4.11. Pharmaceutical generic market share

All OECD countries see the development of generic markets as a good opportunity to increase efficiency in pharmaceutical spending, by offering cheaper products than on-patent drugs for an equivalent health outcome. However, in 2011, generics accounted for about three-quarter of the volume of pharmaceuticals covered by basic health coverage in Germany, the United Kingdom, New Zealand and Denmark, while they represented less than one-quarter of the market in Luxembourg, Italy, Ireland, Switzerland, Japan and France (Figure 4.11.1).

The share of the generic market has increased significantly over the past decade in some countries that had low levels in 2000 (Figure 4.11.2). In Portugal, the generic market grew from virtually zero in 2000 to 30% in volume and 23% in value in 2011. In Spain, the generic market share reached 34% in volume and 15% in value in 2011, up from 3% in 2000. While this growth in the generic market share in Portugal and Spain preceded the 2008-09 economic recession, these efforts have been extended by policies recently implemented in these two countries to reduce their budgetary deficits.

Some of the differences in the share of the generic market across countries can be explained by market structures, notably the number of off-patent medicines or the preferences of doctors (who may be influenced by pharmaceutical representatives) for new on-patent medicines, but the generic take-up also very much depends on policies implemented by countries (OECD, 2010b; Vogler, 2012).

A majority of OECD countries allow physicians to prescribe in International Non-proprietary Names (INN), but professional behaviour is not only shaped by laws. While English doctors write 80% of their prescriptions in INN, French doctors do so for only 12% (OECD, 2010b). Similarly, pharmacists are allowed to substitute generics for brand-name drugs in a majority of OECD countries, and even mandated to do so in some countries (e.g., Denmark, Sweden). However, a mandate is not necessary for high generic penetration since countries like New Zealand and the United Kingdom have high penetration rates without mandate.

Financial incentives for physicians, pharmacists and patients have been implemented to foster the development of generic markets. For instance, in England, Primary Care Trusts were financially responsible for all health care spending for their patients and therefore had a direct interest to contain pharmaceutical costs. In France, social health insurance pays bonuses to physicians for high rates of generic prescription through a pay-for-performance scheme.

Patients have a financial interest to choose cheaper drugs when their co-payment is expressed as a percentage of the price or when fixed co-payments are lower for generics or in "reference price" systems. For example, in 2006, Switzerland increased the co-payment rate for brand-name drugs for which cheaper generics are available from 10 to 20%. In France, patients have to pay in advance for their drugs and be reimbursed later when they refuse generic substitution.

Pharmacists margins are set in relation to the price of medicines and are therefore higher (in absolute terms) for more expensive products. With such an incentive, pharmacists are penalised when they substitute a generic for a more expensive drug. Several countries have reversed or at least neutralised this incentive (e.g., France). Other countries have created positive incentives: in Switzerland for instance, pharmacists receive a fee for generic substitution. In several countries (e.g., Norway), pharmacists have the obligation to inform patients about the possibility of a cheaper alternative.

Beyond encouraging generic take-up, it is also important to promote the lowest possible price for generics if the purpose is to contain cost. Figure 4.11.1 suggests, for instance, that the differential between brand-name prices and generic prices is much higher in the United Kingdom than in Germany, since the generic share in value is much lower in the United Kingdom than in Germany while the generic share in volume is similar. One possible way to put pressure on generic prices is tendering. New Zealand introduced competitive tendering for generic drugs in 1997, which resulted in up to 84% to 96% price reductions within five years for a few products (OXERA, 2001).

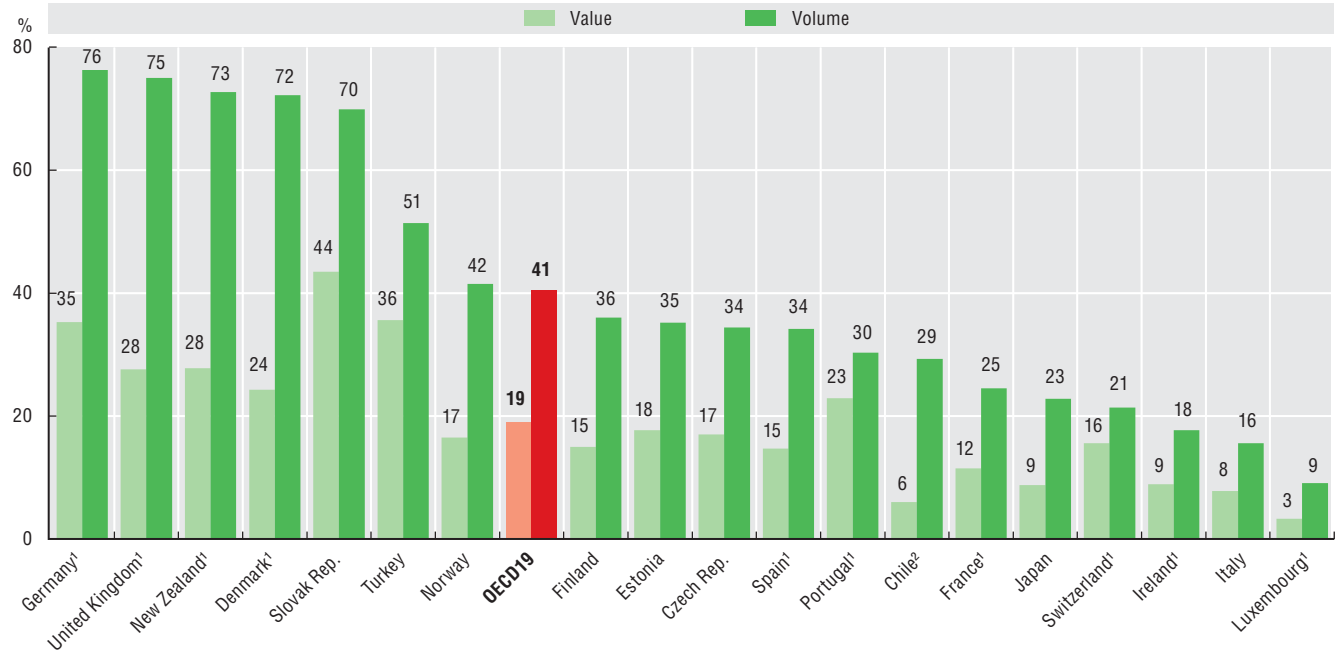
Definition and comparability

A generic is defined as a pharmaceutical product which has the same qualitative and quantitative composition in active substances and the same pharmaceutical form as the reference product, and whose bioequivalence with the reference product has been demonstrated.

Generics can be classified in branded generics (generics with a specific trade name) and unbranded generics (which use the international non-proprietary name and the name of the company).

In most countries, the data cover all pharmaceutical consumption. However, in some countries, it only covers pharmaceuticals that are reimbursed by public insurance. In Chile, data refer only to sales in community pharmacies. In several countries, data only cover reimbursed pharmaceutical consumption.

4.11.1. Share of generics in the total pharmaceutical market, 2011 (or nearest year)

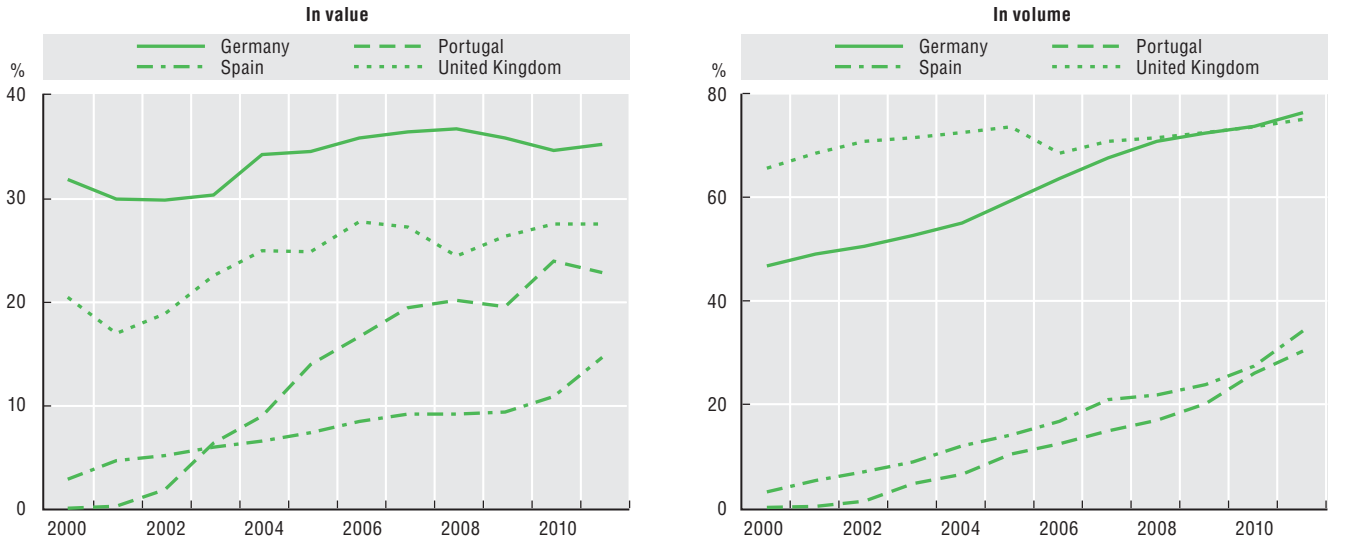


1. Reimbursed pharmaceutical market.
2. Community pharmacy market.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932917769

4.11.2. Trend in share of generics in the pharmaceutical market, selected countries, 2000 to 2011



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932917788

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