.

When the pressure arrives, it may be too late to get out of its way. This means the time to prepare is now. The companies that build early-warning signals, make themselves more nimble and chart a path to an entirely new model will be best placed to weather it.

[1] ZS Impact Institute, November 2026 (n=305). All figures are shares of respondents who answered each item. Bases vary by item and are shown in the notes to each section and in the methodology appendix. In this report, "China-origin" means discovered, developed, funded or primarily advanced through China-linked organizations, infrastructure or capital.

[2] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Science and Data Policy, "Comparing U.S. and International Market Size and Average Pricing for Prescription Drugs, 2017-2022," ASPE Issue Brief, December 2024, https://aspe.hhs.gov/reports/international-market-size.

[3] Audrey Kearney, Alex Montero, Julian Montalvo III, Isabelle Valdes, Ashley Kirzinger, and Liz Hamel, "Public Views on Prescription Drug Costs: Regulation, Affordability and TrumpRx," KFF Health Tracking Poll, March 13, 2026, https://www.kff.org/public-opinion/public-views-on-prescription-drug-costs-regulation-affordability-and-trumprx/.

[4] Volume-offset question asked of commercial, corporate strategy, policy and analyst respondents only (n=101). Commercial leaders n=46.

[5] The analysis models three hypothetical future scenarios in which MFN pricing applies to 50% of Medicare volume, 100% of Medicare volume or all U.S. volume; scenarios do not represent current policy. The analysis covers 10 selected drugs with projected 2033 U.S. sales and patent expiry after 2031, excluding obesity drugs: Skyrizi, Rinvoq, Dupixent, Vyvgart, Enhertu, Idafang, Winrevair, Imeroprubart, Alyftrek and Bimzelx. 2035 sales are projected from 2033 Evaluate Pharma forecasts using adjusted 2030-33 growth rates. MFN price is modeled as 102% of the lowest available purchasing-power-parity-adjusted price across 13 reference markets, consistent with the GLOBE methodology. For four products modeled as potentially IRA-eligible (Skyrizi, Rinvoq, Dupixent and Enhertu), Medicare starting price is an estimated maximum fair price assumed at 38% below U.S. list price; other starting prices use the U.S. list price. Medicare payer mix is held constant through 2035 based on 2026 YTD shares of prescription dollars. The model assumes full convergence to the modeled MFN price, no price elasticity and no product-specific confidential rebates or net prices. Required Medicare volume uplift and ex-U.S. revenue growth represent the increases needed to offset modeled U.S. revenue losses and are illustrative, not forecasts of demand.

[6] Tom Randall, "Biopharma Sentiment Index | Q3 2026 Survey Results," Endpoints News (Endpoints Signal), October 20, 2026, https://endpoints.news/biopharma-sentiment-index-q3-2026-survey-results/.

[7] Diego F. M. Oliveira, Qian Huang, Teresa K. Woodruff, and Brian Uzzi, "How the 2025 NIH Grant Terminations Varied by Researchers' Demographic Groups," PNAS PNAS 123, no. 13, March 31, 2026, https://doi.org/10.1073/pnas.2527755123.

[8] Anil Oza, Jonathan Wosen, and J. Emory Parker, "Analyzing FY 2026 NIH Grants: Budget Spent, but Uncertainty Lingers," STAT, October 2, 2026, https://www.statnews.com/2026/10/02/nih-grant-funding-fy2026-analysis/.

[9] J.P. Morgan, Q4 2025 Biopharma Licensing and Venture Report (December 2025). It reports 9 biopharma IPOs raising $1.6 billion through Q4 2025, the least active in over a decade. https://www.jpmorgan.com/content/dam/jpmorgan/documents/cb/insights/outlook/jpm-biopharma-deck-q4-2025.pdf

[10] PitchBook-NVCA, Venture Monitor, Q3 2026. It reports that AI accounted for 82.7% of U.S. venture deal value through September. https://nvca.org/pitchbook-nvca-venture-monitor/.

[11] ZS Impact Institute, November 2026. Item E3x1: average share of large pharma pipelines sourced externally (in-licensed or acquired), today vs. 2035 (60% today, 68% in 2035, n=305). Internally originated share falls from 40% to 32%.

[12] PharmCube, out-licensing deal value for China, accessed December 25, 2025. Values are announced total deal value, including milestone payments. Deal-value figures from PharmCube follow its own definitions of China-based activity, which may differ from the survey's definition of "China-origin."

[13] Goldman Sachs, "China Is Increasing Its Share of Global Drug Development," December 17, 2025, accessed November 12, 2026, https://www.goldmansachs.com/insights/articles/china-is-increasing-its-share-of-global-drug-development. Development-share figures from Goldman Sachs follow its own definitions of China-based activity, which may differ from the survey's definition of "China-origin."

[14] ZS Impact Institute, November 2026. Item C3: expected position of China vs. U.S. by 2035 on speed from target identification to a clinical candidate (60%) and cost of early clinical development (80%), share expecting China to be ahead (n=305). Item B11r5: likelihood that biotechs need stronger clinical evidence and commercial validation before they can secure financing on attractive terms, share rating "likely" or higher (79%, n=276).

[15] ZS Impact Institute, November 2026. Item B9r4: likelihood that policy and reimbursement pressures lead Western pharma to limit licensing of China-originated assets, share rating "likely" or higher (48%, n=250). By company size: large pharma 54% (n=67), mid-size biotech 40% (n=53), small biotech 40% (n=58).

[16] ZS Impact Institute, November 2026, item C4: "If each of the following U.S. policies were implemented/expanded within the next five years, how would a typical global biopharma company change its China-linked innovation sourcing?" Asked of a subset of 137 respondents comprising R&D, business development and corporate strategy leaders as well as analysts and R&D and pricing policy experts. Question tested four hypothetical policy scenarios: a. Executive orders like the U.S. Data Security Program restricting transfer/use of sensitive genomic, health or clinical data involving China-linked entities; b. U.S. outbound investment controls extended to biotech licensing, JV and equity transactions (COINS Act / BINSA); c. Policies like the Biotech Investment National Security Act of 2026 scrutinizing U.S. investment in Chinese biotech; d. Restrictions on using China-only clinical datasets for U.S. regulatory approval; Share selecting "largely avoid China-linked sourcing" was under one in five in every scenario.

[17] U.S. Department of the Treasury, "Treasury Issues Proposed Rule to Implement Comprehensive Outbound Investment National Security Act," press release, October 22, 2026, https://home.treasury.gov/news/press-releases/sb0667/ ; Outbound Investment Security Program Regulations, proposed rule, 91 Fed. Reg. 67396 (proposed on October 26, 2026), https://www.federalregister.gov/documents/2026/10/26/2026-21786/outbound-investment-security-program-regulations; Biotech Investment National Security Act of 2026, S. 5316, 119th Cong. (introduced August 6, 2026), https://www.govinfo.gov/app/details/BILLS-119s5316is; and H.R. 9102, 119th Cong. (introduced June 2, 2026), https://www.govinfo.gov/app/details/BILLS-119hr9102ih.

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This research was led by Julia Duncan, with additional contributions from Maria Whitman and Mike Martin. ZS gratefully acknowledges their work.

Methodology

The ZS Impact Institute conducted an online survey of 305 biopharma executives and external industry experts from September 15 to October 15, 2026, covering the full value chain and the outside forces that shape it. Respondents qualified based on their job title and decision-making role. ZS also conducted 15 in-depth qualitative phone interviews, each lasting 60 minutes.

Industry executives (n=226). Respondents lead R&D, manufacturing and supply chain, commercial and market access, business development, corporate strategy and regional operations. Nearly all (96%) hold VP or head-of-function roles or above, and 46% are C-suite or EVP/SVP level. By company size, 87 work at large pharma companies (more than $10 billion in revenue), 67 at mid-size biotechs ($2 billion to $10 billion), 70 at small or emerging biotechs (less than $2 billion) and two at other organizations.

External experts (n=79). The group includes policy specialists (35), industry analysts and business development advisers (29) and early-stage biotech investors (15).

Geography: Respondents are based in the U.S., Europe, China, Japan and other Asia-Pacific markets. The sample includes 39 executives from China-headquartered companies.