

Pharmaceuticals play a vital role in the health system and policy makers must balance the access of patients to new effective medicines, while providing the right incentives to manufacturers to go on developing new generations of drugs. At the same time, health care budgets are limited. After inpatient and outpatient care, pharmaceuticals represent the third largest expenditure item of health care spending and accounted for around a sixth of health expenditure in the European Union in 2014, not taking into account spending on pharmaceuticals in hospitals.

In 2014, the total pharmaceutical bill across the European Union was more than EUR 200 billion. However, there are wide variations in pharmaceutical spending per capita across countries, reflecting differences in volume, structure of consumption and pharmaceutical prices (Figure 5.8). With more than EUR 500 per capita – adjusted for differences in countries’ purchasing powers – Germany (EUR 551) and Ireland (EUR 523) spent far more on pharmaceuticals than any other European country and at least 30% more than the average EU citizen (EUR 402). At the other end of the scale, Denmark, Estonia, Poland and Latvia had relatively low spending levels, below or around EUR 250 on a per capita basis.

Public protection against the costs of pharmaceuticals – provided either by residence-based entitlement schemes or compulsory private insurance – is not as developed as for other health services, such as inpatient and outpatient care (Figure 5.9). Across EU countries, public schemes covered a much higher proportion of the costs of health services (83%) compared with pharmaceuticals (64%) in 2014. Public coverage for pharmaceuticals is highest in Germany, Luxembourg and the Netherlands where more than three-quarters of total pharmaceutical costs are covered by a public scheme. Private sources have to cover more than half of the total pharmaceutical bill in eight EU countries, with public coverage the lowest in Cyprus (20%) and Bulgaria (23%).

The growth in spending on pharmaceuticals has remained below total health spending growth over the last decade, with average annual growth rates in the 2009-14 period much lower compared to pre-crisis years (Figure 5.10). Between 2009 and 2014, expenditure on pharmaceuticals dropped by 1.1% in real terms on average in the European Union – mainly triggered by cuts in public spending – while it increased by 1.4% each year in the 2005-09 period. The reduction was particularly steep in Greece (-8.5%), Portugal (-7.5%) and Denmark (-5.3%). Greece, Ireland and the Slovak Republic have also seen significant reversals in growth of pharmaceutical spending following the crisis compared to the pre-crisis period. Many governments made cutting pharmaceutical expenditure a priority to rein in public spending during the economic and financial crisis. The policy measures taken include reforms that have aimed to shift some of the burden of pharmaceutical spending away from the public purse to private payers. These 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 recent years, measures of this kind have been taken by many EU countries. Other measures include general price reductions by cutting manufacturer prices, pharmacy and wholesale margins as well as promoting the use of less costly generics.

In Estonia, Latvia, Lithuania and Romania, on the other hand, average growth rates in the 2009-14 period are around or above pre-crisis level. A number of countries, including Austria, Germany and France, have seen increases of pharmaceutical spending in 2014 again due to steep growth in spending for certain high-cost drugs such as hepatitis C drugs or oncological 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 approximately). 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.

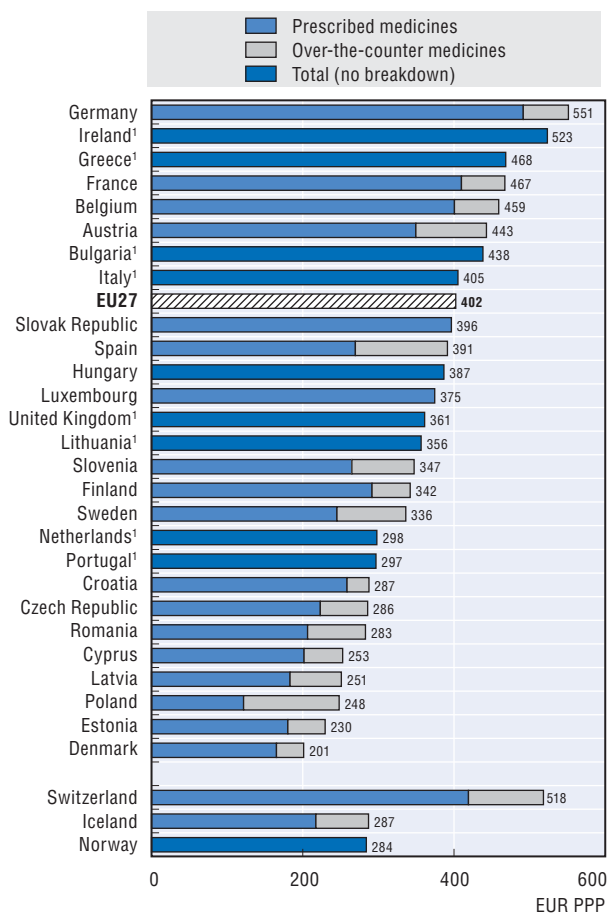
Health services refer to inpatient and outpatient care (including day cases), long-term health care and auxiliary services.

For the calculation of pharmaceutical spending growth rates in real terms, economy-wide GDP deflators are used.

### Reference

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>.

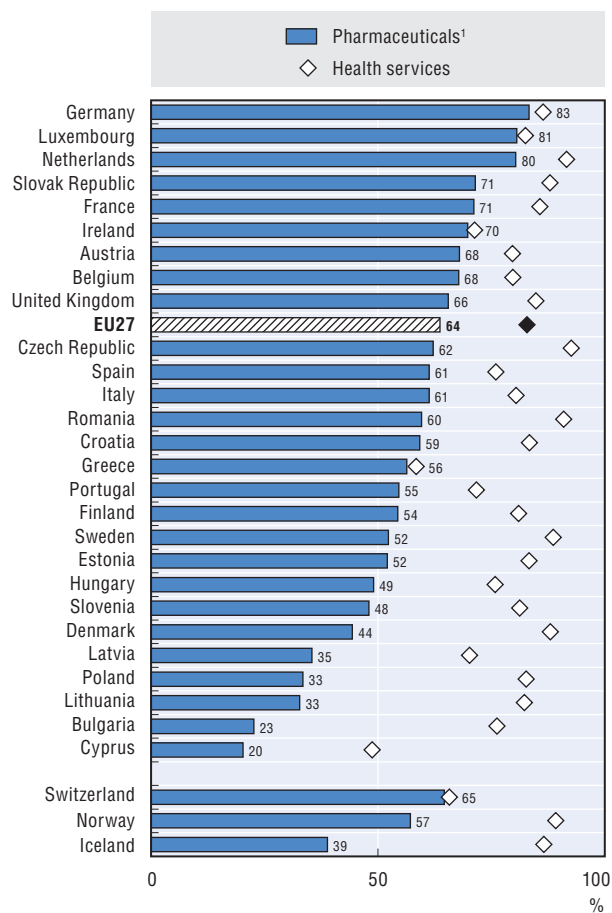
5.8. Expenditure on pharmaceuticals per capita, 2014 (or nearest year)



1. Includes medical non-durables.  
Source: OECD Health Statistics 2016.

StatLink <http://dx.doi.org/10.1787/888933429302>

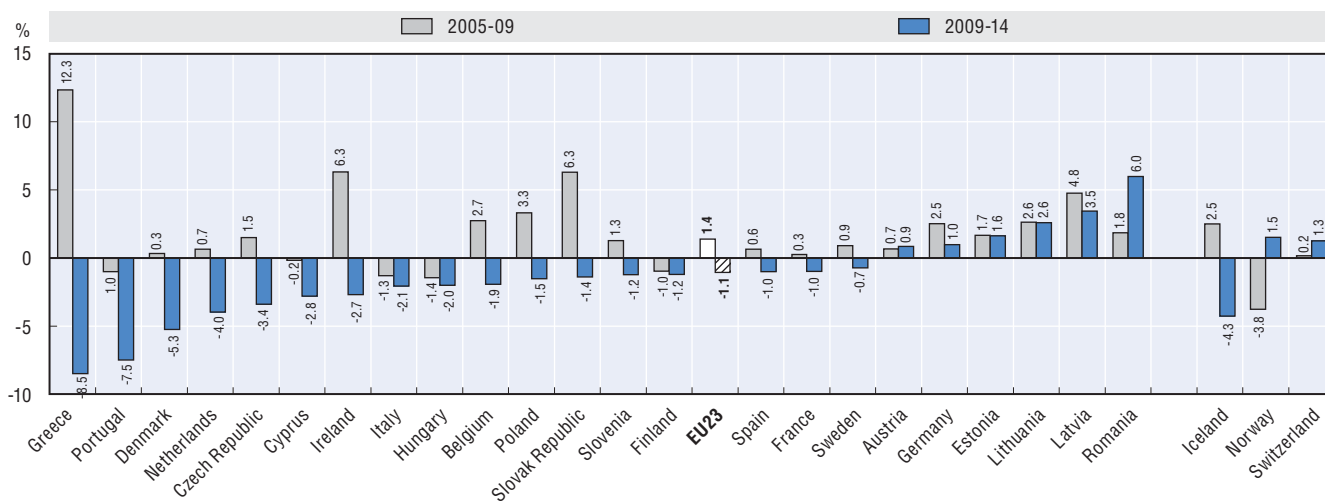
5.9. Public share of spending on pharmaceuticals compared with health services, 2014 (or nearest year)



1. Includes medical non-durables.  
Source: OECD Health Statistics 2016.

StatLink <http://dx.doi.org/10.1787/888933429311>

5.10. Average annual growth in pharmaceutical expenditure<sup>1</sup> per capita, in real terms, 2005-09 and 2009-14 (or nearest year)



1. Includes medical non-durables.  
Source: OECD Health Statistics 2016.

StatLink <http://dx.doi.org/10.1787/888933429320>



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