

Pharmaceutical expenditure

Pharmaceuticals play a vital role in the health system. Policymakers need to balance access for new medicines while providing the right incentives to industry and acknowledging that health care budgets are limited. After inpatient and outpatient care, pharmaceuticals represent the third largest expenditure item of health care spending; accounting for more than a sixth (16%) of health expenditure on average across OECD countries in 2015 (not taking into account spending on pharmaceuticals in hospitals).

Similar to other health care functions, the cost of pharmaceuticals is predominantly covered by government financing or compulsory insurance schemes (Figure 10.1). Across OECD countries, these schemes cover on average around 57% of all retail pharmaceutical spending, with out-of-pocket payments (39%) and voluntary private insurance (4%) financing the remaining part. Coverage is most generous in Germany and Luxembourg where government and compulsory insurance schemes pay for 80% or more of all pharmaceutical costs. In eight OECD countries, public or mandatory schemes cover less than half the amount spent on medicines. This is the case in Poland (34%), Latvia (35%), Canada and the United States (both 36%). In these countries, voluntary private insurance or out-of-pocket payments play a much bigger role in financing pharmaceuticals.

The total retail pharmaceutical bill across OECD countries was more than USD 800 billion in 2015. However, there are wide variations in pharmaceutical spending per capita across countries, reflecting differences in volume, patterns of consumption and pharmaceutical prices, as well as in the use of generics (Figure 10.2). The United States spent far more on pharmaceuticals than any other OECD country on a per capita basis (USD 1 162), and more than double the OECD average. Switzerland (USD 982) and Japan (USD 798) also spent significantly more on medicines per capita than other OECD countries. At the other end of the scale, Denmark (USD 282), Israel (USD 313) and Estonia (USD 326) had relatively low spending levels.

Around 80% of total retail pharmaceutical spending is for prescribed medicines, with the rest spent on over-the-counter medicines (OTC). OTC medicines are pharmaceuticals that can generally be bought without prescription and their costs are in most cases fully borne by patients. The share of OTC medicines is particularly high in Poland, accounting for half of pharmaceutical spending, but also in Spain (34%) and Australia (31%).

Average annual pharmaceutical spending growth in the 2009-15 period has been much lower compared with pre-crisis years (Figure 10.3). Between 2009 and 2015, expenditure on pharmaceuticals dropped by 0.5% per year on average across the OECD – mainly driven by cuts in spending by government or compulsory schemes and patent expiry of

some “blockbuster” pharmaceuticals – while it increased by 2.3% each year in the 2003-09 period. The reduction was particularly steep in European countries that were affected by the economic and financial crisis, such as Greece (-6.5%), Portugal (-5.9%) and Ireland (-4.4%). As a response to mounting pressures on public budgets, many governments made reducing pharmaceutical expenditure a priority to rein in public spending. The policy measures included the de-listing of products (i.e. excluding them from reimbursement) and the introduction or increase of user charges for retail prescription drugs (Belloni et al., 2016).

In more recent years a number of countries, including Germany, Switzerland, Belgium and the United States have seen the return of higher pharmaceutical spending growth again, partly due to steep increases in spending for certain high cost drugs such as Hepatitis C drugs or oncology drugs.

Definition and comparability

Pharmaceutical expenditure covers spending on prescription medicines and self-medication, often referred to as over-the-counter products. In some countries, other medical non-durable goods are also included. It also includes pharmacists' remuneration when the latter is separate from the price of medicines. Final expenditure on pharmaceuticals includes wholesale and retail margins and value-added tax. Total pharmaceutical spending refers in most countries to “net” spending, i.e. adjusted for possible rebates payable by manufacturers, wholesalers or pharmacies.

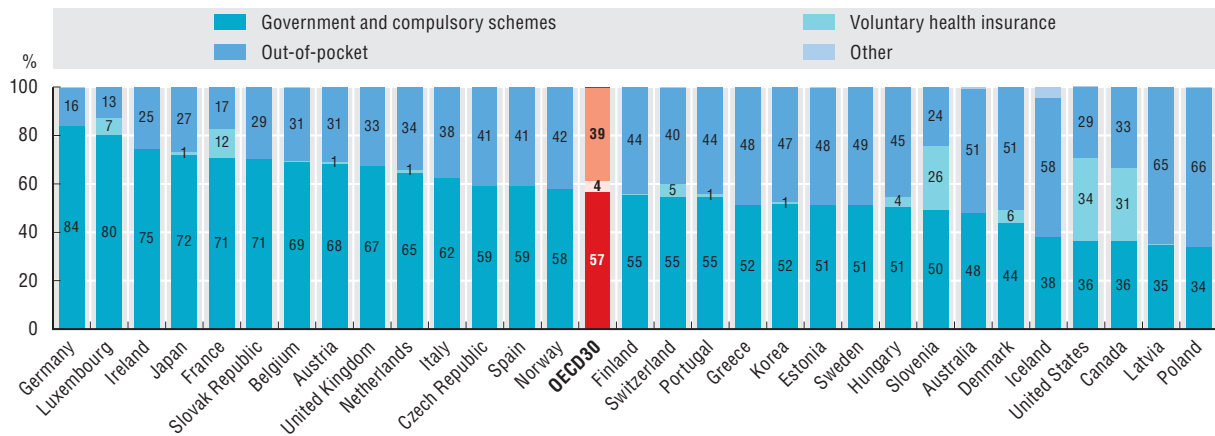
Pharmaceuticals consumed in hospitals and other health care settings—as part of an inpatient or day case treatment are excluded (data available suggests that their inclusion would add another 10-20% to pharmaceutical spending). Comparability issues exist with regards to the administration and dispensing of pharmaceuticals for outpatients in hospitals. In some countries the costs are included under curative care whereas in others under pharmaceuticals.

Pharmaceutical expenditure per capita is adjusted to take account of differences in purchasing power.

References

Belloni, A., D. Morgan and V. Paris (2016), “Pharmaceutical Expenditure and Policies: Past Trends And Future Challenges”, *OECD Health Working Papers*, No. 87, OECD Publishing, Paris, <http://dx.doi.org/10.1787/5jm0q1f4cdq7-en>.

10.1. Expenditure on retail pharmaceuticals¹ by type of financing, 2015 (or nearest year)



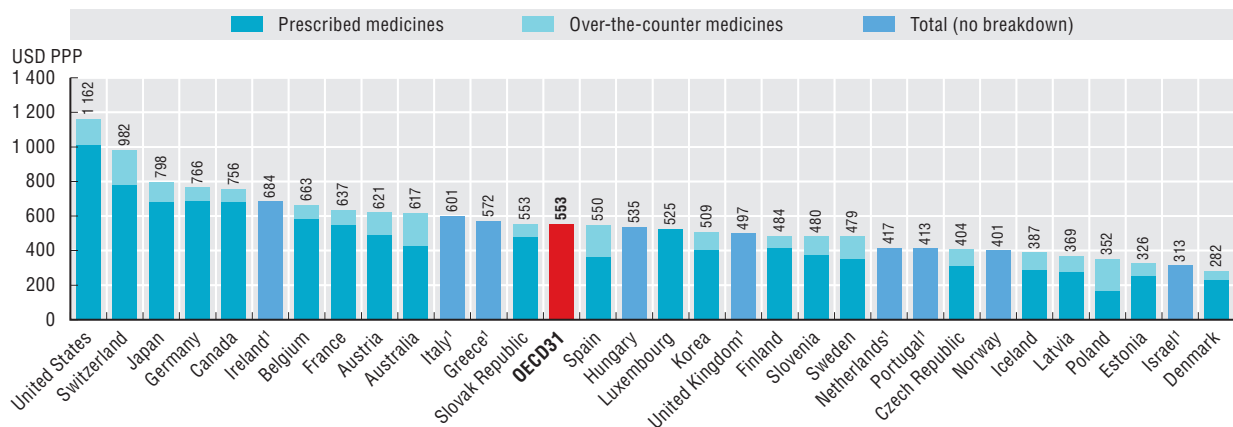
Note: "Other" includes financing from non-profit-schemes, enterprises and the rest of the world.

1. Includes medical non-durables.

Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933605388>

10.2. Expenditure on retail pharmaceuticals per capita, 2015 (or nearest year)

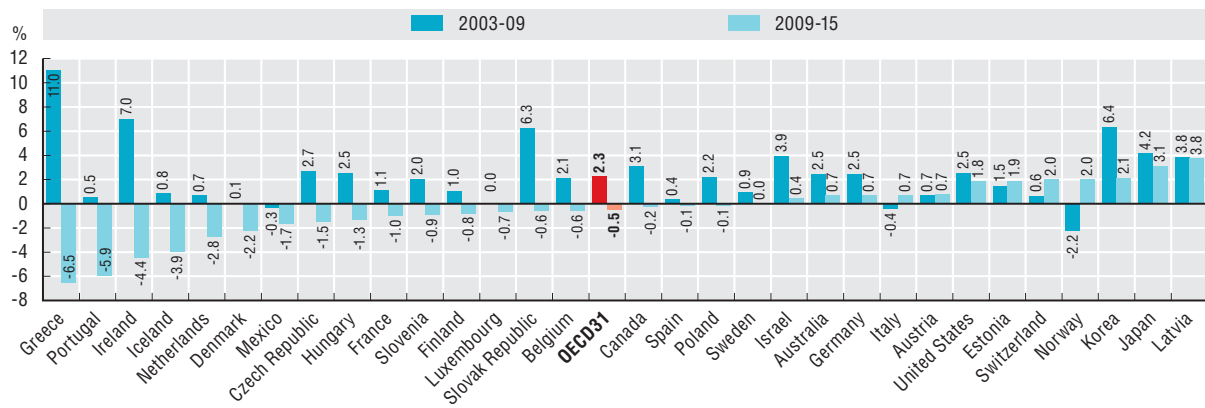


1. Includes medical non-durables (resulting in an overestimation of around 5-10%).

Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933605407>

10.3. Average annual growth in retail pharmaceutical expenditure¹ per capita, in real terms, 2003-09 and 2009-15 (or nearest period)



1. Includes medical non-durables.

Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933605426>



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