

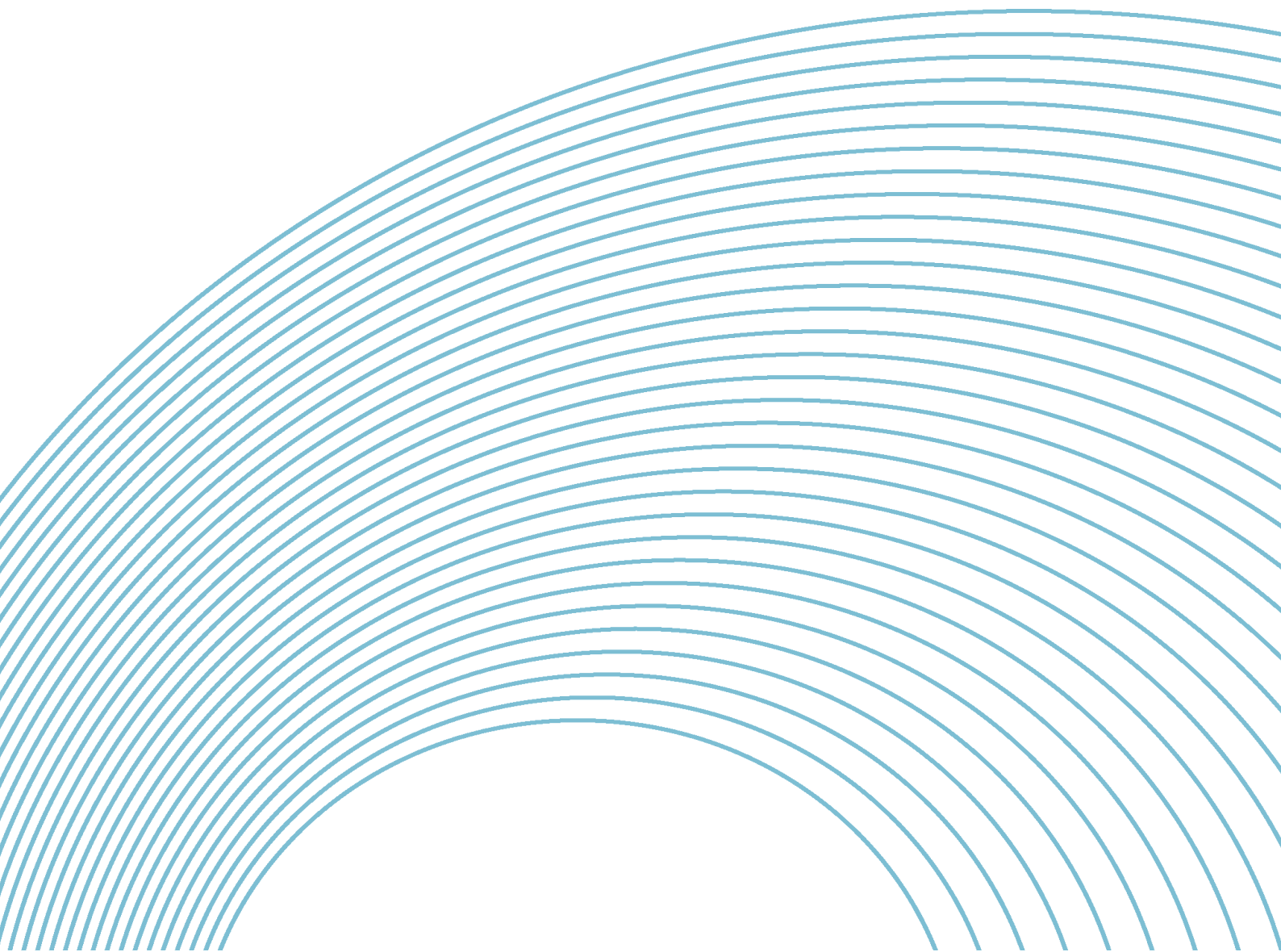
TLV

THE DENTAL AND

PHARMACEUTICAL BENEFITS AGENCY

International price comparison 2025

An analysis of Swedish pharmaceutical prices in relation
to 19 other European countries



The Dental and Pharmaceutical Benefits Agency (TLV) is a government agency tasked with determining which pharmaceutical products and medical devices should be subsidised by the state in the form of high-cost protection. TLV also decides which dental care procedures should be covered by the high-cost protection scheme as part of the national dental care subsidy. TLV is the supervisory authority for the pharmacy market.

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Preface

The assignment of the Dental and Pharmaceutical Benefits Agency (TLV) includes monitoring and analysing the development of pharmaceutical prices from an international perspective. The purpose of this report is to compare how Swedish pharmaceutical prices develop in relation to prices in other European countries.

To achieve this, we have analysed price and volume data for pharmaceuticals in Sweden and 19 other European countries. The dataset covers the first quarter of each year during the period 2014–2025 and includes pharmaceuticals with and without generic competition.

The report should be viewed as a basis for TLV's ongoing monitoring of Swedish price dynamics and how prices in Sweden relate to those in other countries. The report has been published annually since 2014.

The working group consisted of Christoffer Karlsson and Martin Löwing Jensen.

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Summary

TLV's international price comparison is primarily intended to show how Swedish prices for pharmaceuticals compares to prices in other countries. Although foreign price levels do not drive TLV's decisions, the comparisons are valuable: they put what we in Sweden pay for pharmaceuticals into perspective and, in turn, offers insights into how the Swedish systems for pricing and reimbursement operate.

A weaker Swedish krona is the single most important reason why Swedish relative prices have continued to fall. The exchange rate effect is most noticeable when comparing pharmaceuticals without generic competition, since Swedish list prices typically remain unchanged while a pharmaceutical is under patent. By contrast, within the 'product-of-the-month' system prices change from month to month, which adds some degree flexibility to pricing. TLV has also raised certain price ceilings within the system, creating additional scope for price adjustments.

When considering the results for the **segment without generic competition**, it is important to remember that the analysis is based on list prices (Pharmacy Purchase Price, PPP) and therefore excludes confidential discounts agreed under Managed Entry Agreements (MEAs). At least in some comparator countries, such agreements are more widely used than in Sweden, partly because of the value we have placed on the transparency that comes with using list prices. In 2025, Swedish list prices are 18 per cent lower than the European average for pharmaceuticals without generic competition.

Have companies been able to adjust list prices to offset currency changes when launching new pharmaceutical products to the Swedish market? A new analysis shows no clear evidence that this is the case. It also remains unclear how much room there is for such compensation within Sweden's value based pricing system.

For the **segment with generic competition**, our assessment is that the impact of discounts and repayments tends to be less significant. Uncertainty concerning the effect and costs of older pharmaceuticals is lower, which reduces the need for risk sharing, and competitive dynamics provide other, more effective, measures to reduce prices and manage costs. In 2025, Swedish list prices are 54 per cent lower than the European average for pharmaceuticals with generic competition.

The 'product-of-the-month' system creates strong incentives for companies to set competitive prices. New analysis this year indicates that it is not primarily price ceilings that push prices down; rather, it is the system's ability to incentivise firms to offer competitive bids. The aim of the 'product-of-the-month' system is not the lowest possible price at any cost, but rather stable access to pharmaceuticals at the best possible price. TLV has adjusted the price ceiling regulations to increase pricing flexibility and reduce the risk of shortages.

1 Introduction

1.1 About the assignment

The purpose of this report is to analyse Swedish pharmaceutical prices from an international perspective. Under the Ordinance (2007:1206) with instructions for the Dental and Pharmaceutical Benefits Agency (TLV), the agency shall:

- monitor and analyse developments in other countries and draw on their experience,
- compare the price level in Sweden with the price level in other countries for relevant products in the pharmaceutical sector, and
- track price developments in the pharmaceutical sector from an international perspective.

The report has been published annually since 2014.

1.2 Disposition

Following the introduction (Chapter 1), three analysis chapters (Chapters 2–4) present results that, in different ways, contribute to the picture of Swedish pharmaceutical prices in an international context. Chapter 5 then discusses the conclusions that should be drawn from the results. Finally, the appendices provide definitions of key terms, more detailed information on methods and data, sensitivity analyses, and the list of pharmaceutical groupings used in the report (Appendices 1–3).

1.3 Background and information about the pharmaceutical market

This section provides brief descriptions of the dataset, the selection of pharmaceuticals and countries, and exchange rate developments. For fuller descriptions of the dataset, methods and selection, see Appendix 2.

1.3.1 Selection of pharmaceuticals and price information

The dataset covers **prescription pharmaceuticals for human use that are included in the pharmaceutical benefits in Sweden and dispensed at retail pharmacies**. This scope reflects TLV's mandate, which primarily concerns these pharmaceuticals. Hospital pharmaceuticals and vaccines are therefore not included in the comparison. Pharmaceuticals that may be used under communicable disease provisions are part of the selection, but their volumes are excluded when they are prescribed under the Communicable Diseases Act. A pharmaceutical dispensed on prescription in Sweden may be used as a hospital pharmaceutical in another country, and the split between prescription use and hospital use also differs across countries.

The price comparison is based on list prices, specifically the pharmacy purchase price (PPP). TLV does not have access to so-called net prices — i.e., the prices ultimately paid for the pharmaceuticals. Net prices are often regulated in specific agreements, so called Managed Entry Agreements (MEAs), between the payer (for example, the state or an insurer) and the marketing authorization holder and are typically strictly confidential. Potential discount effects are therefore not considered in the analysis, either for Sweden or for comparator countries. In Sweden, such agreements exist for 66 reimbursed pharmaceuticals (of roughly 3,300)¹, which is judged to be relatively few compared with many other countries.

Patent protection for pharmaceuticals in the EU

In the EU, patents for pharmaceuticals normally last 20 years from the filing date under the European Patent Convention. To compensate for the time between patent filing and marketing authorization, companies may apply for Supplementary Protection Certificates (SPCs), which can extend protection by up to five years. In practice, the period of market exclusivity for a pharmaceutical can therefore range from around 7 to up to 20 years.

Differences in the timing of patent expiry arise because SPC duration is calculated from the date of national marketing authorization, which varies between countries. This, in turn, is influenced by companies' launch strategies, administrative processes and national rules governing supplementary protection. Firms sometimes use strategies such as evergreening to prolong exclusivity; how implications of such strategies are assessed varies across Member States.

Determining when a pharmaceutical's patent protection ends can be challenging. Protection often consists of multiple patents, which may expire at different times. In addition, once a party other than the marketing authorization holder places generic products on the market, the validity of the patents may have to be tested in court. Being the first generic company in a new market can therefore involve commercial risk.

Analyses are carried out for two segments: **pharmaceuticals with generic competition and pharmaceuticals without generic competition**.

Competition can be defined in various ways; in this report, generic competition is defined based on the Swedish context, and includes pharmaceuticals present within TLV's 'product-of-the-month' system (the substitution system used in Swedish retail pharmacies). The reason for the segmentation is that both price levels and the processes for pricing pharmaceuticals with and without generic competition differ substantially.

¹ TLV (2025a). Prognos av besparingar från sidoöverenskommelser 2025–2028.

The selection is primarily based on pharmaceuticals with high sales in Sweden. The core of the selection comprises the 200 bestselling products in Sweden during the year. These are supplemented with new and innovative pharmaceuticals examined in the WAIT survey², as well as substances with relatively low sales in Sweden but high sales in the comparator countries. All products included in earlier selections are also retained. The selection in this year's report covers 90 per cent of sales value within the benefits in the first quarter of 2025. The selection criteria mean that most prescription only human pharmaceuticals included in the Swedish pharmaceutical benefits are part of the sample. Which pharmaceuticals that are then included in the different analyses depends on the inclusion criteria set for each analysis. See Appendix 2 for details of the selection.

To enable price comparisons between countries, **all prices have been converted into Swedish kronor (SEK)**. Exchange rate data are taken from Eurostat. To avoid short-term currency movements affecting the analysis from one year to the next, a three-year moving average is used for exchange rates.

On reviewing the material each year, **anomalies are identified that raise questions about the accuracy of the information**. In the data set used for this year's report, a number of cases have been identified concerning both product prices and the pack size stated. In such cases, TLV has initiated dialogue with IQVIA for clarification. TLV's ability to independently verify price and pack information from other countries is very limited.

Swedish **pharmaceutical prices are compared with prices in 19 other countries**. These are described in more detail in the next section and in the appendix.

1.3.2 About the comparator countries

The comparison with the countries included in the selection is considered to provide a relevant and accurate picture of Swedish pharmaceutical prices. All countries are in Europe, and the majority are also EU Member States³. This means that, to some extent, the countries share legislation and market for pharmaceuticals. The original choice of countries was made both because comparisons with them were expected to give a fair picture of prices in Sweden, but also due to data availability. The selection has been stable over time, which facilitates comparisons between years.

The countries have healthcare and health insurance systems that, in broad terms, resemble those in Sweden, although there are also significant differences in how they are organised. Each system for pricing and reimbursement of pharmaceuticals is complex, and no two operate in exactly the same way. How these systems have

² IQVIA (2025). EFPIA Patients W.A.I.T. Indicator 2024 Survey.

³ Norway, Switzerland and the United Kingdom are not members of the EU; however, Norway and Switzerland are part of the European Single Market.

been designed depends on the broader context in which they have evolved. Is health insurance administered by public authorities or by private insurers? Is it mandatory to have health insurance that covers the costs of pharmaceuticals? What proportion of pharmaceuticals are prescribed and dispensed through pharmacies? How are responsibilities divided between central government and the regions? These are a few examples of aspects in which countries' health insurance systems differ, and which may affect pricing and decisions on reimbursement status.

One aspect in which countries differ is whether pharmaceutical prices are centrally regulated—i.e., set by a public authority as in Sweden—or whether companies are free to set whatever price they wish. It is also worth noting the many ways in which systems remunerate the different parts of the supply chain, such as wholesalers and pharmacies.

Table 1. Countries included in the selection

Belgium	Portugal
Denmark	Switzerland
Finland	Slovakia
France	Spain
Greece	United Kingdom ⁴
Ireland	Sweden
Italy	Czechia
Netherlands	Germany
Norway	Hungary
Poland	Austria

Even so, there are common methods across systems for determining the price and reimbursement status of individual pharmaceuticals, which can be described and compared to some extent—something that has been done previously (for example by WHO⁵ and PPRI⁶). See the information box “Policy instruments for pricing and reimbursement” for a quick overview of commonly used tools. For those wishing to explore further, we have prepared short descriptions of pricing and reimbursement systems for a few of the countries covered in the report. These are published as an external appendix to this report and are available on TLV’s website.

⁴ Volume data pertain to United Kingdom, price data sourced from England and Wales

⁵ WHO (2020). WHO guideline on country pharmaceutical pricing policies.

⁶ PPRI, pharma profiles/briefs

Policy instruments for pricing and reimbursement

External reference pricing (ERP)

- Prices are set in relation to prices in other countries. For example, list prices may be observed in a number of countries and the reference price calculated as the median or the average of the three lowest prices. Also referred to as international reference pricing.
- Access to reliable price data is the main challenge, not least given the prevalence of confidential prices.
- In *internal* reference pricing (IRP), prices are instead set in relation to pharmaceuticals that have already been priced, often within the same ATC group.

Value-based pricing (VBP) / Health Technology Assessment (HTA)

- Pricing is based on the value the pharmaceutical is expected to deliver, assessed through health-economic evaluation within an HTA-framework. If the benefits are determined to justify the cost, the price is accepted.
- Which benefits and costs are included varies between countries. VBP is used in all countries in the selection, but to differing extents and purposes. Dedicated HTA bodies often provide decision support.

Industry negotiations

- Negotiations between pharmaceutical companies and payers (e.g. a public authority or an insurer) are commonly used. Reference prices and HTA findings are often used as inputs, though other factors may also play a role.
- The content of the agreements concluded after negotiations (usually called 'side agreements' in Swedish and Managed Entry Agreements, MEAs, in English) varies. In Sweden, the focus has been on regulating the net price through repayments; provisions addressing different types of risk also occur.
- The content of these agreements is, as a rule, confidential.

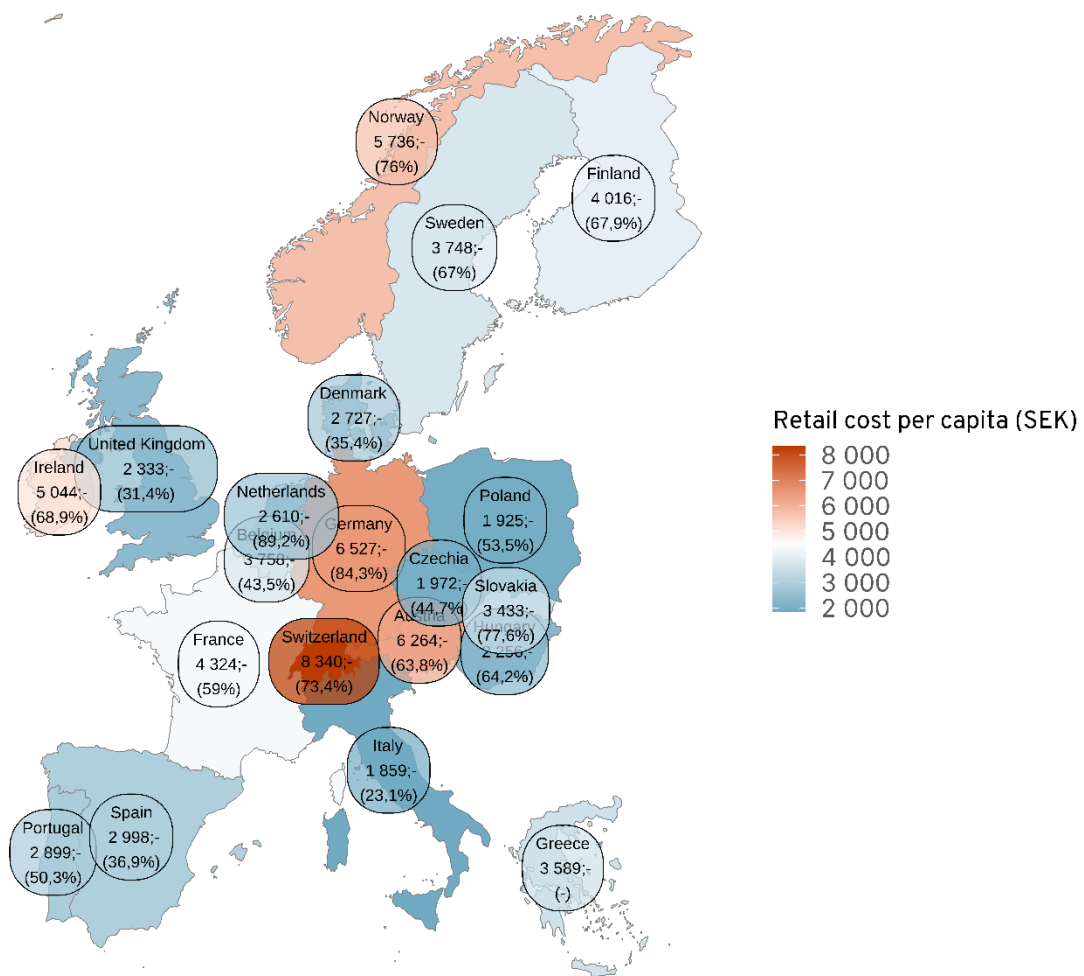
Older pharmaceuticals

- In all countries except the United Kingdom and Austria, generic substitution at pharmacies is permitted.
- A common way to promote generic competition is to apply rule-based, stepwise price reductions as more generic alternatives become available. Another approach is the auction-type system used in Sweden (the 'product-of-the-month' system).
- Competition also arises for biological pharmaceuticals when patent protection expires, often in the form of biosimilars. A biosimilar is a biological pharmaceutical that is highly similar to an already authorised biological reference pharmaceutical in the EU. In some countries, such as Norway, Poland and the Netherlands, substitution to biosimilars at pharmacies is permitted.

Costs per capita and the distribution between retail and hospital pharmaceuticals vary between countries

In Sweden, expenditure on pharmaceuticals dispensed in retail (outpatient) care amounts to SEK 3,750 per capita, which represents 67 per cent of total pharmaceutical costs (retail and hospital pharmaceuticals) (Figure 1).

Figure 1 Retail pharmaceutical costs per capita and share of total pharmaceutical costs, by country, 2025 (share and SEK)



Source: IQVIA and TLV.

Note 1: The figure shows the country, retail pharmaceutical cost, and the retail share (in brackets). For details, see Appendix 2.

Note 2: The data do not cover total pharmaceutical sales for Czechia, Greece, Italy, the Netherlands, Slovakia, Spain and the United Kingdom. Data for Sweden are based on wholesaler sales (WHS sell-in).

Ireland, Finland, Austria and Hungary are the countries that are the most similar to Sweden in terms of the share of total pharmaceutical costs incurred from

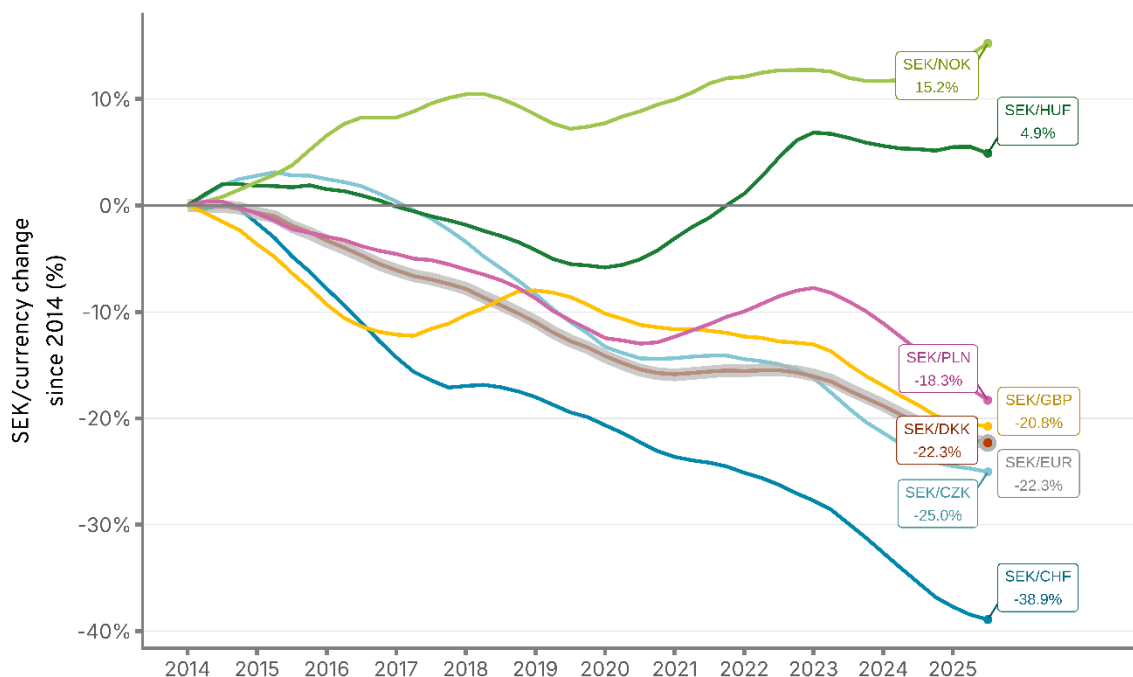
prescription pharmaceuticals. This may indicate that pharmaceuticals are administered and prescribed to patients in a similar way to Sweden.

Germany, Austria, Switzerland and Ireland have higher per capita retail pharmaceutical costs than Sweden. Three of these also have a higher retail share of total pharmaceutical costs (Figure 1). Among the Nordic countries in the analysis, Denmark differs most from Sweden: retail accounts for about 35 per cent (compared with 67 per cent in Sweden) of total pharmaceutical costs (Figure 1). This is because, to a greater extent than in Sweden, more expensive pharmaceuticals in Denmark are procured by the regional health authorities as hospital pharmaceuticals and are therefore funded by the regions.

1.3.3 The Swedish krona has weakened against other currencies

The Swedish krona has continued to lose value relative to most currencies used in the comparison countries, as shown in Figure 2. When a pharmaceutical is sold on the Swedish market at a fixed, nominal price, both the price expressed in, for example, euro and the value of sales will decline as the krona weakens. This has been the case in recent years.

Figure 2 The value of the Swedish krona compared with the currencies of the comparison countries, calculated with a variable exchange rate (three-year moving average), 2014–2025, percentage change



Source: Eurostat and TLV.

Twelve countries—i.e., almost two in three countries in the price comparison—use the euro. Since 2014 the Swedish krona has lost just over 22 per cent of its value against the euro (Figure 2). All else being equal, this implies that the Swedish price

level would have appeared to fall by 22 per cent over 2014–2025 even if the actual price level had remained constant. At the start of 2025 the Swedish krona strengthened slightly against the euro, which has been described as a potential break in the trend. Because we use a three-year moving average, this development is not yet visible in our series. Instead, the krona had weakened by a further 4 per cent in the first quarter of 2025 compared with the same period a year earlier.

2 Analysis: bilateral price comparisons

In this analysis, Swedish prices are compared with prices in each of the 19 comparator countries in so-called bilateral price comparisons.⁷ Swedish volumes are used as weights, which means the results should be interpreted from a Swedish perspective—what would Sweden’s pharmaceutical consumption have cost if it had been purchased at the list prices prevailing in other countries?

In the bilateral comparisons, prices are compared only for those pharmaceuticals that are used both in Sweden and in the comparator country. For example, if Finland uses 59 per cent of the pharmaceuticals that Sweden uses, the comparison includes only those pharmaceuticals. The degree to which the two product baskets overlap is called the match rate and is shown in the figures. The higher the match rate, the more robust the results. Pharmaceuticals that are used in both countries but have very small sales in the comparator country (less than 0.5 per cent of Sweden’s sales measured as units per capita) are excluded from the comparison with that country.

The comparison places greater weight on pharmaceuticals with high sales in Sweden. If these pharmaceuticals are also low-priced in Sweden, Sweden’s relative position improves, since countries tend to have lower prices for the pharmaceuticals they use most.

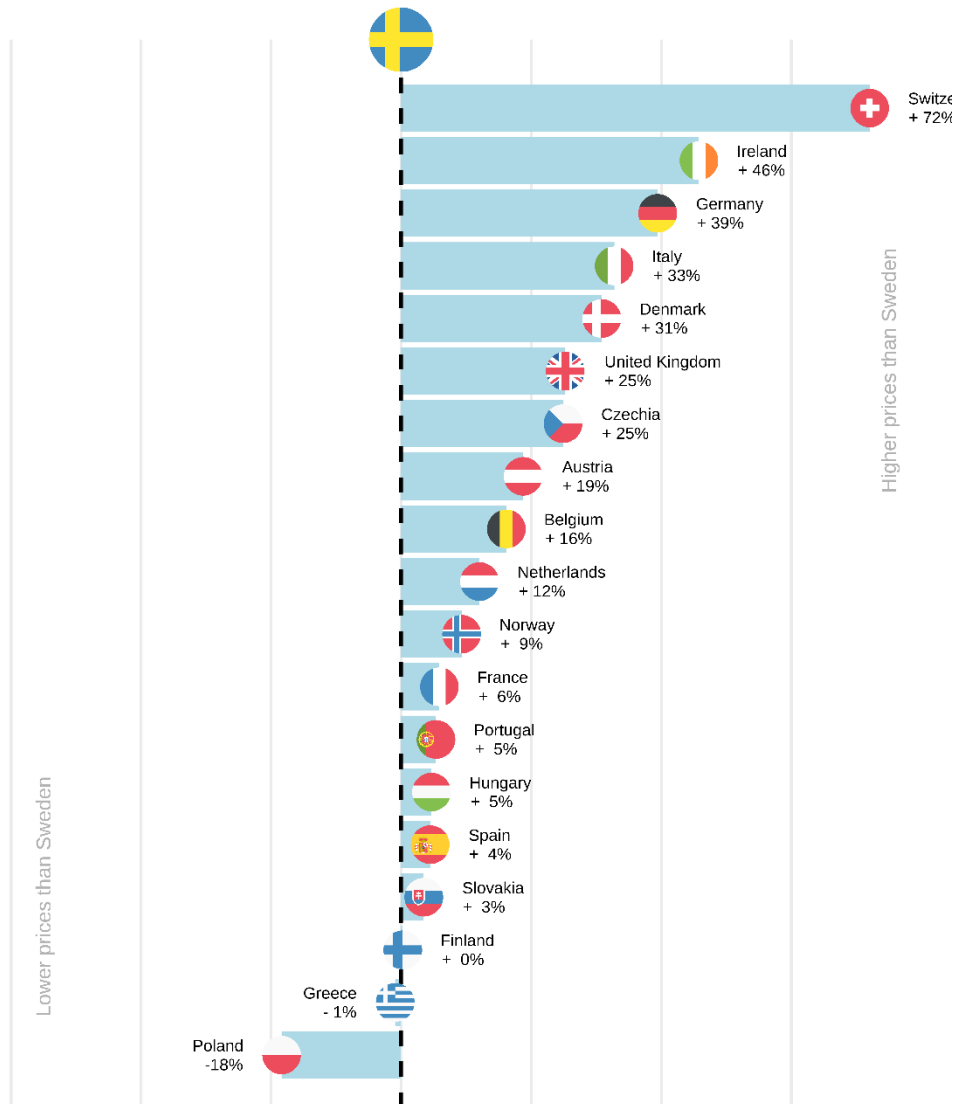
Note also that one should avoid comparing, for example, Denmark’s index values with Germany’s, since the comparisons do not necessarily include the same set of pharmaceuticals.

2.1 Swedish prices remain low in relation to many countries

This analysis shows that Swedish list prices for **pharmaceuticals without generic competition** are—together with Finland’s—the third lowest among the European comparator countries in 2025 (Figure 3). This is a change from last year, when Swedish prices ranked sixth lowest, but the development reflects relatively small shifts between countries. The implication is that Swedish consumption of pharmaceuticals without generic competition would have been 9 per cent more expensive at Norwegian prices than at Swedish prices, or 18 per cent cheaper at Polish prices. Since last year, Swedish prices have fallen relative to all countries except Norway, Finland and the Netherlands.

⁷ All methods are described in Appendix 2

Figure 3 Bilateral price comparisons for pharmaceuticals without generic competition used in Sweden, 2025, percentage deviation



Source: IQVIA and TLV.

Note 1: Prices refer to the first quarter of 2025. Volumes cover 12 months of sales (April 2024 through March 2025). Distance from Sweden has been calculated using a bilateral price index.

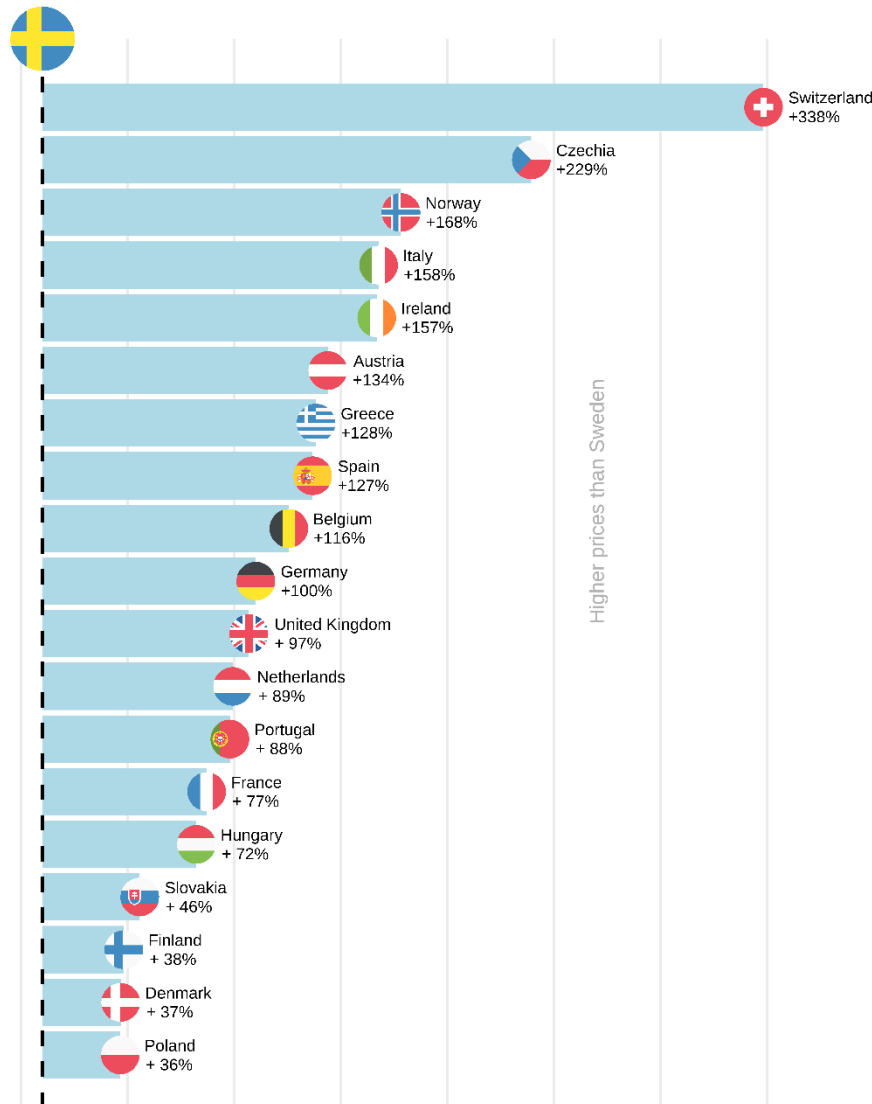
Note 2: Match-rate classification: high $\geq 70\%$; medium 40–69%; low $< 40\%$.

As usual, the most important explanation for Sweden's low prices is the weakening of the Swedish krona. Exchange rate effects and other possible explanatory factors are discussed later in the report.

For **pharmaceuticals with generic competition**, Swedish list prices are the lowest among the comparator countries in 2025 (Figure 4). Sweden's ranking is

therefore unchanged from the previous year, and the price level gap has widened versus all comparator countries except Italy and Denmark.

Figure 4 Bilateral price comparisons for pharmaceuticals with generic competition used in Sweden, 2025, percentage deviation



Source: IQVIA and TLV.

Note 1: Prices refer to the first quarter of 2025. Volumes cover 12 months of sales (April 2024 through March 2025). Distance from Sweden has been calculated using a bilateral price index.

Note 2: Match rate classification: high $\geq 70\%$; medium 40–69%; low $< 40\%$.

Last year, by contrast, the distance between Swedish prices and those in most other countries narrowed compared with the results for 2023. The explanation offered was that many companies raised prices after TLV decided in 2023 to increase the price ceiling (the highest permitted price within a package size group) for certain

pharmaceuticals in the ‘product-of-the-month’ system.⁸ This year, the distance to the European average increased in the groups that received price ceiling increases. A plausible explanation is that prices for some of the pharmaceuticals whose prices initially rose in line with the higher price ceilings have since fallen again. The distance also increased in groups where price ceilings were not raised.

The figure shows that Swiss list prices are more than three times higher than list prices in Sweden. The Swiss system fundamentally relies on both external and internal reference pricing and therefore differs markedly from Sweden’s ‘product-of-the-month’ system. Generally, prices for generic alternatives must be 30 to 40 per cent lower than the originator price to be reimbursed, and a price review is conducted every three years. A factor that is likely to matter for the results is the share of generics actually used in each country, since higher generic use generally leads to stronger competition and lower prices.

Swedish list prices are most similar to those in Poland, Denmark and Finland. In Poland, the use of generic pharmaceuticals is extensive, and reference prices are set through a mix of internal reference pricing, stepwise price reductions at generic entry, and price negotiations and HTA. The Danish system is in many respects similar to the Swedish one, with the difference that the price period is 14 days rather than one month as in Sweden. Finland instead uses an internal reference pricing system in which the maximum reimbursement amount is based on the lowest price in the substitution group. Reference prices are updated quarterly after companies have notified their prices.

2.2 A weakening krona is an important explanation for low Swedish prices

As described above, Swedish list prices for **pharmaceuticals without generic competition** have moved from being the sixth lowest to the third lowest. Figure 5 shows that Swedish prices have fallen relative to those in other countries over the past decade. In 2014, Swedish prices were the fifth highest among the comparator countries, compared with the third lowest in 2025. This means Sweden has moved 13 positions, the largest change during the period.

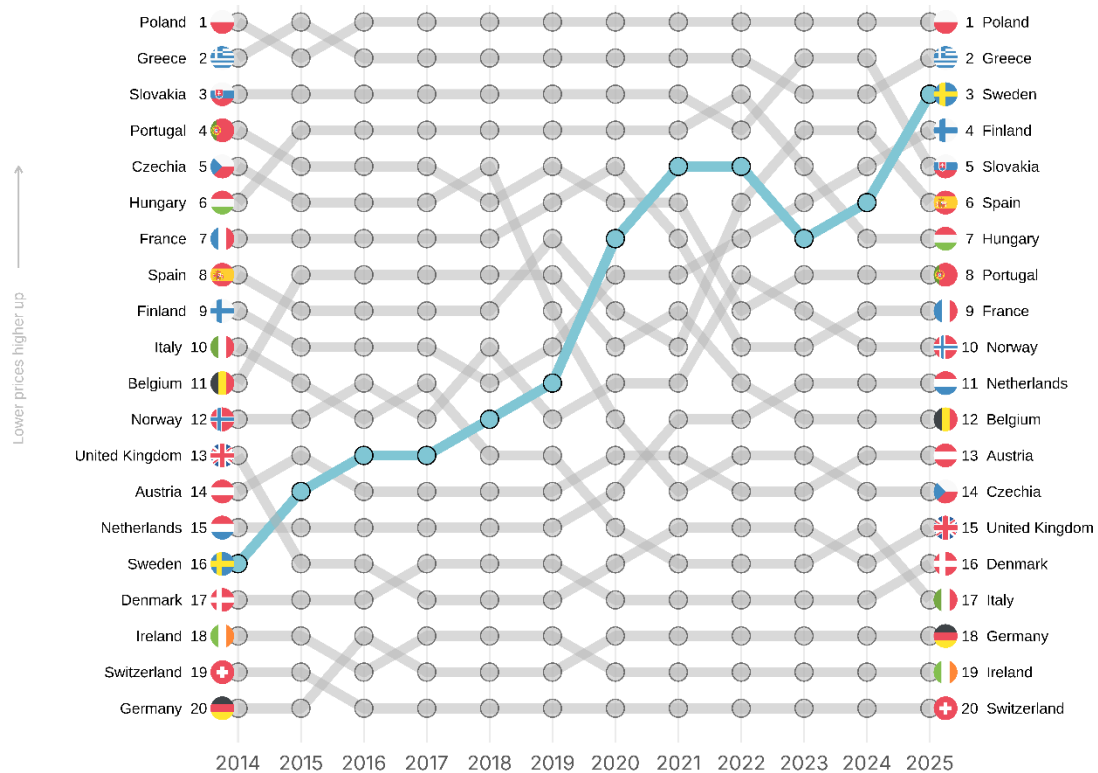
Other countries also show changes over time. It is important to remember, however, that results for other countries should be interpreted with caution, since the analysis is based on Sweden’s consumption and Sweden’s product basket in each year.

By far the most important reason for this development is the weakening of the Swedish krona, which is discussed in more detail in the next section. In this context, it is instructive to compare Sweden’s trajectory with Norway’s. Over the past decade, the Norwegian krone has lost more value against the euro than the Swedish krona—just over 40 per cent compared with 20 per cent for the Swedish krona.

⁸ TLV (2023). Preliminära takpriser och nya fastställda takpriser.

Despite this, Norway's position has not shifted in the same way as Sweden's. The key explanation is that exchange rate movements feed through to pricing via Norway's ERP system. This applies not only to pricing of new products but also to the regular reviews of prices for the bestselling products.

Figure 5 Price ranking for pharmaceuticals without generic competition, calculated with a variable exchange rate (three-year moving average), 2014–2025, ranking



Source: IQVIA and TLV.

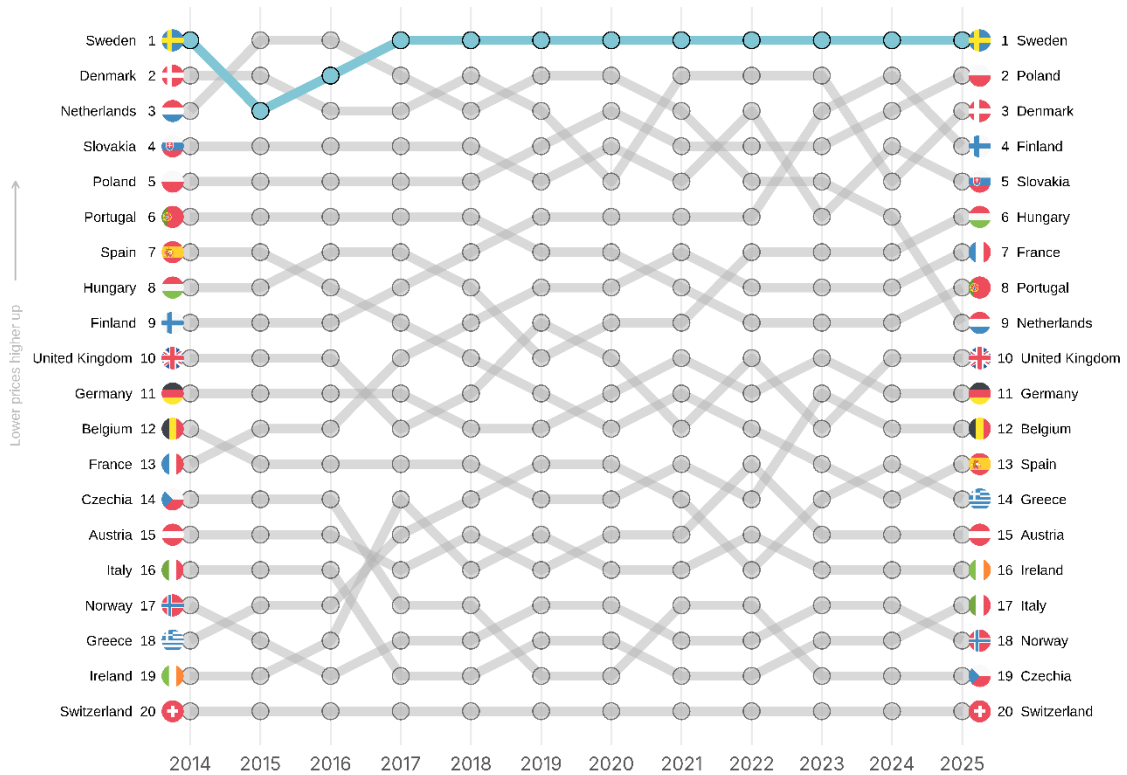
Note: Prices refer to the first quarter of each year. Volumes cover 12 months of sales. Distance from Sweden (used to rank countries) has been calculated using a bilateral price index.

For **pharmaceuticals with generic competition**, Sweden's position has not changed since last year. With the exception of 2015 and 2016, Swedish prices have been the lowest throughout the period since 2014 (Figure 6). Low Swedish prices are commonly attributed to the 'product-of-the-month' system and its ability to create incentives for companies to set competitive prices for substitutable pharmaceuticals.

In recent years, shortages that have occurred in the pharmaceutical market—including those within this segment—have been discussed. One explanation put forward is that price ceilings in the Swedish 'product-of-the-month' system have limited the possibility for price increases too much, thereby contributing to the

situation. In the next chapter, Section 3.2.1 analyses the relationship between low Swedish generic prices and price ceilings.

Figure 6 Price ranking for pharmaceuticals with generic competition, calculated with a variable exchange rate (three-year moving average), 2014–2025, ranking



Source: IQVIA and TLV.

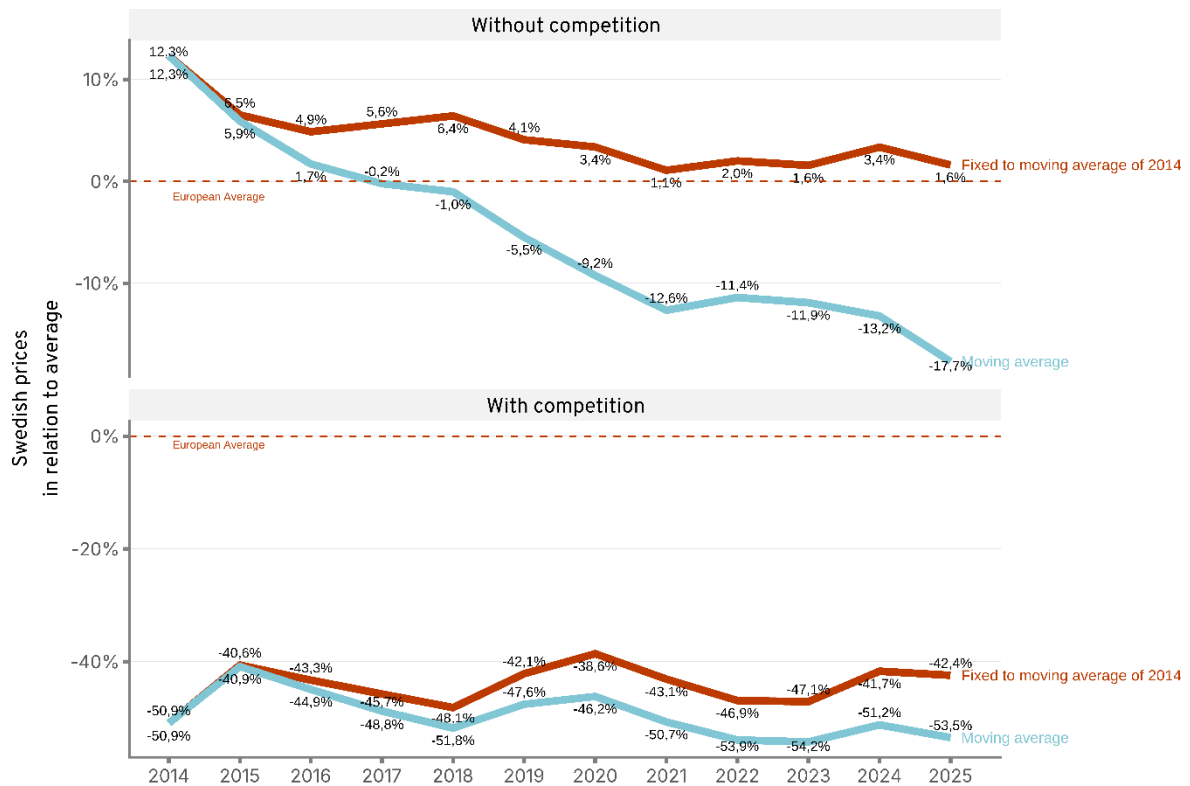
Note: Prices refer to the first quarter of each year. Volumes cover 12 months of sales. Distance from Sweden (used to rank countries) has been calculated using a bilateral price index.

Last year, Denmark moved from having the second lowest prices to the fifth lowest. Prices were 27 per cent above Swedish prices for 2023 and 43 per cent for 2024. This year's results show a decline in the distance to Sweden, with prices now 37 per cent above Swedish prices. The Netherlands and Spain are the two countries whose ranking differs most compared with 2014.

2.2.1 With a constant exchange rate, Sweden's relative prices have not fallen as much

This section reports the percentage deviation between prices in Sweden and the average prices in the comparator countries during the years 2014–2025. To illustrate the strong influence of the exchange rate, results are shown using both a variable and a fixed exchange rate. The red lines in Figure 7 show Sweden's relative price development with the exchange rate fixed to 2014 levels. The blue lines show price development with an exchange rate calculated using a three-year moving average.

Figure 7 Relative price development, exchange rate calculated using a three-year moving average (blue lines) and the fixed 2014 exchange rate (red lines), by segment (panel), 2014–2025, percentage change



Source: IQVIA and TLV.

Note 1: Prices refer to the first quarter of each year. Volumes cover 12 months of sales. Distance from the European average has been calculated using a cross sectional comparison.

Note that the development shown by the red and blue lines does not depend solely on changes in Sweden's price level. Sweden's relative price development is also affected by how the European average rises or falls over time. If other countries' prices decline while both the exchange rate and Swedish prices remain unchanged, Sweden's position relative to the average will deteriorate. In other words, if Sweden's price level in kronor is unchanged from one year to the next while the European average price falls, Sweden's relative price level will increase compared with the average.

With a variable exchange rate (three-year moving average), Sweden's relative prices for **pharmaceuticals without generic competition** have fallen by around 30 percentage points since 2014 (Figure 7). If, instead, the exchange rate is fixed at the 2014 level, Swedish prices have fallen by 11 percentage points. Calculated in this way, Sweden's relative prices have been above the European average (by between 2 and 12 per cent) throughout the period, albeit on a declining trend. In 2025, Swedish relative prices for this segment decreased by 4.5 per cent; using a fixed exchange rate they fell by 1.8 per cent.

The weaker Swedish krona is thus the main explanation for Sweden's declining relative prices. However, relative prices are also influenced by changes in actual prices—i.e., prices set in countries' own currencies—in both Sweden and the comparator countries, and by changes in the Swedish product basket.

Two events in the Swedish system that may have had a bearing on Swedish price levels in this segment can be noted for the period in question. In 2014, price reductions under the '15-year rule' were introduced, under which prices for older pharmaceuticals that have not seen the emergence of generic competition are cut by 7.5 per cent. On implementation in 2015, prices for many such pharmaceuticals were reduced. In addition, a number of re-assessments of biosimilars were carried out in 2015–2017, leading to relatively large price cuts. More generally, prices in the Swedish system do not change much during the first fifteen years—i.e., while pharmaceuticals remain under patent and in the segment without generic competition. There is therefore reason to believe that changes in Sweden's consumption of pharmaceuticals (for example, new pharmaceuticals being introduced in the benefits, or a pharmaceutical losing patent protection and moving segment), as well as price changes in comparator countries, are important drivers of the results.

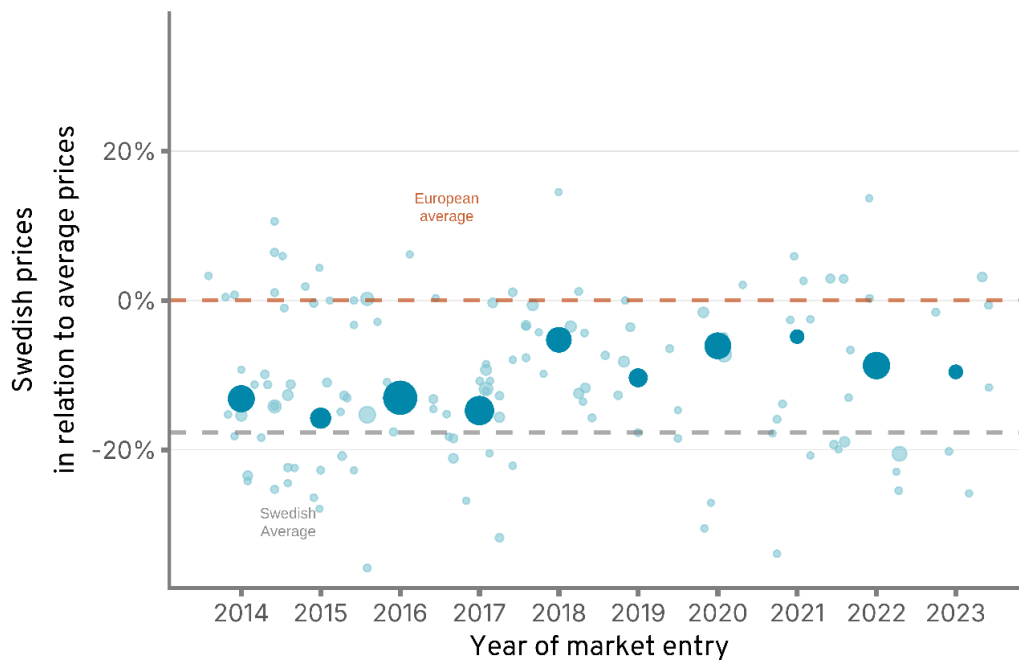
By contrast, prices in this segment do not necessarily remain stable in other countries. In Germany, for example, prices are renegotiated under the so-called AMNOG process after just six months, following a period of essentially free pricing. In other countries, such as the United Kingdom, the Netherlands and Italy, both agreements and budget caps can affect list prices, even though it is more common with repayments and discounts with effects on the net price level.

Exchange rate movements have not had the same decisive impact on relative price development for pharmaceuticals with generic competition (Figure 8). One reason may be that the 'product-of-the-month' system allows companies to adjust their prices once a month. Sweden's relative prices in this segment have been around 40 to 50 per cent below the European average throughout the period, irrespective of whether a variable or fixed exchange rate is applied. Over the past year, Sweden's relative prices fell slightly (about two percentage points) after having risen last year when many companies increased prices for packs of pharmaceuticals affected by the raised price ceilings TLV implemented in 2023.

Has pricing for new pharmaceuticals been affected by the weaker krona?

A natural question is whether companies have priced new launches with the weakening Swedish krona in mind. One way to explore this is to examine whether relative prices differ depending on launch year. Figure 8 shows Swedish relative prices by launch year—i.e., the year the product was first launched in any of the countries in the selection—for products without generic competition.

Figure 8 Swedish relative prices at launch, by substance (light blue) and annual average (dark blue), by launch year, 2023 exchange rate, 2014–2023, percentage deviation



Source: IQVIA and TLV.

Note: The light blue points show relative prices by substance. The dark blue points show the annual average. Point size is proportional to sales value in 2025.

In the figure, the light blue dots represent substances. Each substance is represented by the first combination of substance, form and strength that was launched. For these products, the price index is then calculated in the usual way, based on the first available price in each country, expressed in 2023 prices. Countries for which the first observed price occurs more than two years after the product has received a price in any country are excluded from the comparison. Point size is proportional to sales value in 2025. The dark blue dots are annual averages calculated using the same inclusion criteria as described above. The most recent products included were launched in 2023.

Relative prices vary somewhat between launch years, but the relationship to the European average appears more or less constant. There may be an upward level shift after 2018, followed by a downward trend. If list prices had been adjusted in a way that compensated for the weakening currency, we would have seen a trend of rising relative prices over the period in Figure 8. The analysis shows no clear signs that this is the case. Because we compare a limited number of substances, individual observations can have a relatively large impact on the averages, so developments should be interpreted with some caution. The scope for this kind of compensation within Sweden's value-based pricing system is not entirely clear and is discussed further in the chapter Conclusions and discussion.

2.2.2 Sweden's relative prices are also low for the European product basket

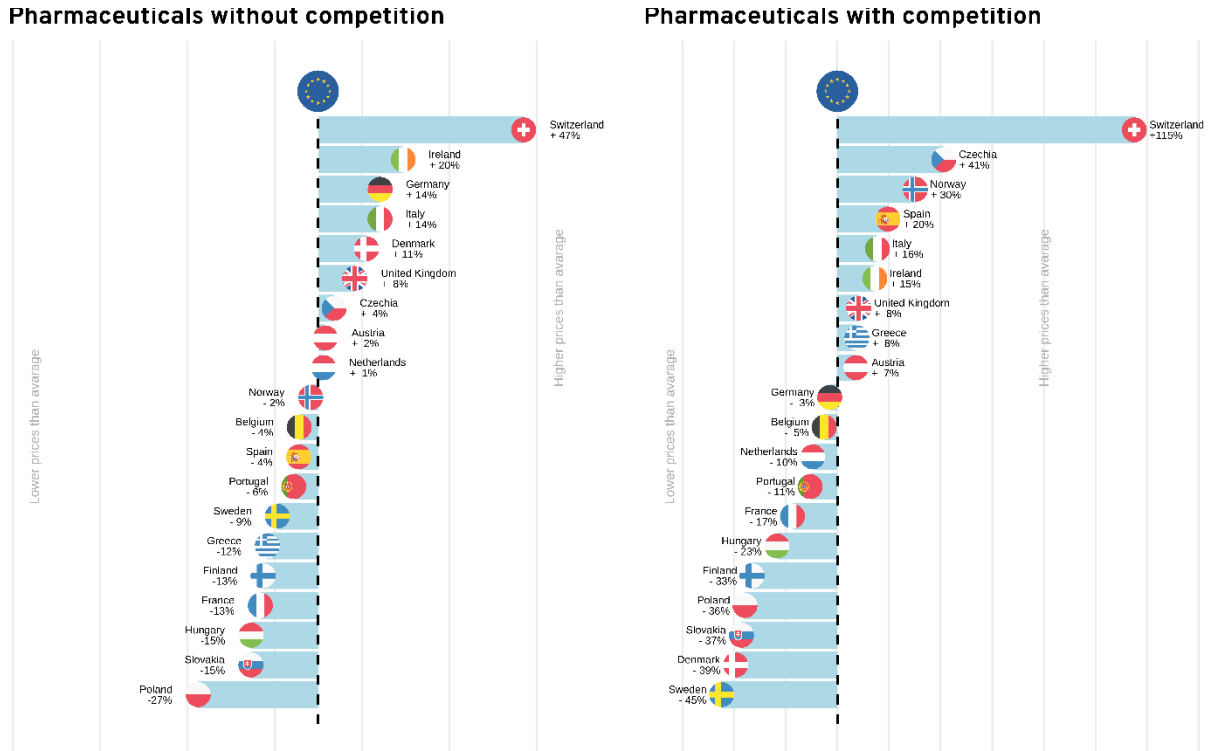
The focus of this report is primarily to analyse prices for pharmaceuticals from a Swedish perspective. This is reflected, among other things, in our use of Swedish volumes as weights when calculating price indices. The analysis in this section is an exception in that we apply a “European” perspective to weighting—all countries’ pharmaceutical use is allowed to influence the comparison. The analysis is intended to add another perspective on Swedish pharmaceutical prices, but results should still be interpreted with care regarding differences between comparator countries, since the pharmaceuticals analysed were selected from a Swedish perspective.

The analysis in Figure 9 includes price information from all countries’ pharmaceutical use. Each country’s price data is compared across all possible bilateral country pairs, meaning every country receives a price index calculated based on its own pharmaceutical use. Finally, an overall average index—a “European average”—is calculated that considers the pharmaceutical use of all comparator countries. The average is unweighted, which means each country’s index has the same impact on the overall average index.

This analysis shows that Swedish prices are 9 per cent below the European average for pharmaceuticals without generic competition (Figure 9, left), which ranks Sweden as the country with the seventh lowest prices among the comparator countries in 2025. This differs from the results reported in Figure 4, and the difference is attributable to the alternative way of calculating the index.

For pharmaceuticals with generic competition, Sweden’s prices are 45 per cent below the European average (Figure 9, right), which makes Sweden the country with the lowest prices in Europe when each comparator country’s own pharmaceutical use is taken into account.

Figure 9 Price comparison for each country's price index versus the European average index, without and with generic competition, exchange rate calculated as a three-year moving average, 2025, share (per cent)



Source: IQVIA and TLV.

Note: Prices refer to the first quarter of 2025. Volumes cover 12 months of sales (April 2024 through March 2025). Distance from the European average is calculated as a bilateral average.

3 Analysis: price comparison by pharmaceutical group

The relationship between Sweden's pharmaceutical prices and those in other countries differs across groups of pharmaceuticals. In these analyses we look more closely at Sweden's relative pharmaceutical prices—i.e., Swedish prices in relation to average prices—broken down by pharmaceutical group. The aim is to track price developments at a finer level of detail, both to identify areas where Swedish prices appear to diverge from other countries' prices and to increase understanding of what drives the overall results in the previous chapter. First, relative prices are set in relation to total sales value in Sweden. We then follow price developments in the different pharmaceutical groups over time. Descriptions of the groups, which are constructed based on ATC codes, are provided in Appendix 4.

3.1 Low Swedish prices in many groups without generic competition

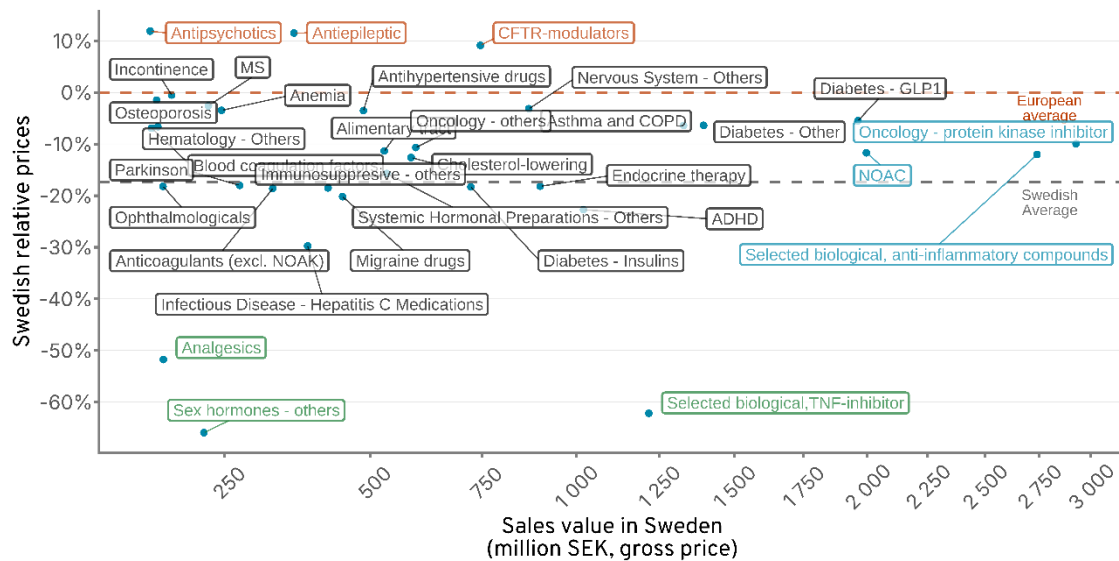
In 2025, the highest sales value within the **segment without generic competition** is found in the groups Selected biological, anti-inflammatory compounds, Oncology – Protein Kinase Inhibitors, and NOAC⁹. These are the same groups as last year.

Taken together, sales in these groups account for just under one third of total sales value within the segment. Sweden's relative price level for Selected biological, anti-inflammatory compounds, which was slightly above the average last year, is now below (12 per cent) the European average, as discussed further below. Price levels for Oncology – Protein Kinase Inhibitors and NOAC remain below the European average, at 10 and 12 per cent respectively (Figure 10).

It is also worth noting that the sales value for pharmaceuticals in the group Diabetes – GLP1 is almost as large in 2025 as in the NOAC group. This reflects an increase in sales value for products based on GLP1 analogues and a decrease in this segment for NOAC products, partly due to patent expires.

⁹ NOAC stands for non-vitamin K oral anticoagulant

Figure 10 Swedish relative prices for pharmaceutical groups without generic competition compared with the European average, total PPP (SEK million), 2025



Source: IQVIA and TLV.

Note 1: Prices refer to the first quarter of 2025. Volumes cover 12 months of sales (April 2024 through March 2025). Distance from the European average has been calculated using a cross-sectional comparison.

Note 2: Blue boxes correspond to the pharmaceutical groups with the highest sales. Red boxes correspond to the groups furthest above the European average in 2025. Green boxes correspond to the groups furthest below the European average in 2025. Pharmaceutical groups with sales (PPP) below SEK 150 million have been excluded from the figure.

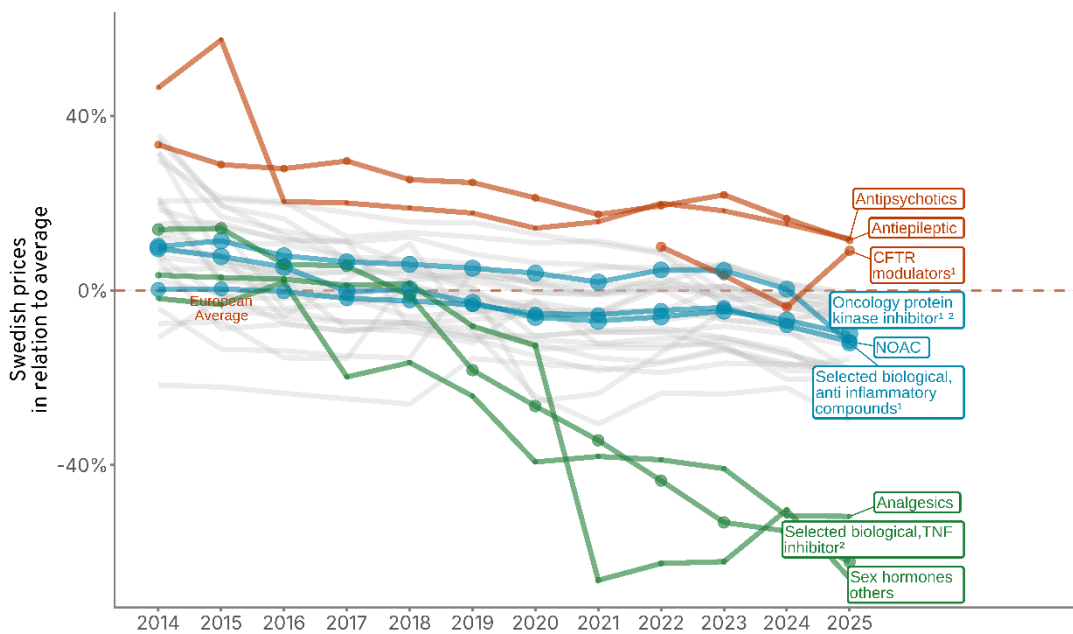
Note 3: The intervals on the x-axis increase exponentially (logarithmic scale). This allows all pharmaceutical groups to be shown together with less overlap.

The historical development for pharmaceutical groups without generic competition shows a general downward trend in the relative price level over 2014–2025 (Figure 11). The trend is partly explained by Sweden's depreciating exchange rate, as shown earlier in Figure 7. Below we describe developments for the groups that in 2025 had the highest sales or were positioned highest or lowest in relative price compared with the European average.

Sweden's relative prices have shown a slightly declining trend for the groups with the largest sales in 2025. For NOAC pharmaceuticals, the distance from the average has increased since last year, from 9 to 13 per cent below the average. Patents for some of the substances in the group are expiring, which naturally affects prices both in Sweden and abroad. In Sweden, as in several other countries, generic products based on rivaroxaban and dabigatran etexilate are now sold. Over the period, we see Sweden's relative price level for rivaroxaban shift from roughly 15 per cent below the average to just over 12 per cent above the average. This is driven by sharp price declines in other countries (on average across the included countries, prices fall by 29 per cent). Note that this includes only those pharmaceuticals that have not yet faced generic competition in Sweden, which is a smaller share of the substance's total sales.

Apixaban is the substance with the highest sales within the NOAC group and therefore strongly influences the group's placement. The distance between Swedish prices and the European average increases, driven by the fact that the price per unit sold in Sweden falls for the strengths covered in the analysis (2.5 mg and 5 mg). This is because the company submitted an application for a price reduction in 2024, and not because of generic competition.

Figure 11 Historical relative price development for pharmaceutical groups without generic competition, exchange rate calculated as a three-year moving average, 2014–2025



Source: IQVIA and TLV.

Note 1: Prices refer to the first quarter of each year. Volumes cover 12 months of sales. Distance from the European average has been calculated using a cross-sectional comparison. Circle size indicates sales value (total sales, PPP).

Note 2: Blue lines correspond to the pharmaceutical groups with the highest sales in 2025. Red lines correspond to the groups furthest above the European average in 2025. Green lines correspond to the groups furthest below the European average in 2025. Grey lines correspond to the remaining groups with sales above SEK 150 million in 2025. Groups with sales below SEK 150 million in 2025 have been excluded from the figure.

Note 3: The number 1 indicates that active managed entry agreements existed for the group in 2025; the number 2 indicates that managed entry agreements existed in one or more of the other years for the group.

For the group Oncology – Protein Kinase Inhibitors, we see no major changes compared with the previous year.

Selected biological, anti-inflammatory compounds have been 0–11 per cent above the European average during 2014–2024. In 2025, Swedish prices are 12 per cent below the European average. One of the substances with the largest price decline in Sweden is ustekinumab, the fourth best-selling substance in the group in terms of packs sold. In May 2024, biosimilars entered the Swedish market for ustekinumab, which has contributed to low prices. Swedish prices for this substance have moved

from roughly 10 per cent above the European average in 2024 to just over 38 per cent below the European average in 2025.

Among the groups that in 2024 were furthest above the European average, Antiepileptics have shown a declining price level over 2014–2025, from 33 per cent to 16 per cent above the European average (Figure 11). The decline is mainly due to a re-assessment initiated in 2014, in which the price of the originator product (levetiracetam) in the group was reduced by 45 per cent, and the substance has taken a larger share of packs sold over time.¹⁰

For Antipsychotics, Sweden's relative prices fell sharply in 2016 and have since been relatively stable with a slight upward trend. The larger drop in relative price in 2016 is due to certain products (pharmaceuticals with the active substance quetiapine)—which had a higher relative price than other products in the group—being included in the 'product-of-the-month' system (i.e., facing generic competition) and thus leaving the grouping without generic competition. Between 2024 and 2025, Sweden's position fell from 14 per cent above the average to 12 per cent above the average. Within the group, we see Sweden's distance from the European average narrowing for one of the group's top selling substances (haloperidol). Here it is prices in other countries that rise (mainly for haloperidol tablet 1 mg, the combination within the substance with the largest number of packs sold in Sweden in 2025).

CFTR-modulators are pharmaceuticals used to treat cystic fibrosis. Kaftrio, the pharmaceutical with the highest sales in Sweden within this group, obtained reimbursement status at the end of 2022 and therefore appears in our comparison from 2023 onwards. Over the period April 2024 to March 2025, sales measured at PPP amounted to SEK 750 million, an increase of just over 30 per cent compared with the previous measurement period (April 2023–March 2024). Swedish prices are about 9 per cent above the European average. The change observed between 2024 and 2025 is due to a decline in the European average rather than changes in Swedish list prices.¹¹ For these pharmaceuticals, Sweden has managed entry agreements, which means that list prices do not reflect the actual cost of the pharmaceuticals. Other countries are also very likely to have agreements for these pharmaceuticals.

For the pharmaceutical groups that in 2025 were furthest below the European average, price levels have fallen sharply since 2014—from around the European average (between two per cent below and 14 per cent above) to 52–66 per cent below the average in 2025. Sweden's relative prices for Selected biological, TNF-inhibitors have declined since 2018. This is because biosimilars are now available on the market at prices significantly lower than the originators. Use of biosimilars has increased, which has contributed to Sweden's relative price level falling for the

¹⁰ TLV (2014). Levetiracetam kvarstår i högkostnadsskyddet efter prissänkningar.

¹¹ In the data, Poland's list price falls sharply between 2024 and 2025, and thus the EU average does as well. This drives the change we see for Sweden relative to the EU average over the same period.

group. Companies selling the originators also reduced their list prices when the managed entry agreement expired.

For Analgesics, the price level has decreased gradually since 2016—from around the European average to 52 per cent below the average in 2025. The falling relative price level is due to certain products (the substances gabapentin and pregabalin)—which have a lower relative price level than other products in the group—accounting for an increasing share of sales in the group from 2020. Between 2024 and 2025, we observe that the price per unit sold for these substances has increased, but for the group as a whole the distance from the average is at a similar level to 2024.

For the group Sex hormones – Other, the price level fell from about 13 per cent below the European average in 2020 to 66 per cent below the average in 2021. This is because the European average (price levels in certain comparator countries) increased for some pharmaceuticals in the group, while pharmaceuticals that in Sweden have a lower price level than the European average increased their sales. For testosterone, certain forms see the introduction of generic competition and therefore are not part of this segment during 2024–2025. These account for about 50 per cent of packs sold for the substance. This means that roughly 50 per cent of packs sold move from this segment to the segment with generic competition.

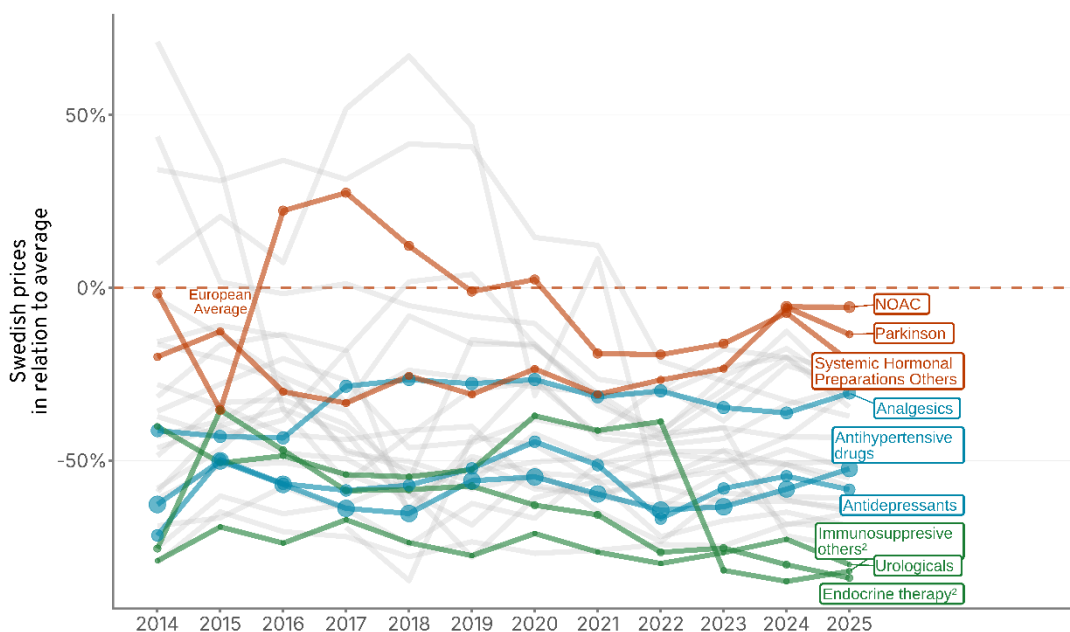
3.2 Swedish relative prices are low for all groups with generic competition

For pharmaceuticals with generic competition, grouped by pharmaceutical group, Antihypertensive drugs, Analgesics and Antidepressants have the highest sales in Sweden in 2025. For these groups, Sweden's relative price level is 30–58 per cent below the European average (Figure 12). Sweden's price level is highest for NOACs (6 per cent below the average), Parkinson (13 per cent below) and Systemic Hormonal Preparations – Others (21 per cent below). The two groups that were above the average in last year's report are not included this year. Sex hormones – Other have fallen in price in Sweden and are now about 15 per cent below the European average. Sales measured as packs have risen slightly, but the group's sales value is now below SEK 50 million, which is why it is not shown in this analysis.

Swedish prices are lowest (80–84 per cent below average) for Endocrine therapy, Urologicals and Immunosuppressive - Others (Figure 12). Contraceptives, which was among the groups furthest from the average in last year's report, has fallen further in price per unit sold, and the sales value is now below SEK 50 million; consequently, the group is not shown in the analysis.

the segment with generic competition from 2022, but whose price effects were clearly reflected in the group's results in 2023 (this price comparison covers only prices in the first quarter of each year).

Figure 13 Historical relative price development for pharmaceutical groups with generic competition, exchange rate calculated as a three-year moving average, 2014–2025, share (per cent)



Source: IQVIA and TLV.

Note 1: Prices refer to the first quarter of each year. Volumes cover 12 months of sales. Distance from the European average has been calculated using a cross-sectional comparison. Circle size indicates sales value (total PPP).

Note 2: Blue lines correspond to the pharmaceutical groups with the highest sales in 2025. Red lines correspond to the groups furthest above the European average in 2025. Green lines correspond to the groups furthest below the European average in 2025. Grey lines correspond to the remaining groups with sales above SEK 50 million in 2025. Pharmaceutical groups with sales below SEK 50 million in 2025 have been excluded from the figure.

Note 3: The number 1 indicates that active managed entry agreements existed for the group in 2025; the number 2 indicates that managed entry agreements existed for the group in one or more of the other years.

3.2.1 Low-priced generics lie far below Swedish price ceilings

In TLV's annual international price comparison, Swedish prices for generic pharmaceuticals have been among the lowest in every one of the 11 years the report has been published. At the same time, shortages and the role of Sweden's 'product-of-the-month' system have been discussed more frequently in recent years. This section therefore explains how Sweden's system for pricing and substitution of pharmaceuticals with generic competition within the pharmaceutical benefits works.

Price ceilings limit how high prices can be

In Sweden's system for pharmaceuticals with generic competition, companies are free to set prices up to a maximum permitted price—known as a price ceiling. Price ceilings are defined and set for each group of packs. Packs are grouped by substance, pharmaceutical form, strength and size interval, referred to as a package size group. The price ceiling within a package size group evolves in line with how companies' prices develop. When generic competition arises, the price ceiling is initially set to the highest price in the package size group at that time. If any pack's price falls below 30 per cent of the price that applied when generic competition first arose, and substitutable pharmaceuticals have been on the market and sold for at least four months, the highest permitted price is set to 35 per cent of the price that applied when generic competition first arose. Price ceilings are set for all package size groups with the same substance and pharmaceutical form and mean that no pack can exceed the established price ceiling level. These price ceilings remain unchanged once set.

In 2023, TLV implemented general price ceiling increases covering just over half of the groups that had generic competition at the time (on average, a group received an increase corresponding to 20 per cent of its then current price ceiling). The selection of package size groups included in the intervention was made using fixed criteria. Today, TLV permits price increases to a greater extent than previously, on applications submitted by companies, for pharmaceuticals where other treatment alternatives are available.

The 'product-of-the-month' system contributes to price competition and low prices

Beyond limiting how high prices may be in a package size group, Sweden's 'product-of-the-month' system plays a major role in keeping prices low for pharmaceuticals with generic competition. In each package size group, one pack is designated each month as the 'product of the month'¹² and two packs as backup. The product of the month is the pack with the lowest price, sufficient shelf life and the ability to supply the entire market for the whole month. Pharmacies should offer substitution to this pack (if one exists), and the prescriber, the pharmacy or the patient must actively decline substitution for the product of the month not to be dispensed. Roughly 15 per cent of packs sold are dispensed in which prescriber, pharmacy or patient opposes substitution. Since the majority of sales accrue to products of the month, the system creates incentives for companies to compete on price, which in turn contributes to low prices in the Swedish market.

In recent years, Sweden—like many other countries—has seen shortages. Shortages can impact the availability and accessibility of pharmaceuticals in Swedish pharmacies. In discussions about the development of shortages in Sweden, low prices for generics have been highlighted as a contributing factor. As this report

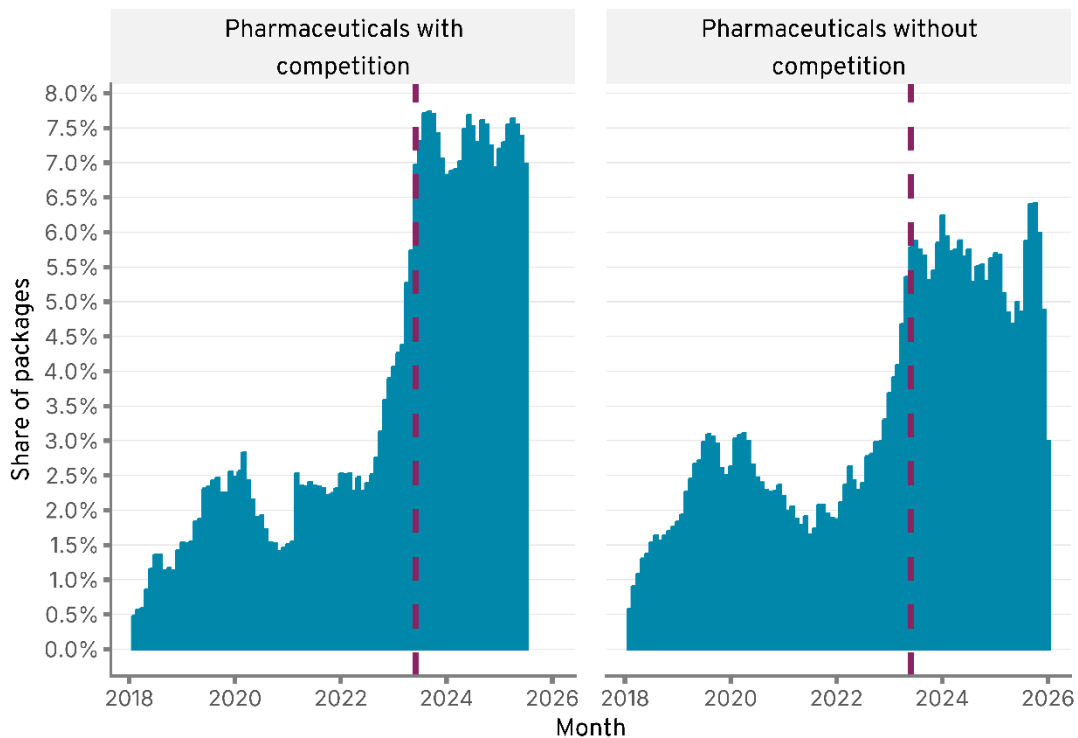
¹² If two packs have the lowest price per unit and confirmed supply, more than one pack may be the product of the period within the pack-size group.

aims specifically to compare Swedish prices with those in other countries, it is relevant to examine this relationship.

Increasing number of pharmaceuticals reported as in shortage in Sweden

In Sweden, companies notify upcoming and ongoing shortages to the Swedish Medical Products Agency. In 2023 (the vertical lines in Figure 14), the Agency introduced fines for companies that fail to notify a shortage. The requirement applies to companies “that cannot supply pharmaceuticals so that supply meets demand”.

Figure 14 Share of marketed packs within the pharmaceutical benefits with an ongoing reported shortage, split by whether the pharmaceutical has generic competition or not, by month from January 2018 to October 2025, share (per cent)



Source: TLV and the Swedish Medical Products Agency.

Note: The vertical dashed line marks the point at which the Swedish Medical Products Agency introduced fines for companies that fail to notify a shortage (June 2023).

The number of pharmaceuticals with a shortage has increased, most notably in 2023. This increase is seen for pharmaceuticals both with and without generic competition. Within the ‘product-of-the-month’ system, the share of marketed packs with a reported shortage is between 7 and 8 per cent in 2023–2025, while the share is between 5.5 and 6 per cent for packs outside the ‘product-of-the-month’ system. We cannot disentangle how much of the increase is due to the introduction of fines and how much reflects changing conditions for companies to meet market demand.

Pharmaceuticals priced far below the price ceiling play a decisive role in Sweden's low prices for generics

Our analyses in this price comparison show that Swedish prices for pharmaceuticals with generic competition are low compared with the European average. As noted earlier, these prices are constrained by price ceilings—i.e., the highest permitted price within each package size group. In this part of the analysis, we examine the role price ceilings play in the low prices we observe. Is it primarily the limiting effect of price ceilings that pushes prices down, or is it rather the mechanisms of the 'product-of-the-month' system (the available pack with the lowest unit price should generally be dispensed, which incentivises companies to compete on price) that lead to Sweden's low prices?

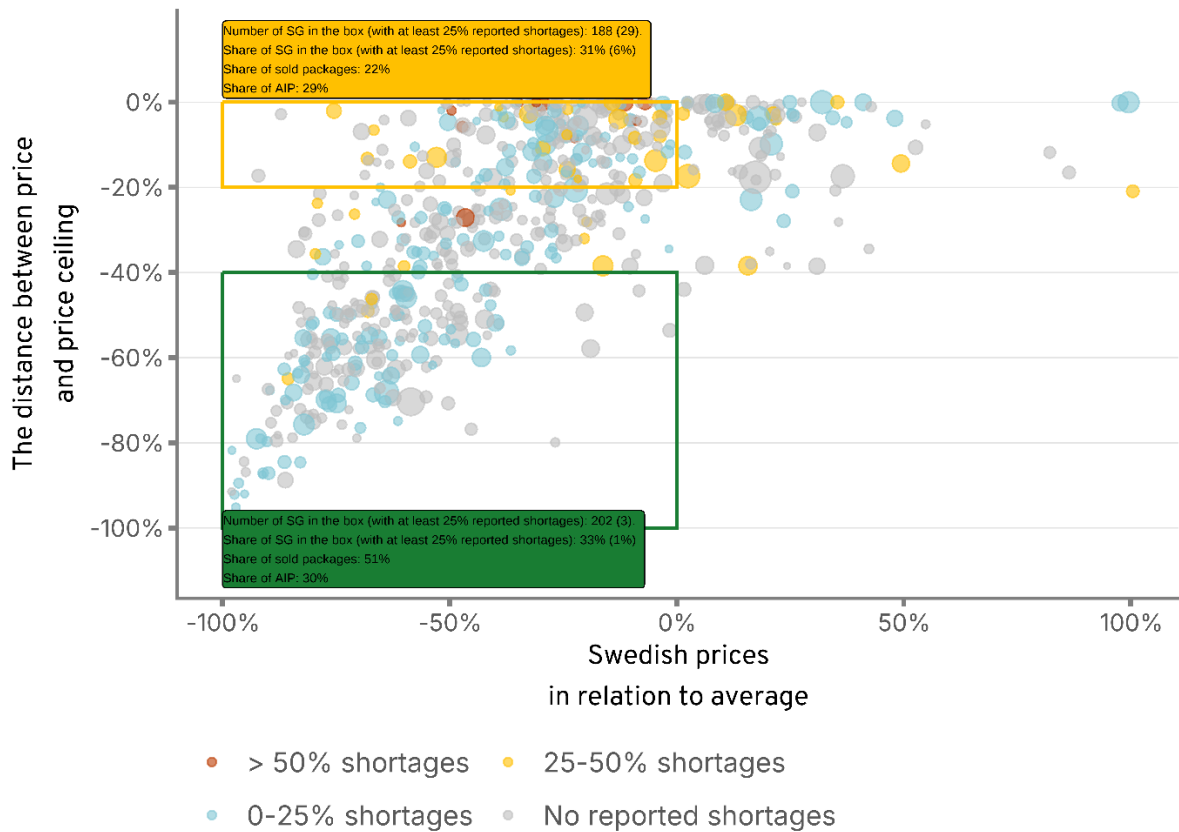
Figure 15 covers pharmaceuticals with generic competition and investigates the relationship between Swedish price levels and the European average (x-axis) and the distance of Swedish prices to the maximum permitted price within each package size group (the price ceiling) (y-axis). Each circle represents a pharmaceutical (a unique combination of substance, pharmaceutical form and strength). Each circle is also color-coded based on whether the pharmaceutical had reported ongoing shortages at any point between January and March 2025.

Two areas are highlighted in the figure. The green box represents pharmaceuticals that lie far from the price ceiling (the average distance from the ceiling for a unit sold is 40 per cent or more) and have a price below the European average. These pharmaceuticals could, in principle, raise their prices, and the price ceiling is not restricting for an average unit sold. In this box are 33 per cent of the pharmaceuticals in the comparison, accounting for 51 per cent of packs sold and 30 per cent of sales value (PPP). In this segment, three pharmaceuticals have shortages that affect more than 25 per cent of packs.

The yellow box contains pharmaceuticals that lie close to the price ceiling (within 20 per cent) and have prices below the European average. In this box are 31 per cent of the pharmaceuticals in the comparison—slightly fewer than in the green box. However, sales are much lower measured in packs (22 per cent), while sales value (PPP) is similar (29 per cent). In this segment, 29 pharmaceuticals have shortages that affect more than 25 per cent of packs.

Because our price comparison gives pharmaceuticals with large sales (measured as packs) greater weight in the averages we report, and because the majority of packs sold lie far below the price ceilings, the results of this price comparison are driven by pharmaceuticals priced well below their price ceilings. In other words, it is not price ceilings that explain why Swedish prices lie far below the European average in this comparison; rather, it is the combination of generic substitution at pharmacies and companies competing each month to be the lowest priced pack.

Figure 15 Relationship between the distance of pharmaceutical prices to the maximum permitted price (price ceiling) (y-axis) and the distance of Swedish pharmaceutical prices to the European average (x-axis), sales value (size), share of shortages (colour)



Source: TLV, Medical Products Agency and IQVIA.

Note 1: Distance to the price ceiling is based on price ceilings and price data between January and March 2025. Sales cover April 2024 through March 2025. Each circle represents a pharmaceutical (a unique combination of substance, pharmaceutical form and strength, which in Sweden's system for pharmaceuticals with generic competition is called a substitution group (in the textbox referred to as SG)).

Note 2: Colour indicates the share of packs (NPL pack IDs) for a pharmaceutical within the 'product-of-the-month' system that were reported having a shortage at any time between January and March 2025. For example, if Pharmaceutical A has four unique packs in Sweden's 'product-of-the-month' system and three were reported as having shortages between January and March 2025, Pharmaceutical A's circle will be coloured red.

In Figure 15 we do not see that pharmaceuticals with widespread shortages (red and yellow circles) occupy any particular distance from the European average; rather, they are spread across the scale. Many of these are located in the upper part of the figure, where prices lie close to the ceiling, and prices may be below, above or at the European average. Where companies consider a price ceiling too low, they must apply to TLV for a price increase. The price ceiling system has no mechanism that automatically adjusts price ceilings upwards over time.

In summary, it is not pharmaceuticals whose prices are constrained by price ceilings that explain the results in this price comparison; instead, it is pharmaceuticals priced far below their price ceilings. Price ceilings limit how prices can evolve over

time and how large the difference may be between the highest and lowest price within a package size group. In our analyses we see no clear relationship between reported shortages and Sweden's prices in an international perspective. Establishing the relationship between a pharmaceutical's distance to its price ceiling and the presence of shortages is difficult. Shortages can contribute to higher list prices—and thus prices closer to the ceiling—for example, due to higher prices resulting from limited global supply or reduced competition in a group during periods with ongoing shortages. At the same time, shortages can potentially arise or be exacerbated by the price ceiling's constraining function—especially when production costs rise or global supply tightens but prices are not permitted to adjust accordingly.

4 Analysis: relative prices over the life cycle of pharmaceuticals

The purpose of the life cycle analyses is to assess how Sweden's relative pharmaceutical prices evolve from market entry onwards. As in the rest of the report, the analyses are primarily divided into the segments *with* and *without* generic competition. A clear result from these analyses is how important this division of the market is, as price dynamics in the two segments are markedly different.

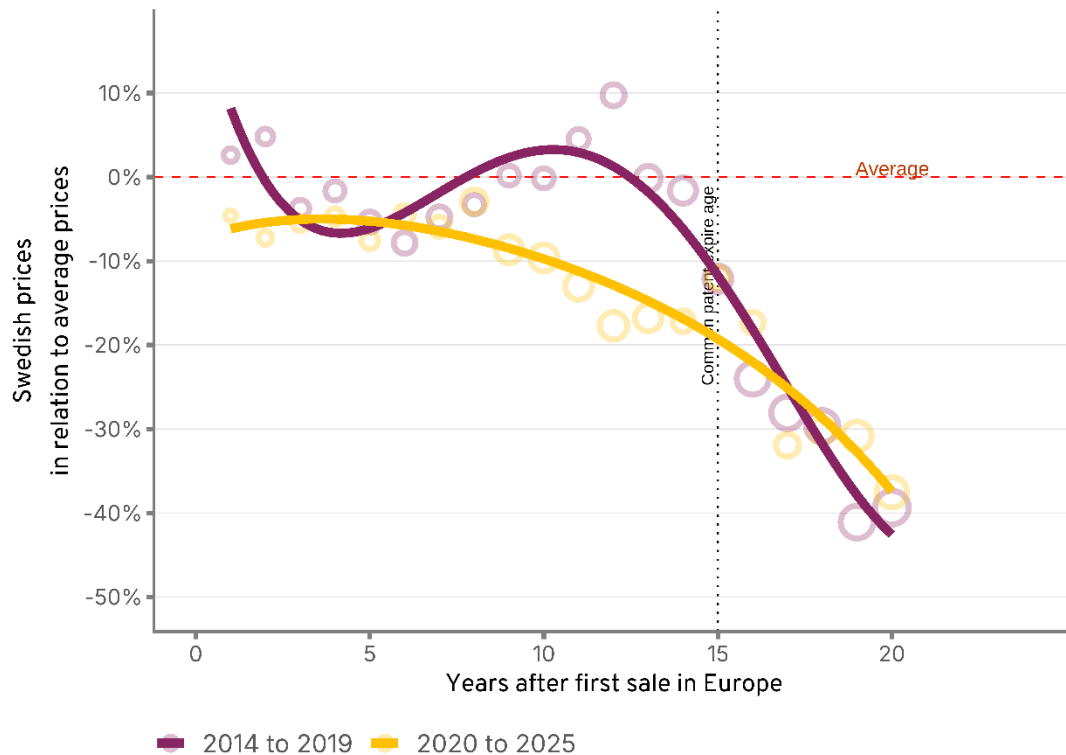
4.1 Swedish prices are lower throughout the life cycle

We have analysed how Sweden's relative pharmaceutical prices change over a life cycle in two different periods (2014–2019 and 2020–2025), where each year corresponds to the number of years since a pharmaceutical was granted marketing authorization for sale in Sweden and in each comparison country (European average).

The analysis shows that the price curve shifted downwards for the entire life cycle in the latter period, meaning that Sweden's relative prices are lower today than five years ago (Figure 16). The analysis also shows that Swedish prices were below the European average for almost the entire life cycle in 2020–2025. Previously (2014–2019), Swedish relative prices tended to rise for pharmaceuticals that had been on the market for 10–14 years, after which they fell below the European average.

That Sweden's relative price level is lower in 2020–2025 than in 2014–2019 is mainly due to the Swedish krona depreciating more during the latter period. In the Swedish system, prices for pharmaceuticals generally do not change while they are under patent protection. Nor do we see clear signs that companies have priced to compensate for the steadily weakening krona. TLV has no mechanism in place to adjust prices in line with exchange rate fluctuations, which contributes to the gap between Sweden's relative price level and the European average widening with the age of the pharmaceutical.

Figure 16 Swedish pharmaceutical prices compared to the European average, per year after marketing authorization, by period (2014–2019 and 2020–2025). Exchange rate calculated as a three-year moving average. Percentage of average



Source: IQVIA and TLV.

Note 1: Prices in the first quarter of each year. Volumes are for a 12-month sales period. The gap to the European average has been calculated per pharmaceutical age using a cross-sectional comparison, with the exception that countries lacking price data are assigned the average price.

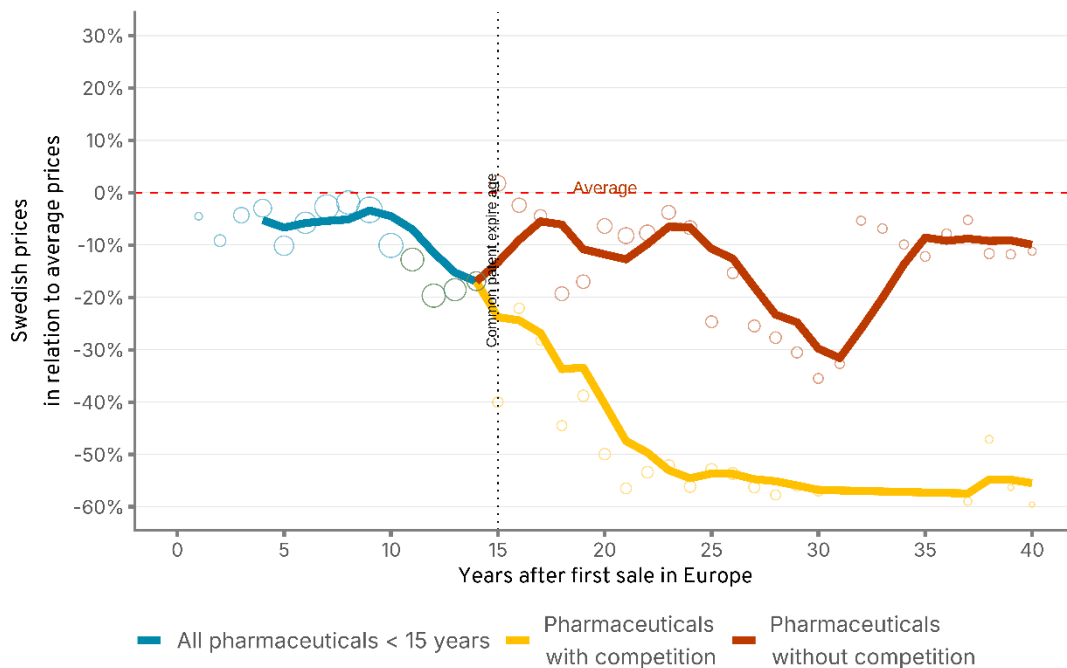
Note 2: The red dotted line shows average prices for 20 European countries. The position of the circles indicates the actual deviation from the European average at each age, while their size indicates the value of sales in Sweden for pharmaceuticals at that age compared to other ages. The purple and yellow curves are model adaptations of the circles (fourth degree polynomial regression) used to illustrate the trend over the pharmaceutical's life cycle.

The analysis in Figure 16 illustrates the Swedish pharmaceutical life cycle in terms of Swedish prices compared to European average prices. Values below and above zero per cent indicate that Swedish prices are lower or higher, respectively, than the European average for pharmaceuticals at the same stage of their life cycle. The analysis is performed for two sales periods: 2014–2019 and 2020–2025. The position of the circles corresponds to price deviations from the European average, while their size indicates sales volume. The solid lines represent Swedish price development over the life cycle relative to the European average. The dashed line at 15 years on the market roughly indicates when patent protection expires. In many cases, this coincides with the onset of generic competition, which in Sweden means that the pharmaceuticals enter the 'product-of-the-month' system.

4.1.1 Lower prices when generic competition arises

Pharmaceuticals with generic competition – which are included in Sweden’s ‘product-of-the-month’ system – have a lower relative price level after 15 years on the market than pharmaceuticals without generic competition. The difference in relative prices emerges immediately when competition is introduced but reaches its lowest point (51–69 per cent below the European average) once the pharmaceuticals have been on the market for more than 25 years (Figure 17).

Figure 17 Swedish pharmaceutical prices – total, and for pharmaceuticals with and without generic competition – by year after marketing authorization. Exchange rate calculated as a three-year moving average. 2021–2025. Percentage of European average



Source: IQVIA and TLV.

Note 1: Prices in the first quarter of each year. Volumes are for a 12-month sales period. The gap to the European average has been calculated per pharmaceutical age using a cross-sectional comparison, with the exception that countries lacking price data are assigned the average price.

Note 2: The figure should be interpreted as Sweden’s average relative price per pharmaceutical age during the period 2021–2025.

Note 3: The red dotted line shows average prices for 20 European countries. The position of the circles indicates the actual deviation from the European average each year, while their size indicates the value of sales in Sweden for pharmaceuticals at that age compared with other ages. The dark blue, light blue and red curves are model adaptations of the circles (moving average, with $n = 4$ periods) used to illustrate the trend over the pharmaceutical’s life cycle.

Sweden’s price level for pharmaceuticals without generic competition remains below the European average for almost all years on the market (Figure 17). After 15 years on the Swedish market, prices are reduced in line with the so called ‘15-year rule’ for pharmaceuticals without, or with limited, competition by 7.5 per cent, which helps to keep long term prices down for pharmaceuticals without

competition. At 25–30 years on the market, we see a substantial decline in Sweden's relative prices, because certain pharmaceutical groups (mainly Analgesics) at this age have high sales and low prices compared with the European average, and have not yet reached more than 30 years.

4.2 Life cycle analyses highlight differences and similarities across countries' systems

A life cycle analysis—an analysis of price development after a number of years since marketing authorisation, compared with the European average—has been performed for all countries in the price comparison. The results indicate that countries' different pricing and reimbursement systems lead to substantial differences in how relative price levels evolve over time from market entry.

In Sweden, decisions on reimbursement are based on whether the cost of a pharmaceutical is deemed reasonable in relation to the health benefits of the treatment—so called value-based pricing. Other countries have regulations that address prices after pharmaceuticals have been on the market for a few years. For example, Finland has reimbursement decisions that apply for a maximum of three years for a new active substance and up to five years for other pharmaceuticals, after which companies must reapply for reimbursement.¹³ In the life cycle analyses we see that Finland previously had lower relative prices for pharmaceuticals that are between five and 15 years old, but in recent years (2020–2025) Finland's price level has approached the European average (Figure 18).

Another example is France, where price and reimbursement decisions are reviewed after five years on the market.¹⁴ In addition, France applies price–volume agreements at market entry—under which the unit price is reduced once sales exceed a specified threshold—which after a number of years are converted into list price reductions under framework agreements with manufacturers.¹⁵ Previously (2014–2019), France had lower relative prices than Sweden for pharmaceuticals that had been on the market for up to 15 years. In more recent years (2020–2025), Sweden's relative price level has fallen from market entry and is now below France's in relation to the European average for pharmaceuticals that have been on the market for more than ten years.

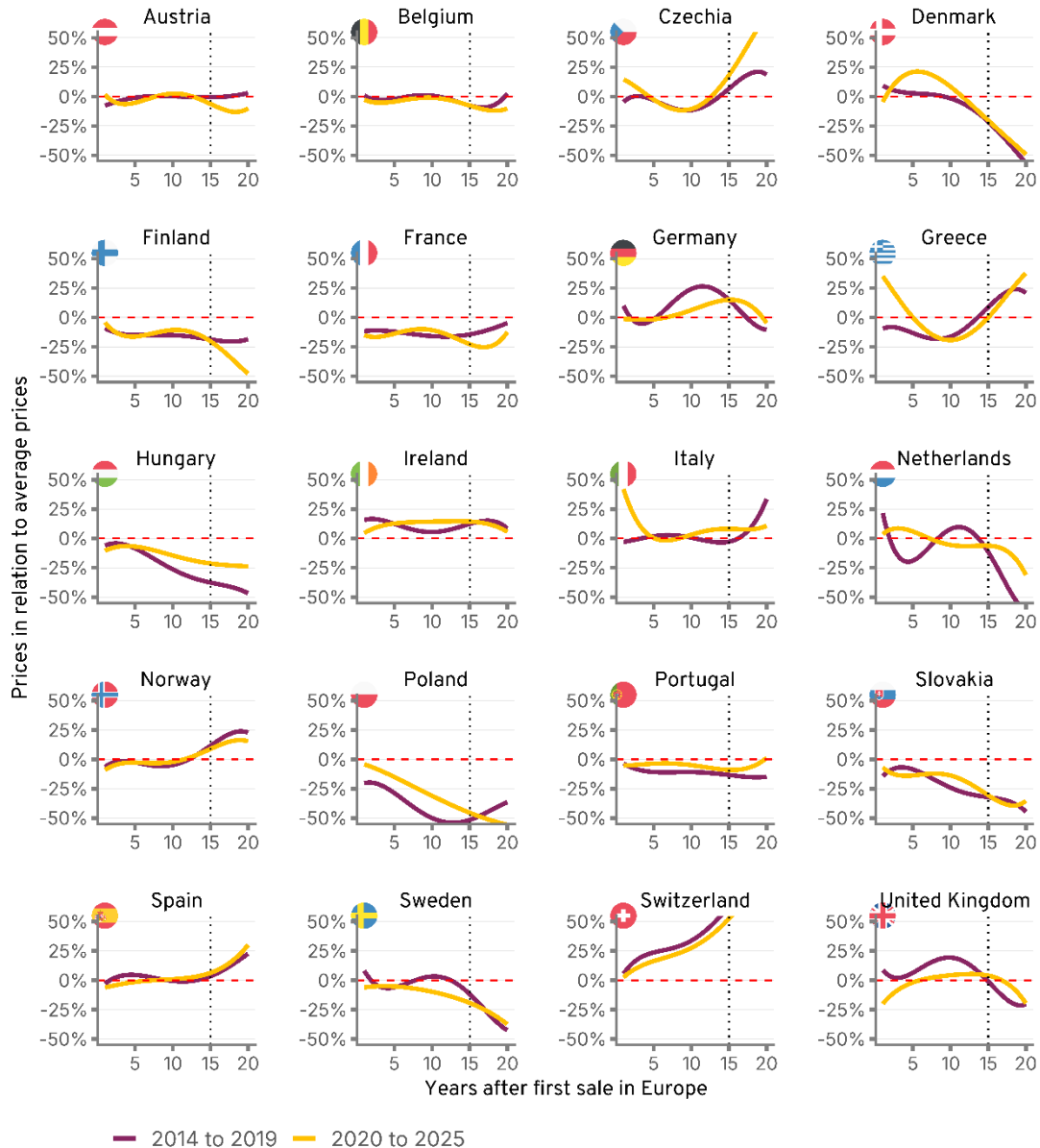
Norway applies international reference pricing (based on nine other countries, including Sweden) when setting pharmaceutical prices. An annual review is conducted to ensure that local prices remain at a desirable level relative to the reference countries. Norway's price levels are very close to the European average for pharmaceuticals that have been on the market for just under 15 years. After 10–15 years on the market, Norway's relative prices rise, while Sweden's fall.

¹³ HILA (2025). Anvisning om villkorlig ersättning.

¹⁴ Or, Z. et al. (2023). France: Health system review 2023.

¹⁵ Lumell (2024). Internationell utblick – Metoder för att dämpa kostnadsökning för läkemedel genom att ta hänsyn till försäljningsvolym.

Figure 18 All countries' pharmaceutical prices compared with the European average, per year after marketing authorisation, by period (2014–2019 and 2020–2025). Exchange rate calculated as a three-year moving average. Percentage of average



Source: IQVIA and TLV.

Note 1: Prices in the first quarter of each year. Volumes are for a 12-month sales period. The gap to the European average has been calculated per pharmaceutical age and country using a cross-sectional comparison, with the exception that countries lacking price data are assigned the average price.

Note 2: The purple and yellow curves are model adaptations (fourth degree polynomial regression) used to illustrate the trend over the pharmaceutical's life cycle.

Note 3: The y-axis is fixed across all countries and truncated at ± 50 per cent. This means that the entire life cycle is not shown for countries with deviations larger or smaller than these limits.

Sweden's relative price level declines for pharmaceuticals that have been on the market for 10–15 years. After 15 years on the market, many pharmaceuticals enter

the ‘product-of-the-month’ system (generic competition and substitution arise). Denmark and the Netherlands show a similar development to Sweden and also have systems for the generic substitution of off patent pharmaceuticals. In Denmark, we also see that relative prices have increased more during the first five years on the market in recent years (2020–2025) than they did previously (2014–2019).

4.3 Generic competition drives lower prices in all countries

Figure 19 illustrates how prices develop on average over a pharmaceutical’s life cycle for each country in the comparison. In contrast to earlier life cycle analyses, price dynamics over the life cycle are analysed for each country separately, without comparing prices across countries. European best-sellers and new and innovative pharmaceuticals¹⁶ are included, regardless of whether Sweden has recorded sales of these products. The split into the segments without and with generic competition shown in Figure 19 is, for all countries, based on the product’s status in Sweden.

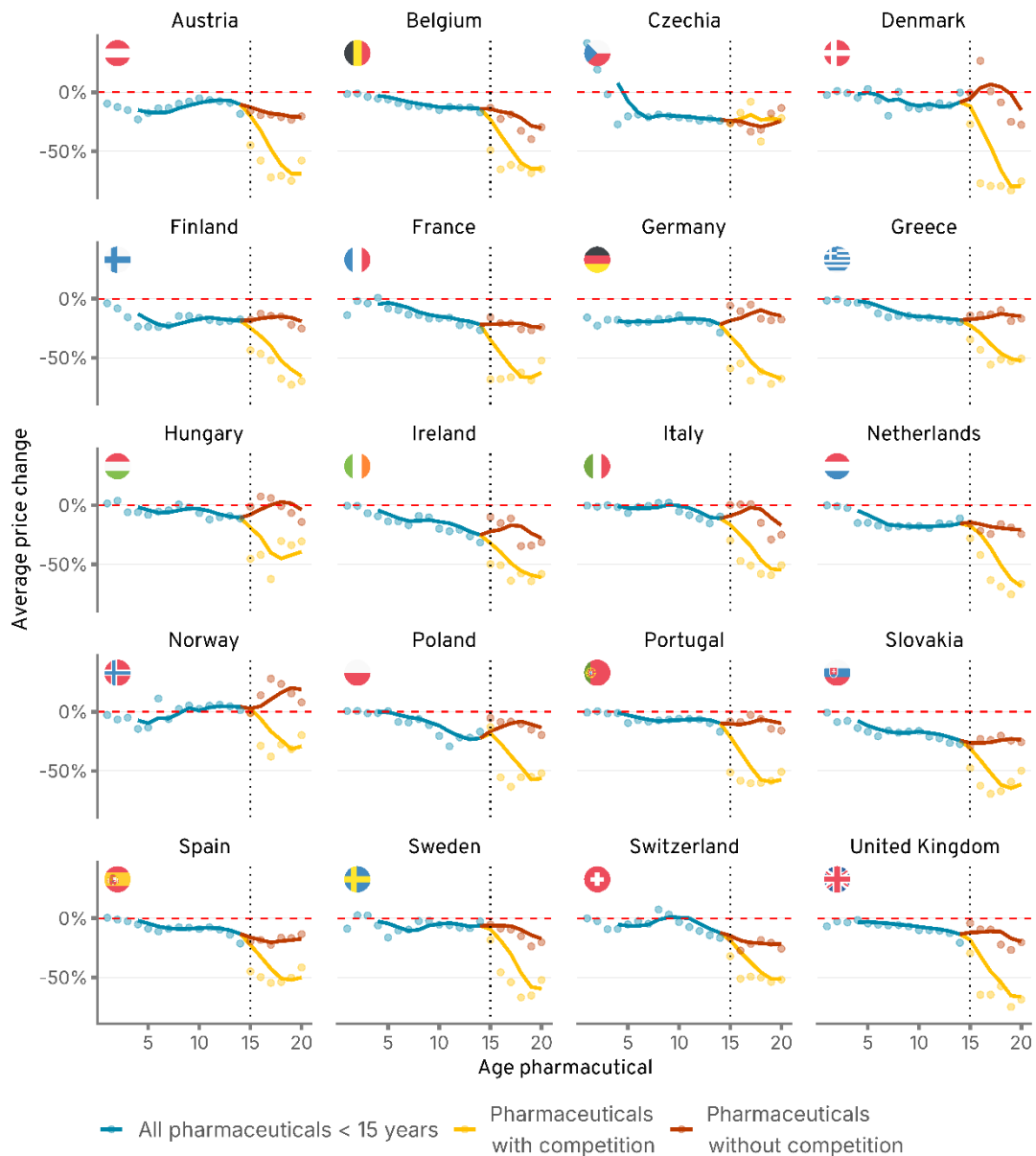
All countries show lower prices after 15 years on the pharmaceutical market, especially for products that face generic competition. Denmark has the greatest reduction, with the price level a few years after patent expiry falling by roughly 70 per cent for pharmaceuticals with generic competition (according to the Swedish definition). For Sweden, the price level for pharmaceuticals with generic competition has decreased by around 38 per cent on average once 15 years on the market have passed.

Many countries also show a clear initial reduction in prices during the first five years on the market—for example Finland, France, Ireland, the Netherlands, Czechia, Germany and Austria. In some countries the price level then rises somewhat, which does not necessarily imply actual price increases; rather, it may reflect changes in the country’s product basket across the life cycle.

In Sweden, we see a distinct price cut for pharmaceuticals after 15 years on the market, particularly for products with generic competition that enter the ‘product-of-the-month’ system. Prices also fall for pharmaceuticals where no or limited competition has arisen, as Sweden routinely cuts prices of products older than 15 years by 7.5 per cent.

¹⁶ IQVIA (2025). EFPIA Patients W.A.I.T Indicator 2024 Survey.

Figure 19 Domestic price trend by year after marketing authorisation for all countries, 2021–2025. Percentage of first observed list price in the country (2014–2025)



Source: IQVIA and TLV.

Note 1: Prices in the first quarter of each year. Volumes are for a 12-month sales period.
 Note 2: The dark blue, yellow and red curves are model adaptations of the circles (moving average, with $n = 4$ periods) used to illustrate the trend over the pharmaceutical life cycle.

Note 3: Norway and Czechia should be interpreted with caution for pharmaceuticals older than 15 years. The structure of their reimbursement systems means that list prices and transaction prices differ significantly. The observations in the figure show only developments in list prices.

The analysis in Figure 19 was performed by identifying the first price for each pharmaceutical and country during the period 2014–2024. The actual price in each subsequent year is then compared with the first identified price. The analysis requires a first price prior to the product being on the market for 15 years for it to be included in each country's analysis. Pharmaceuticals with a percentage change

exceeding 200 per cent are excluded. The analysis includes price development and products in the years 2021–2025.

5 Conclusions and discussion

The main purpose of this report is to compare pharmaceutical prices in Sweden with prices in other countries. In Sweden we use a value-based model for pricing new pharmaceuticals, which means that a pharmaceutical is reimbursed if TLV judges its cost to be reasonable in relation to the demonstrated health benefits. A pharmaceutical that delivers substantial benefit is allowed to have a high price, regardless of what it costs in other countries. Older pharmaceuticals, for which patent protection has expired and generic competition has arisen, are priced within the ‘product-of-the-month’ system. Prices in other countries do not influence TLV’s decisions in this segment either. Nevertheless, there is a need to understand whether Sweden pays more or less for pharmaceuticals than other countries—both to ensure that we obtain as much value as possible for taxpayers’ money and also to provide perspective on how our systems for pricing and reimbursement function.

As in previous years, this year’s analyses show that Swedish list prices for pharmaceuticals are low from an international perspective, particularly for pharmaceuticals that face generic competition. List prices provide some insight into how price levels differ between countries, but they offer limited information about what is actually paid in the countries we compare with. This chapter discusses several factors that are important pieces of the puzzle when interpreting the results of the report.

Agreements with confidential net prices complicate the analyses

To enable comparisons of price levels across countries, we have chosen the available methods and data sources we consider most suitable: price index calculations based on list prices for pharmaceuticals. When interpreting the results, it is important to remember the difference between what we want to measure—the actual (net) prices—and what we do measure—the public list prices. Confidential managed entry agreements with undisclosed net prices are common features of the pricing and reimbursement systems of several countries, in many cases more so than in Sweden according to our assessment. This means that our results will consistently make Swedish relative prices appear lower, compared to prices in other countries, than they actually are.

This is judged to be particularly true for newer pharmaceuticals, i.e. for the segment without generic competition. In addition to regulating prices, agreements may aim to manage risk—for example, the risk that costs turn out to be higher than anticipated, that the pharmaceutical’s effect is lower than expected, or that unexpected adverse effects emerge. Such risks primarily arise when pricing and reimbursing new, relatively expensive pharmaceuticals, which suggests that both the prevalence and the impact of such agreements would be greater in this segment. Among pharmaceuticals that face competition, other effective policy tools are available, for example rule-based or competition-based mechanisms. Moreover,

knowledge about the costs and performance of older pharmaceuticals is greater given that they have been used for a longer period of time. We therefore assess that public list prices reflect the actual price level better for pharmaceuticals with generic competition than for pharmaceuticals without generic competition.

It is also worth noting that, beyond the issue of list versus net prices, other mechanisms and policy tools influence how much each country ultimately pays for its pharmaceuticals. Two common examples are budget caps and agreements with industry that set boundaries for how much, for example, the sales value may grow per year. The former essentially sets an annual cap on total pharmaceutical expenditure and is used in a number of countries. An example of the latter is the United Kingdom, where companies participating in the voluntary scheme collectively pay back a share of their revenues on the portion of growth that exceeds two per cent per year.¹⁷ These policy tools typically have no direct impact on list prices, which means they are not considered in this report. They can, however, have a significant impact on what countries ultimately pay for their pharmaceuticals. In Sweden, neither budget caps nor limits on the growth of sales, revenues or profits are currently used.

In this context, it is also worth mentioning that the share of the list price that actually accrues to the company marketing the pharmaceutical varies. We have not found recent cross-country comparisons of how this differs between countries, but older sources indicate that the average margin accruing to the wholesale level has been relatively low in Sweden.¹⁸ In addition, Sweden is one of very few countries that does not levy VAT on pharmaceuticals.¹⁹

The krona's depreciation has had a large impact on Swedish pharmaceutical prices

The clearest and most important explanation for the continued decline in Sweden's relative prices is that the Swedish krona has lost substantial value over the past 10–15 years, not least against the euro. The impact of the exchange rate appears to have been most pronounced in the segment without generic competition. One possible explanation is that Sweden's 'product-of-the-month' system allows companies to adjust their prices to a greater extent than is the case for newer, still patented, pharmaceuticals, since prices are updated monthly. The revision of price ceilings carried out in 2023 has further increased the system's flexibility in this regard. In Sweden, prices for new pharmaceuticals typically remain the same throughout the period before patent expiry and the onset of generic competition. This means that prices are not adjusted when the exchange rate changes.

Do companies take this into account when applying for prices for new pharmaceuticals? When the price is set in Swedish krona, and the krona weakens, earnings in euros fall and the Swedish price becomes lower when expressed in

¹⁷ ABPI (2025). What is the Voluntary Scheme?

¹⁸ Kanavos et al. (2011). The pharmaceutical distribution chain in the European Union: structure and impact on pharmaceutical prices

¹⁹ EFPIA (2025). The Pharmaceutical Industry in Figures

euros. Ultimately, Sweden is a relatively small market, but our price may potentially affect other markets through reference pricing. A conceivable scenario would have been that companies request higher prices to compensate for lower earnings and lower euro denominated prices. The analysis of Swedish relative prices by launch year indicates that companies have not succeeded in compensating for the weakening krona, although the results are not entirely clear. It is also unclear how much scope for compensation exists within our value-based pricing system—if prices have always been close to our willingness to pay, there is little room for adjustment.

One possible way forward is the negotiations (the ‘tripartite consultations’ in Swedish) between the company, the regions and TLV with the aim of reaching a managed entry agreement. In 2025 the number of such cases under consideration has been at a record high. In these agreements, the parties can arrive at a solution whereby companies obtain a Swedish list price they can accept at a cost that the regions and TLV can accept.

The ‘product-of-the-month’ system contributes to competition and low prices

Swedish prices are the lowest among all countries in the segment of pharmaceuticals with generic competition, which is attributed to Sweden’s ‘product-of-the-month’ system. We consider it reasonable to assume that the gap between list and net prices is smaller in this segment, which increases our confidence that the results reflect reality.

A new analysis shows that it is, for the most part, not the substitution groups in which the price ceiling restricts prices that drive this result. Rather, the results point to the system’s ability to create incentives for companies to set competitive prices as the reason for Sweden’s low prices. The aim of the ‘product-of-the-month’ system is not always to deliver the lowest conceivable prices, but rather to ensure good and stable access to pharmaceuticals at the best possible price. To support this, TLV has reviewed the design of the price ceiling rules to allow prices some room to move.

That prices appear increasingly lower does not mean our costs are decreasing

It is worth noting that even if Swedish list prices have become increasingly lower compared with prices in other countries over time—and the value of what we pay declines when expressed in other currencies—this has no dampening effect on our pharmaceutical costs. In 2024, total pharmaceutical costs increased by 10 per cent (SEK 3.8 billion) compared with the previous year, primarily due to higher volumes.²⁰ The year before, the corresponding figures were nine per cent (SEK 3.2 billion).²¹

²⁰ TLV (2025b). Uppföljning av läkemedelskostnaderna.

²¹ TLV (2024). Kostnadsutveckling och långsiktigt hållbar finansiering av läkemedel.

Sweden is not alone in having to manage how public spending on pharmaceuticals develops. Each year, new pharmaceuticals are launched which, in addition to providing substantial benefits to society, also increase costs. Pricing and reimbursement systems are strained by these rising costs, and in several countries, efforts are made to address this through agreements with industry, confidential contracts or budget caps. Recent developments in the United States²²—namely the administration’s desire to introduce pricing based on a Most-Favoured-Nation (MFN) principle—risk further increasing pressure in regard to pricing and price levels in Europe, even if much remains uncertain.

Countries’ pricing and reimbursement systems are heterogeneous and complex

Countries’ systems for pricing and reimbursing pharmaceuticals differ greatly—there are no two that work in exactly the same way. The context in which they have developed and operate (for example healthcare and health-insurance systems) also varies and is organised in many different ways. The processes that lead to reimbursement decisions and the pricing of pharmaceuticals are moreover complex. When interpreting the results of this report, this should be seen both as a possible explanation for why prices vary between countries and as a factor that complicates analysis. Two examples of complicating factors are that product baskets differ and that a product used in retail pharmacies in Sweden may not be used in the same way in other countries. This, combined with the net price issue, makes it difficult to draw firm conclusions about the effects that different types of policy tools have on pricing and reimbursement decisions.

²² White House (2025). Delivering most favored nation prescription drug pricing to American patients

References

TLV (2025a) - Prognos av besparingar från sidoöverenskommelser 2025–2028, 2025

https://www.tlv.se/download/18.2477631719a767c5ba525aa2/1763381068723/uppdaterad_ater_baringsprognos_2025%E2%80%932028.pdf

TLV (2025b) - Uppföljning av läkemedelskostnaderna, 2025

https://www.tlv.se/download/18.b67e1a11975d2fb8c238303/1750317533382/uppfoljning_av_lakemedelskostnaderna_2025.pdf

IQVIA (2025) - EFPIA Patients W.A.I.T Indicator 2024 Survey, 2025

<https://www.iqvia.com/library/publications/the-patients-wait-indicator-2025><https://www.lif.se/globalassets/pdf/rapporter-externa/wait/efpia-patient-wait-indicator-2024.pdf>

WHO (2020) - WHO guideline on country pharmaceutical pricing policies, 2020

<https://www.who.int/publications/i/item/9789240011878>

PPRI - pharma profiles/briefs

https://ppri.goeg.at/ppri_pharma_profiles

TLV (2023) - Preliminära takpriser och nya fastställda takpriser, 2023

<https://www.tlv.se/beslut/beslut-lakemedel/preliminara-och-gallande-takpriser.html>

TLV (2014) - Levetiracetam kvarstår i högkostnadsskyddet efter prissänkningar, 2014

<https://www.tlv.se/lakemedelsforetag/omprovning-av-lakemedel/arkiv-avslutade-omprovningar-lakemedel/2014-09-02-levetiracetam-kvarstar-i-hogkostnadsskyddet-efter-prissankningar.html>

Hila (2025) – Anvisning om villkorlig ersättning, 2025

https://www.hila.fi/content/uploads/2024/02/Ehdollinen-korvattuuvuus_ohje-hakijoille_04_03_2025_SV.pdf

Or, Z, et al. (2023) - France: Health system review 2023, 2023

<https://eurohealthobservatory.who.int/publications/i/france-health-system-review-2023>

Lumell (2024) - Associates, Internationell Utblick – Metoder för att dämpa kostnadsökning för läkemedel genom att ta hänsyn till försäljningsvolym, 2024.
https://www.tlv.se/download/18.f12b6071926b1480d46afd/1728454443978/internationell_utblick_metoder_for_att_dampa_kostnadsokning_for_lakemedel_genom_att_ta_hansyn_till_forsaljningsvolym.pdf

TLV (2024a) - Kostnadsutveckling och långsiktigt hållbar finansiering av läkemedel, 2024

https://www.tlv.se/download/18.65e492871900c7849a27cfa/1718348658291/kostnadsutveckling_och_langsiktigt_hallbar_finansiering_av_lakemedel_2024.pdf

White House (2025) - Delivering most favoured nation prescription drug pricing to American patients

<https://www.whitehouse.gov/presidential-actions/2025/05/delivering-most-favored-nation-prescription-drug-pricing-to-american-patients/>

ABPI (2025) – What is the Voluntary Scheme?

<https://www.abpi.org.uk/value-and-access/uk-pharmaceutical-pricing/voluntary-scheme-on-branded-pharmaceuticals/>

Kanavos et al. (2011) - The pharmaceutical distribution chain in the European Union: structure and impact on pharmaceutical prices

<https://eprints.lse.ac.uk/51051/>

EFPIA (2025) - The Pharmaceutical Industry in Figures

<https://www.efpia.eu/media/ujopopel/the-pharmaceutical-industry-in-figures-2025.pdf>

TLV (2024b) - Kostnadsutveckling och långsiktigt hållbar finansiering av läkemedel, 2024

https://www.tlv.se/download/18.65e492871900c7849a27cfa/1718348658291/kostnadsutveckling_och_langsiktigt_hallbar_finansiering_av_lakemedel_2024.pdf

Appendix 1. Terms and concepts

15-year rule – Swedish rule (enacted by TLV) which means that the fixed prices of pharmaceuticals older than fifteen years from the time of market approval are reduced by 7.5 per cent compared to the original market value.

Active pharmaceutical ingredient (API) – The substance in a pharmaceutical product that gives it its medical effect.

Approved indication – The symptom, disease state or health problem for which a pharmaceutical's approval applies.

ATC (Anatomical Therapeutic Chemical classification system) – A pharmaceutical classification system. The ATC system has 14 main groups into which pharmaceuticals are classified based on their main indication.

Biological pharmaceutical – A pharmaceutical where the active substance has been produced from biological material of living cells or tissue.

Biosimilar – A biological pharmaceutical that is similar and works in the same way as the approved original biological pharmaceutical.

Dosage form – Different methods for administering a pharmaceutical to the body, such as by tablet, injection or patch.

General reimbursement – When a pharmaceutical is reimbursed for all its uses.

Generic competition – When at least two pharmaceuticals from different manufacturers are substitutable and start to be sold, generic competition arises. This usually leads to the price level falling for pharmaceuticals and can result in large price differences between products.

Generic pharmaceutical – Pharmaceuticals that contain the same active substance as the original pharmaceutical and are used in the same doses to treat the same illness but are sold under a different name and normally marketed by a company other than the producer of the original pharmaceutical.

Generic substitution – The substitution system, which means that pharmacies offer a substitute for a pharmaceutical that is available and has a lower price than the prescribed pharmaceutical and is then fully included in the high cost protection.

Group of substitutable pharmaceuticals – A group of pharmaceuticals which, according to the Swedish Medical Products Agency's list of substitutable medicinal products, are substitutable with each other.

High-cost protection – A system to limit the costs that an individual patient pays over one year for prescribed pharmaceuticals and other items included in the pharmaceutical benefits scheme. In addition to high-cost protection within the pharmaceutical benefits, there are other protections—for example to shield individuals from high dental care costs.

Hospital pharmaceuticals – Pharmaceuticals procured by regions and administered within hospitals. Most common in care provided in hospitals.

HTA (Health Technology Assessment) – Evaluation of medical methods or products. May include parts of or a full health economic evaluation.

Indication – The medical term used to describe the specific symptom, disease state or health problem for which a particular treatment or pharmaceutical is intended to be used.

In-patient care – Care where the patient is admitted to a hospital ward. The opposite is open, or out-patient, care.

IRP (ERP) – International reference pricing – Pricing policy in which the price(s) of a pharmaceutical in one or more countries is/are considered in national pricing. Common synonymous terms are external price reference (EPR), external reference pricing (ERP) or simply reference pricing.

List price – Price paid without regard to discounts or repayments. Corresponds in this report to the pharmacy purchase prices (PPP), which in Sweden is determined by TLV.

MAH (Marketing authorization holder) – The company (or other legal entity) that is authorized to market a medicinal product in one, several or all EU Member States.

Managed entry agreement – An agreement between a pharmaceutical company and public or private payer (individual regions in Sweden) that in Sweden is drawn up within the framework of, or as a result of, TLV's case management. A managed entry agreement regulates one or more circumstances related to the use of a pharmaceutical and can, for example, mean that the cost of treatment is reduced to decrease the health economic uncertainty.

Out-patient care – All care where the patient is not admitted to hospital. Sometime, open care.

Orphan drugs – Pharmaceuticals intended for the treatment, prevention or diagnosis of a disease that is life-threatening or chronically debilitating. The prevalence of the condition in the EU must not be more than 5 in 10,000 according to Regulation (EC) No 141/2000 on orphan medicinal products.

Original brand product – The first pharmaceutical on the market that contains a particular active substance. These pharmaceuticals are under patent protection and are thus not subject to competition from generic equivalents for a number of years.

Package size group – A group of pharmaceuticals based on size of packaging and generic substitution group. Pharmaceuticals within the same package size group can be substituted at the pharmacy.

Parallel imported medicinal products – An approved pharmaceutical that is imported from an EU/EEA country for which it was originally intended, and which, with permission from the Swedish Medical Products Agency, may be marketed in Sweden. Both original pharmaceuticals and generic pharmaceuticals can be parallel imported.

Payment model – An agreement between the purchaser and the company to make a treatment available under specified conditions. The agreement, which is regulated in a Managed Entry Agreement, may mean that payment for a pharmaceutical is not a constant amount per pack but can vary depending on the patient, indication, purchased volume, health outcomes or another factor.

Pharmaceutical benefits – A pharmaceutical included in the pharmaceutical benefits scheme is subsidized and included in the high-cost protection system, which limits how much a patient has to pay for their pharmaceuticals. The provisions on pharmaceutical benefits can be found in the Act (2002:160) on Pharmaceutical Benefits, etc. and in statutes enacted pursuant to that Act.

Pharmaceutical benefits (scheme) – Pharmaceuticals and other goods included in the pharmaceutical benefits scheme are subsidized. By being prescribed to a person entitled to the benefits, the total costs for such goods that the patient has to pay over one year are limited.

Price ceiling – The maximum accepted price (pharmacy purchase price per unit; PPP) of a pharmaceutical in a package size group.

Product of the month (PV) – The pharmaceutical pack that is available, that has the lowest price within each substitution group and pack size group, and that pharmacies must offer their customers as the substitution product. Updated monthly by TLV via tendering.

Prescription pharmaceuticals – Pharmaceuticals that have been prescribed and are dispensed at retail pharmacies.

Prescription pharmaceuticals – Pharmaceuticals that have been prescribed and are dispensed at retail pharmacies.

PV-system – See Product-of-the-month (PV).

Rare condition/Rare disease/Rare health condition – A rare diagnosis/disease/condition that occurs in fewer than 5 in 10,000 inhabitants.

Repayment – A form of reimbursement paid in arrears. In Sweden, pharmaceutical companies disburse repayments to the regions based on what is stipulated in the associated managed entry agreement, where such an agreement exists. Internationally, this is often referred to as a discount.

Restricted reimbursement – Reimbursement for only a certain area of use or a certain patient group.

Retail margin – The regulated compensation that pharmacies receive when they sell prescription pharmaceuticals and other goods within the pharmaceutical benefits scheme (high cost protection). The retail margin is the difference between the pharmacy's retail price (PRP) and purchase price (PPP).

Subsidy – The part of the cost of a pharmaceutical, a dental care procedure or a consumable that is paid by the public sector.

Substitutable pharmaceuticals – Pharmaceuticals that provide the same medical effect because they contain the same active substance, pharmaceutical form and strength, and which the Swedish Medical Products Agency has deemed to be substitutable.

Tripartite consultations – Means that both regions and the pharmaceutical company confer with TLV at the same time in a given case.

Value-based pricing – A pricing strategy based on an ethical platform for prioritisation decided by the Swedish Parliament. The platform has three principles: the 'principle of human dignity', the need and solidarity principle, and the cost-effectiveness principle.

6 Appendix 2. Methodology and data

6.1 Description of data sources

The report primarily uses price and sales statistics from IQVIA covering data from 2014 up to and including 2025. Price data refer to the first quarter of each year, while information on the number of units and packs sold relates to the 12 months up to the end of March each year. Prices used are list prices, which in Sweden correspond to the pharmacy purchase price (PPP) established by TLV. Data on the number of units and packs sold are used to calculate sales value at an annual rate, and to weight pharmaceutical prices when calculating the various price indices in the report.

Sales data from IQVIA are based on reported sales from wholesalers to pharmacies (sell-in data), which is not always directly comparable with data from the Swedish eHealth Agency, which summarises sales at Swedish pharmacies. For example, IQVIA's data categorise all haemophilia products (coagulation factors) as hospital only medication, which is not the case at the Swedish eHealth Agency. IQVIA also informs of minor sample differences. In general, these differences affect hospital only use to a greater extent than sales through retail pharmacies. Some pharmaceutical companies distribute pharmaceuticals directly to pharmacies without using the wholesale channel, which means that such sales are missing or underestimated in IQVIA's dataset. For certain selected high-value pharmaceuticals where data are missing, we have supplemented Swedish sales volumes with sales data from the Swedish eHealth Agency.

In addition to the official prices analysed in the report, both Sweden and other countries use confidential agreements that regulate the cost of certain pharmaceuticals. In applicable cases, such agreements result in realised costs that are lower than would have been the case if the pharmaceuticals had been purchased at list price. In Sweden, such agreements are entered into between a pharmaceutical company and individual regions, and regulate, among other things, repayment of parts of the cost of pharmaceuticals. Public sector pharmaceutical costs are thus affected by repayments from these agreements. Similar agreements also exist in other countries, including those in our selection, but the effects of these are not considered in the report. Broader agreements—often between a public payer and, for example, an industry association—that set the maximum amount the public is willing to pay for pharmaceuticals (so-called budget caps) also affect public sector costs and, to some extent, pharmaceutical prices.

Pharmaceuticals not included in the analyses:

- Hospital pharmaceuticals (pharmaceuticals procured by regions and administered to patients within healthcare).
- Over-the-counter pharmaceuticals.

- Prescription pharmaceuticals not included in the pharmaceutical benefits scheme.
- Infectious disease pharmaceuticals prescribed outside the benefits scheme.

6.2 Selection of pharmaceuticals

Our sample consists of prescription pharmaceuticals for human use that are covered by the pharmaceutical benefits scheme and have the highest sales in Sweden. In addition, substances with relatively low sales in Sweden but high sales elsewhere in Europe, as well as new substances, are included. By complementing the sample with European best-sellers, the comparison is fairer, as a larger number of relevant pharmaceuticals are compared.

Across the entire time series and among the included comparison countries, sales data are available for 956 substances and 7,983 pharmaceuticals. Analyses are largely based on pharmaceuticals sold in Sweden. In analyses of other countries' price dynamics or relative prices, pharmaceuticals that have not been sold in Sweden are also included.

The market is divided into pharmaceuticals without and with generic competition. A pharmaceutical with generic competition is defined as one that is included in Sweden's 'product-of-the-month' system, meaning that it has generic competition and is substitutable at Swedish pharmacies. Divided according to this definition, the analysis includes:

- Pharmaceuticals **without generic competition** with sales in 2025:
 - All countries: 870 substances and 5,573 pharmaceuticals.
 - Sweden: 534 substances and 1,244 pharmaceuticals.
- Pharmaceuticals **with generic competition** with sales in 2025:
 - All countries: 254 substances and 785 pharmaceuticals.
 - Sweden: 254 substances and 768 pharmaceuticals.
- **All pharmaceuticals over the entire time series (2014–2025):**
 - All countries: 956 substances and 7,983 pharmaceuticals.
 - Sweden: 746 substances and 2,588 pharmaceuticals.

In the first quarter of 2025, pharmaceuticals without generic competition accounted for 80 per cent of total sales value in Sweden and pharmaceuticals with generic competition 20 per cent. Measured by sales value, the sample encompasses 90 per cent of sales of prescription pharmaceuticals within the benefits scheme in Sweden in 2025.

6.3 Selection of countries

The 19 European countries included in the comparison group have been more or less the same since the 2015 international price comparison. The countries exhibit both similarities and differences in how pharmaceuticals are financed and distributed, as well as how the pharmaceutical market functions. All countries are in Europe. The majority are EU Member States and thus share, to some extent, both

legislation and a market for pharmaceuticals with Sweden. Within the group there are examples of collaboration on HTA and negotiations with companies concerning agreements that reduce realised costs for pharmaceuticals. Overall, the sample of comparison countries is deemed to provide a relevant picture of Swedish pharmaceutical prices from an international perspective. Keeping the sample constant also facilitates comparisons between years.

It is not possible to determine how the picture of Swedish pharmaceutical prices might be affected if other countries were included in the sample. The 20 countries, including Sweden, are shown below in Table 2.

Table 2. Countries included in the selection

Belgium	Portugal
Denmark	Switzerland
Finland	Slovakia
France	Spain
Greece	United Kingdom ²³
Ireland	Sweden
Italy	Czechia
Netherlands	Germany
Norway	Hungary
Poland	Austria

As part of the work on the International price comparison 2025, the working group has produced short descriptions of the pricing and reimbursement systems for pharmaceuticals in a selection of countries. The purpose has primarily been to raise the level of knowledge about how other countries' systems function. The descriptions are available on TLV's website.

6.4 Calculation methods

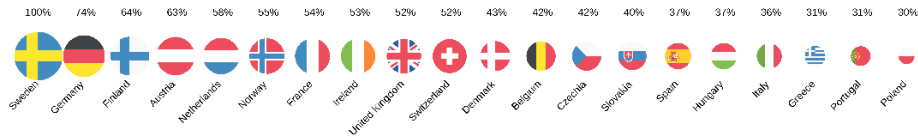
6.4.1 Match rate

A fundamental challenge in comparing prices internationally is that not all countries use the same pharmaceuticals. For example, countries may use different pharmaceuticals to treat the same medical condition, or a pharmaceutical may be approved for reimbursement in only some of the countries in the sample. In this report, the share of the same pharmaceuticals used in two countries is referred to as the match rate. The higher Sweden's match rate with another country, the larger the share of the pharmaceuticals used in Sweden that are also found in the comparison country. The match rate does not take into account differences in prescribing per capita between countries; it only considers the overlap of pharmaceuticals between Sweden's and the other country's product baskets.

²³ Volume data pertain to United Kingdom, prices data sourced from England and Wales

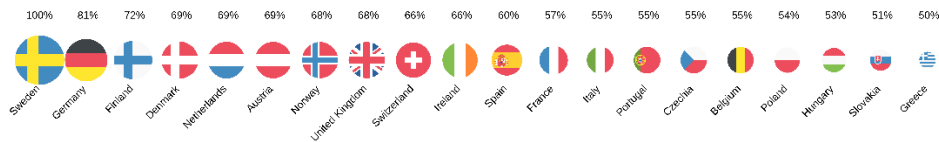
The match rate illustrates the proportion of pharmaceuticals with and without generic competition that are sold through retail pharmacies in Sweden and that are also found in other countries under the same sales criteria (Figure 20 and Figure 21). Combinations of pharmaceutical, country and year where the sales volume per capita was less than 0.5 per cent of the observed value in Sweden are also excluded.

Figure 20 Sweden's match rate for pharmaceuticals without generic competition, percentage, 2025.



Source: IQVIA and TLV.

Figure 21 Sweden's match rate for pharmaceuticals with generic competition, percentage, 2025.

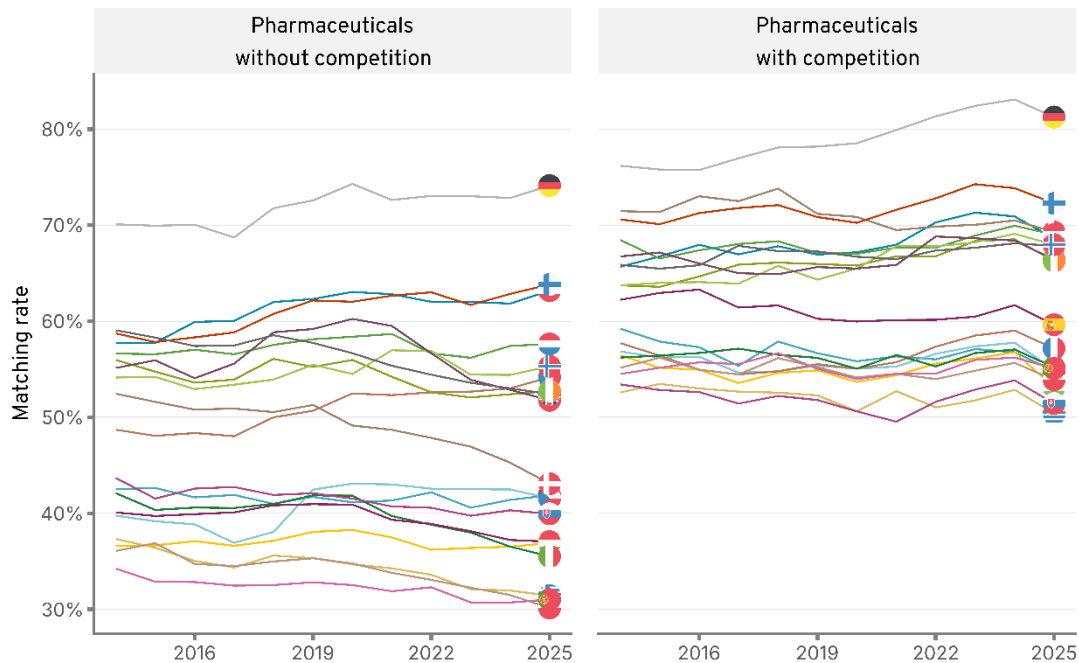


Source: IQVIA and TLV.

In general, match rates are higher for pharmaceuticals with generic competition than for those without. Germany has the highest match rate with Sweden's product basket in both segments. Otherwise, the Nordic countries together with Austria and the Netherlands have the highest match rates with Sweden's product basket for both pharmaceuticals with and without generic competition (with the exception of Denmark, which has a lower match rate for pharmaceuticals without generic competition). The countries with the lowest match rates differ somewhat between the two segments, but Greece, Poland and Portugal are among the five with the lowest match rates in both.

Over time, match rates are relatively stable among the comparison countries. This means that the countries that rank high this year have also ranked high in historical data. In Figure 22, some countries show a downward trend—for example Denmark in the segment of pharmaceuticals without generic competition (from around 50 per cent to around 45 per cent). Others show an upward trend—for example Germany in both the segment with- and without-competition.

Figure 22 Match rates over time for the comparison countries, broken down into pharmaceuticals with and without generic competition.



Source: IQVIA and TLV.

6.4.2 Price indices

The report makes several different comparisons to investigate how Swedish prices compare with those in the other countries in the price comparison. What these comparisons have in common is that they use a price index. In the context of the international price comparison, an index is defined as a comparison between one country's prices and a comparative price. The comparative price may be a European average price or the price in a specific comparison country.

It is standard practice to weight different pharmaceutical prices in a price index by volume. Price differences for pharmaceuticals with high sales are therefore given greater weight than those with low sales, and vice versa. This is done to avoid low-use, high-price pharmaceuticals having a disproportionately large impact on the result.

A price index is a weighted average of a number of pharmaceuticals, usually calculated over time. If we have two periods (period 0 and period t) and n pharmaceuticals, a general price index can be written as:

$$I_p = \frac{p_1^t w_1 + p_2^t w_2 + \dots + p_n^t w_n}{p_1^0 w_1 + p_2^0 w_2 + \dots + p_n^0 w_n} \times 100$$

Where p_i^t denotes the price of pharmaceutical i at time t and w_i denotes the weight assigned to pharmaceutical i . To calculate the relative importance of a pharmaceutical's price, sales volume q for the pharmaceutical is usually used as the

weight. In this analysis, the index is calculated for one period at a time, which means that period 0 and period t are the same. The time indicator is replaced by country: abroad U and Sweden S.

The weight can be either sales volume abroad or sales volume in Sweden. This choice determines whether the price index is interpreted from a Swedish perspective or not. In the pharmaceutical field, it is standard practice to calculate the Laspeyres price index, meaning that price differences are viewed from the perspective of the reference country, which in the context of this report means that Sweden is mainly used as the base.

$$L_p = \frac{p_1^U q_1^S + p_2^U q_2^S + \dots + p_n^U q_n^S}{p_1^S q_1^S + p_2^S q_2^S + \dots + p_n^S q_n^S} \times 100$$

Where p^U denotes the price abroad and q^S the quantity in Sweden. If the price is the same in Sweden and abroad, the index value is 100. An index < 100 (or > 100) means that the pharmaceutical is cheaper (or more expensive) abroad than in Sweden.

A lower (or higher) price index than 100 implies a theoretical cost increase (saving) that could be achieved if Swedish prices were changed in relation to foreign prices, given that Swedish consumption is assumed to be unchanged. This is a strong and unlikely assumption that requires perfectly inelastic demand. If demand is not inelastic, a change in demand will either strengthen or weaken the theoretical cost increase or saving. The supply of pharmaceuticals—i.e., the entry of competing products and improvements to existing ones—is also relevant.

Price indices provide a good picture of how the price level in comparable countries relates to Sweden's price level during the period in question. Absolute index figures should be interpreted with caution, as they are affected by both volume and exchange-rate effects. In this study, we primarily use a three-year moving average exchange rate.

If another country's volume weight is used instead of the reference country's, the absolute level of the price index is adjusted, though not necessarily the ranking between countries.

Bilateral comparison

In the bilateral price comparison, the entire product basket common to both Sweden and the comparison country is used. For example, if Finland uses 59 per cent of the pharmaceuticals used in Sweden, only these pharmaceuticals are included in the price comparison. Pharmaceuticals with very low sales (0.5 per cent of Swedish use) relative to the reference country's local market are excluded. The index value indicates how much more or less the Swedish pharmaceutical use (where the product has had sales in the comparison country and use is not too low relative to Sweden) would cost if purchased at the comparison country's prices. The

bilateral comparison is therefore influenced by the fact that Swedish volumes are used.

Bilateral average

In addition to the bilateral comparison, an alternative metric is also calculated that includes information on pharmaceutical use from all countries. This metric, referred to here as the bilateral average, is calculated by repeating the bilateral comparison for all possible pairwise combinations of countries, i.e., a bilateral index is calculated for each country based on its own product basket. Finally, a total average index is calculated that takes into account the pharmaceutical use of all countries included in the comparison. The average is unweighted, meaning that each country's index has an equal impact on the overall average index.

Cross-sectional comparison

This approach assumes that all countries in the study have all pharmaceuticals used in Sweden. If a country does not use a pharmaceutical, its price is assumed to be equal to the average price of that product in the countries that do use it. To ensure that a sufficient number of countries use a given pharmaceutical, it must have been sold in at least eight countries to be included in the comparison.

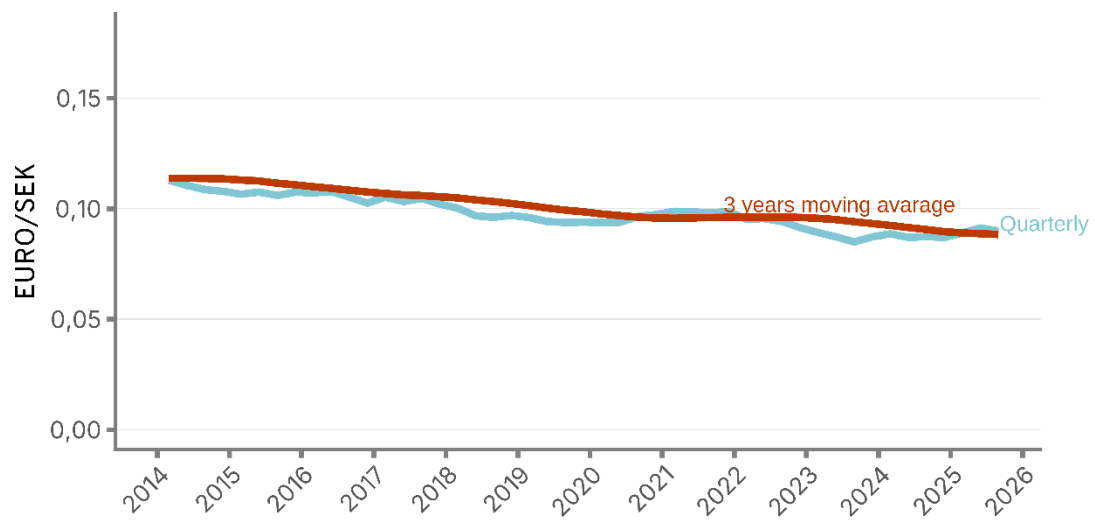
6.4.3 Exchange rates

To enable comparisons between countries, prices must be converted into a common currency, in this case Swedish kronor (SEK). Exchange-rate data are obtained from Eurostat, the statistical office of the European Union. Over the past several years, the Swedish krona has depreciated in value, not least against the euro. This has affected the relationship between pharmaceutical prices in Sweden and in other countries.

To avoid temporary exchange-rate fluctuations influencing the picture of Sweden's relative prices from one year to the next, the report uses a three-year moving average. The method aims to clarify longer-term trends in exchange-rate developments by spreading short-term changes over a longer period. For example, the level of the moving average was higher than the quarterly series for 2024, due to higher levels during 2021 and 2022 compared with the most recent quarter. By the same logic, the use of the moving average has helped to "hold down" Swedish relative pharmaceutical prices during parts of the period when the krona strengthened against the euro, as, for example, in early 2025.

Figure 23 below shows the development of the Swedish krona in relation to the euro. The figure includes both quarterly data and the moving average to clarify the difference between the two methods. The figure shows that the quarterly series fell in value during 2022, before breaking the downward trend in 2023 and 2024. The moving average continued to decline in value in relation to the euro during 2023 and 2024, although the fall was not as pronounced in 2022. In 2025, the moving average was essentially unchanged compared with 2024.

Figure 23 Value of the Swedish krona (SEK) in relation to the euro (EUR), quarterly and as a moving average. Number of euros per krona, 2014–2025.



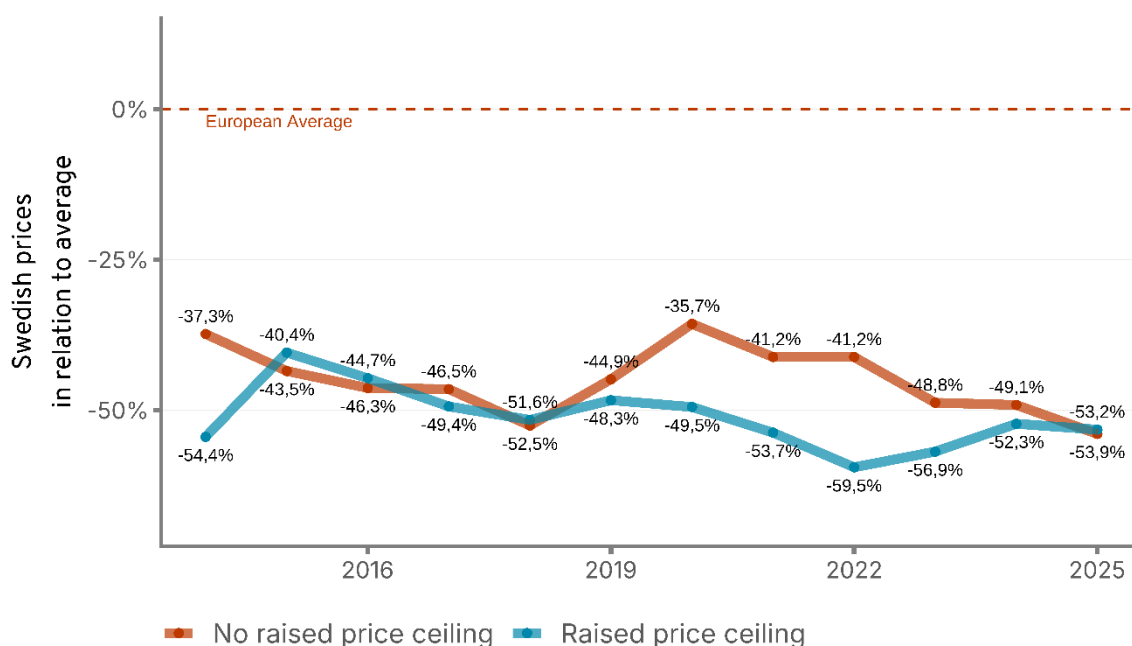
Source: Eurostat.

7 Appendix 3. Sensitivity analyses and in-depth analysis

7.1 Prices lower in groups with and without raised price ceilings

Sweden's relative price level for pharmaceuticals with generic competition has decreased over the last year, both among the substitution groups for which TLV decided in 2023 to raise price ceilings and among the groups that did not receive such increases. For the groups that did receive raised price ceilings, the result can be explained by the fact that prices for some pharmaceuticals that initially followed the higher price ceilings have since fallen again.

Figure 24 Relative price development for pharmaceuticals with generic competition, divided according to whether a pharmaceutical had a raised price ceiling in 2023.



Source: IQVIA and TLV.

Note 1: Prices in the first quarter of each year. Volumes are for a 12-month sales period. The gap to the European average has been calculated using a cross-sectional comparison.

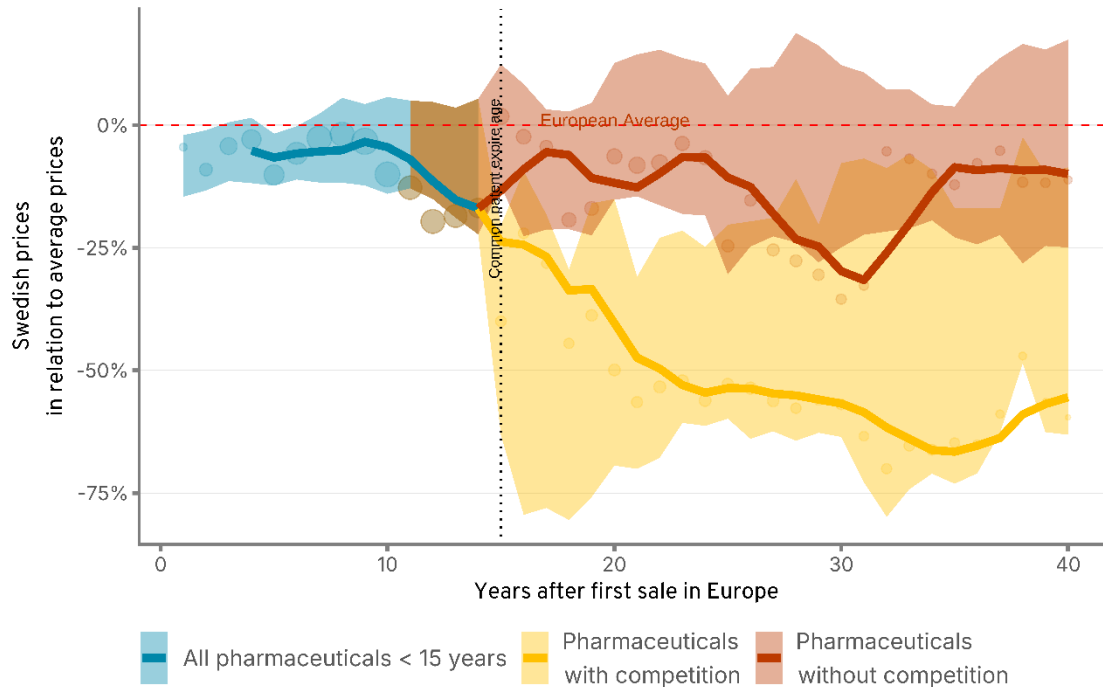
Note 2: Price ceiling increases were decided in April and August 2023. In total, the price ceiling was raised for 957 package size groups (combinations of substance, form, strength and size group), just over half of the groups in the 'product-of-the-month' system. The price ceiling increases concern the maximum permitted price; companies themselves decide whether to raise the price of their packs. The analysis is performed at the substance, form and strength level, meaning that combinations in which any package size group has been subject to an increase are included in the group "Raised price ceiling". We therefore assess that the impact on Sweden's gap to the European average is underestimated in this analysis.

In Figure 24, we see that Sweden's relative prices fell both for those covered by, and those not covered by, the raised price ceiling in 2023. In 2025, the gap to the European average widened by 1.6 and 4.1 percentage points for the groups with and without raised price ceilings, respectively, compared with 2024. The two groups of pharmaceuticals are at similar levels in 2025, around 53–54 per cent below the European average.

7.2 Wide variation in relative prices over the life cycle

The analyses that show how Swedish pharmaceutical prices relate to the European average over the life cycle (Section 4.1.1) present a weighted average.

Figure 25 Swedish pharmaceutical prices for pharmaceuticals with and without generic competition compared to the European average, per year after marketing authorisation. Percentage of average, data for 2021–2025. Exchange rate calculated as a three-year moving average.



Source: IQVIA and TLV.

Note 1: Prices in the first quarter of each year. Volumes are for a 12-month sales period. The gap to the European average has been calculated per pharmaceutical age using a cross-sectional comparison, with the exception that countries lacking price data are assigned the average price.

Note 2: The figure should be interpreted as Sweden's average relative price per pharmaceutical age during the period 2021–2025.

Note 3: The red dotted line shows average prices for 20 European countries. The position of the circles indicates the actual deviation from the European average each year, while their size indicates the value of sales in Sweden for pharmaceuticals at that age compared with other ages. The dark blue, yellow and red curves are model adaptations of the circles (moving average, $n = 4$ periods) used to illustrate the trend over the pharmaceutical life cycle. The shaded area represents the middle 50 per cent of pharmaceuticals (25th to 75th percentile) at a given age and segment.

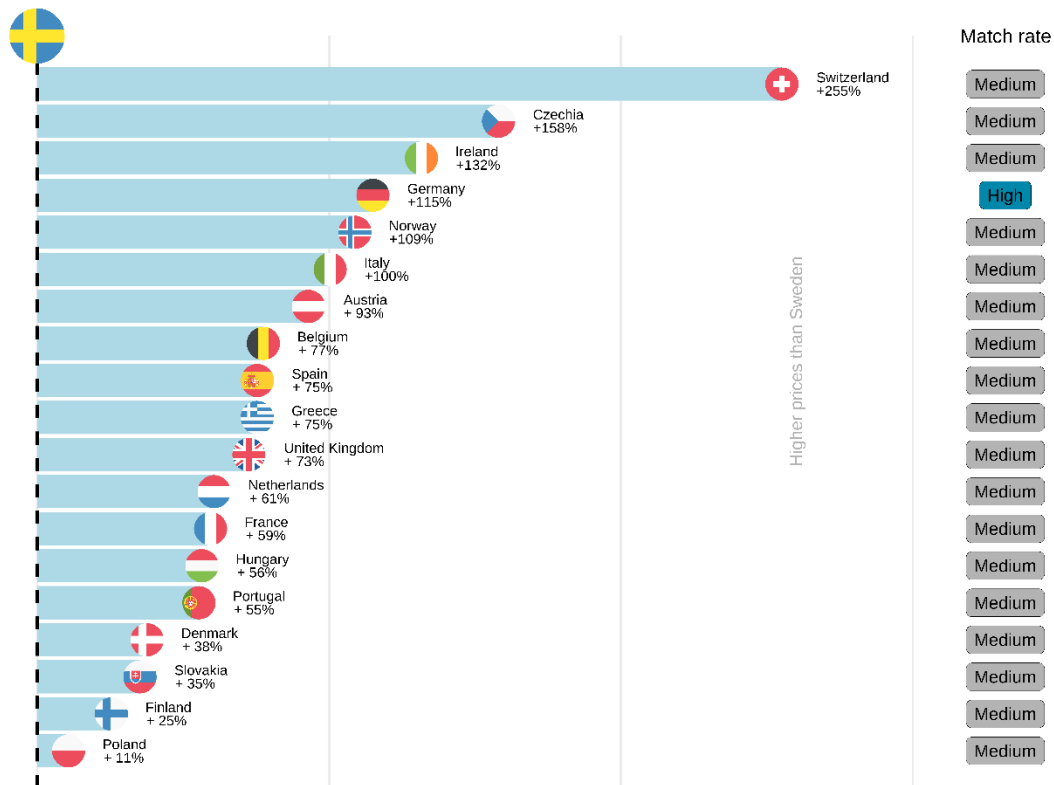
Figure 25 performs the same analysis but also describes the area in which the middle 50 per cent of pharmaceuticals relative to the average can be found (25th to 75th percentile). We can see that the area is largest for pharmaceuticals with generic competition after age 15, with 50 per cent of the groups at age 20 lying between 15 and 70 per cent below the average. That the weighted average lies closer to the lower bound of the area indicates that pharmaceuticals for which Sweden has prices below the average have high sales, measured in number of packs sold.

7.3 Alternative definition of pharmaceuticals with generic competition

In this report, pharmaceuticals with generic competition are defined as those included in Sweden's 'product-of-the-month' system. This means that the division

of pharmaceuticals is based on a Swedish context. In Figure 26, we instead define competition using a classification by IQVIA, pharmaceuticals which are off-patent or that have never been patented, and generics or biosimilars that have never been patented.

Figure 26 Price comparison for pharmaceuticals with competition (alternative definition) used in Sweden. 2025, percentage in relation to Swedish prices.



Source: IQVIA and TLV.

Note 1: Prices in the first quarter of 2025. Volumes cover a 12-month sales period (April 2024 to March 2025). The gap to Sweden has been calculated using a bilateral price index.

Compared with Figure 4, where competition is defined by whether a pharmaceutical is included in Sweden's 'product-of-the-month' system, the difference between Swedish prices and those in many of the comparison countries is smaller under the alternative definition. For example, Poland's gap to Sweden is 11 per cent instead of 36 per cent, and Finland's is 25 per cent instead of 38 per cent. For all countries except Germany and Denmark, the gap between Swedish prices and those in the comparison countries narrows. However, Sweden still has the lowest prices under the alternative definition of competition.

Appendix 4. Pharmaceutical groups

The following is a summary of pharmaceutical groups, and the substances included in each group. These pharmaceutical groups are based on the classifications used by the Swedish National Board of Health and Welfare when forecasting pharmaceutical costs.²⁴ TLV has subsequently revised the groups, which mainly involved classifying additional pharmaceuticals.

Table 1 Pharmaceutical groups and associated substances.

Pharmaceutical groups	Substances
ADHD	Atomoxetine, Dexamfetamine, Guanfacine, Lisdexamfetamine, Methylphenidate
Alimentary tract	Agalsidase Alfa, Agalsidase Beta, Alglucosidase Alfa, Asfotase Alfa, Avalglucosidase Alfa, Balsalazide, Benzydamine, Bisacodyl, Budesonide, Bupropion, Naltrexone, Carglumic Acid, Cerliponase Alfa, Cipaglucosidase Alfa, Cromoglicic Acid, Domperidone, Eliglustat, Esomeprazole, Fidaxomicin, Galsulfase, Givosiran, Glycerol Phenylbutyrate, Glycopyrronium, Granisetron, Idursulfase, Imiglucerase, Lansoprazole, Laronidase, Linaclotide, Loperamide, Mercaptamine, Mesalazine, Methylnaltrexone Bromide, Metreleptin, Migalastat, Miglustat, Misoprostol, Naldemedine, Naloxegol, Netupitant, Palonosetron, Nitisinone, Nystatin, Obeticholic Acid, Odevixibat, Olsalazine, Omeprazole, Ondansetron, Orlistat, Pantoprazole, Phenylbutyrate, Potassium, Prucalopride, Racecadotril, Rifaximin, Sapropterin, Setmelanotide, Sulfasalazine, Teduglutide, Telotristat Etiprate, Trientine, Vancomycin, Velaglucerase Alfa
Analgesics	Acetylsalicylic Acid, Caffeine, Codeine, Codeine, Paracetamol, Fentanyl, Gabapentin, Morphine, Naloxone, Oxycodone, Oxycodone, Paracetamol, Pregabalin, Tapentadol, Tramadol
Anemia	Darbepoetin Alfa, Epoetin Alfa, Epoetin Beta, Epoetin Theta, Epoetin Zeta, Iron Ferric, Luspatercept, Methoxy Polyethylene Glycol-Epoetin Beta, Roxadustat
Anesthetics	Lidocaine, Lidocaine, Prilocaine
Antibiotics and chemo, dermat	Imiquimod, Mupirocin, Penciclovir
Anticoagulants (excl. NOAK)	Acetylsalicylic Acid, Alteplase, Cangrelor, Caplacizumab, Clopidogrel, Dalteparin Sodium, Enoxaparin Sodium, Epoprostenol, Fondaparinux Sodium, Heparin, Iloprost, Selexipag, Ticagrelor, Tinzaparin, Treprostinil, Warfarin
Antidepressants	Amitriptyline, Bupropion, Citalopram, Clomipramine, Duloxetine, Escitalopram, Esketamine, Fluoxetine, Mirtazapine, Moclobemide, Nortriptyline, Paroxetine, Reboxetine, Sertraline, Venlafaxine, Vortioxetine
Antiepileptic	Brivaracetam, Cannabidiol, Carbamazepine, Cenobamate, Clonazepam, Eslicarbazepine Acetate, Felbamate, Fenfluramine, Lacosamide, Lamotrigine, Levetiracetam, Oxcarbazepine, Perampanel, Phenobarbital, Rufinamide, Stiripentol, Topiramate, Valproic Acid, Vigabatrin, Zonisamide

²⁴ National Board of Health and Welfare (2024). Läkemedelsförsäljning i Sverige – analys och prognos 2024–2027.

Antihistamines	Alimemazine, Azelastine, Fluticasone, Clemastine, Desloratadine, Ebastine, Emedastine, Fluticasone Furoate, Levocabastine, Meclozine, Mometasone, Olopatadine, Olopatadine, Phenylpropanolamine, Promethazine, Promethazine, Thiourea
Antihypertensive drugs	Ambrisentan, Amlodipine, Atenolol, Bendroflumethiazide, Bisoprolol, Bosentan, Bumetanide, Candesartan Cilxetil, Candesartan Cilxetil, Hydrochlorothiazide, Diltiazem, Doxazosin, Enalapril, Enalapril, Hydrochlorothiazide, Eplerenone, Eprosartan, Eprosartan, Hydrochlorothiazide, Felodipine, Felodipine, Metoprolol, Finerenone, Furosemide, Hydralazine, Hydrochlorothiazide, Hydrochlorothiazide, Losartan, Hydrochlorothiazide, Quinapril, Hydrochlorothiazide, Valsartan, Irbesartan, Lercanidipine, Losartan, Macitentan, Metoprolol, Nifedipine, Nimodipine, Propranolol, Ramipril, Riociguat, Sacubitril, Valsartan, Spironolactone, Tolvaptan, Valsartan, Verapamil
Antiparasitic Drugs - Others	Artemether, Lumefantrine, Artesunate, Atovaquone, Chloroquine, Hydroxychloroquine, Mebendazole, Mefloquine, Metronidazole, Pentamidine, Tinidazole
Antipsychotics	Aripiprazole, Cariprazine, Chlorprothixene, Clozapine, Haloperidol, Lurasidone, Melperone, Olanzapine, Paliperidone Palmitate, Paliperidone, Perphenazine, Quetiapine, Risperidone, Sertindole, Zuclophenthixol
Anxiolytics and sedatives	Clomethiazole, Melatonin, Midazolam, Nitrazepam, Propiomazine, Remimazolam, Zolpidem, Zopiclone
Asthma and COPD	Acidinium Bromide, Acidinium Bromide, Formoterol, Beclometasone, Formoterol, Beclometasone, Formoterol, Glycopyrronium, Budesonide, Formoterol, Budesonide, Formoterol, Glycopyrronium, Ciclesonide, Fluticasone Furoate, Umeclidinium Bromide, Vilanterol, Fluticasone Furoate, Vilanterol, Fluticasone, Formoterol, Fluticasone, Salmeterol, Formoterol, Formoterol, Glycopyrronium, Glycopyrronium, Indacaterol, Glycopyrronium, Indacaterol, Mometasone, Indacaterol, Indacaterol, Mometasone, Montelukast, Olodaterol, Olodaterol, Tiotropium Bromide, Salbutamol, Salmeterol, Terbutaline, Tiotropium Bromide, Umeclidinium Bromide, Umeclidinium Bromide, Vilanterol
Blood coagulation factors	Avatrombopag, Dabigatran, Efmoroctocog Alfa, Eftrenonacog Alfa, Eltrombopag, Epcizumab, Eptacog Alfa (Activated), Fostamatinib, Lonoctocog Alfa, Moroctocog Alfa, Nonacog Alfa, Nonacog Beta Pegol, Nonacog Gamma, Octocog Alfa, Romiplostim, Rurioctocog Alfa Pegol, Simoctocog Alfa, Susoctocog Alfa, Turoctocog Alfa Pegol, Turoctocog Alfa, Vonico Alfa
Cardiac therapy	Amiodarone, Dronedaron, Etilefrine, Flecainide, Isosorbide Mononitrate, Mavacamten, Mexiletine, Midodrine, Nitroglycerin, Propafenone, Vericiguat
CFTR-modulators	Elexacaftor, Ivacaftor, Tezacaftor, Ivacaftor, Ivacaftor, Lumacaftor, Ivacaftor, Tezacaftor
Cholesterol-lowering	Alirocumab, Atorvastatin, Atorvastatin, Ezetimibe, Bezafibrate, Colesevelam, Colestipol, Colestyramine, Ethyl-Eicosapent, Evolocumab, Ezetimibe, Fenofibrate, Gemfibrozil, Inclisiran, Rosuvastatin, Simvastatin
Contraceptives	Desogestrel, Dienogest, Estradiol, Dienogest, Ethinylestradiol, Drospirenone, Estetrol, Drospirenone, Ethinylestradiol, Ethinylestradiol, Levonorgestrel, Etonogestrel, Levonorgestrel
corticosteroids, dermat.	Betamethasone, Clioquinol, Betamethasone, Salicylic Acid, Clobetasol, Clobetasone, Fluticasone, Fusidic Acid, Hydrocortisone, Hydrocortisone, Oxytetracycline, Mometasone
Dermatology drugs - others	Adapalene, Adapalene, Benzoyl Peroxide, Afamelanotide, Alitretinoin, Azelaic Acid, Betamethasone, Calcipotriol, Clindamycin, Tretinoin, Econazole,

	Econazole, Triamcinolone Acetonide, Hydrocortisone, Miconazole, Isotretinoin, Ivermectin, Pimecrolimus, Terbinafine
Diabetes - GLP1	Dulaglutide, Exenatide, Liraglutide, Lixisenatide, Semaglutide
Diabetes - Insulins	Insulin Aspart, Insulin Aspart, Insulin Aspart Protamine Crystalline, Insulin Degludec, Insulin Degludec, Liraglutide, Insulin Detemir, Insulin Glargine, Insulin Glargine, Lixisenatide, Insulin Glulisine, Insulin Human Base, Insulin Human Base, Insulin Human Isophane, Insulin Human Isophane, Insulin Lispro, Insulin Lispro, Insulin Lispro Protamine
Diabetes - Other	Acarbose, Canagliflozin, Dapagliflozin, Dapagliflozin, Metformin, Dapagliflozin, Saxagliptin, Empagliflozin, Empagliflozin, Linagliptin, Empagliflozin, Metformin, Ertugliflozin, Ertugliflozin, Metformin, Ertugliflozin, Sitagliptin, Glibenclamide, Linagliptin, Linagliptin, Metformin, Metformin, Metformin, Pioglitazone, Metformin, Saxagliptin, Metformin, Sitagliptin, Metformin, Vildagliptin, Saxagliptin, Sitagliptin, Tirzepatide, Vildagliptin
Endocrine therapy	Abiraterone Acetate, Anastrozole, Apalutamide, Bicalutamide, Buserelin, Darolutamide, Degarelix, Enzalutamide, Fulvestrant, Goserelin, Letrozole, Leuprorelin, Medroxyprogesterone, Relugolix, Tamoxifen, Toremifene, Triptorelin
Eyes and Ears - Others	Hydrocortisone, Oxytetracycline, Polymyxin B
Gynecological agents	Bromocriptine, Fezolinetant, Quinagolide
Hematology - Others	Berotrastat, C1 Inhibitor (Human), Conestat Alfa, Icatibant, Lanadelumab, Tranexamic Acid
Immunoglobulins	Bezlotoxumab
Immunostimulatory	Filgrastim, Lenograstim, Lipegfilgrastim, Pegfilgrastim, Peginterferon Alfa-2a, Roppeginterferon Alfa-2b
Immunosuppressive - others	Azathioprine, Canakinumab, Ciclosporin, Diroximel Fumarate, Imlifidase, Lenalidomide, Methotrexate, Mycophenolate Mofetil, Mycophenolic Acid, Pirfenidone, Pomalidomide, Satralizumab, Siltuximab, Spesolimab, Tacrolimus, Thalidomide, Voclosporin
Incontinence	Darifenacin, Fesoterodine, Mirabegron, Oxybutynin, Tolterodine
Infectious Disease - Hepatitis C Medications	Elbasvir, Grazoprevir, Glecaprevir, Pibrentasvir, Ledipasvir, Sofosbuvir, Sofosbuvir, Sofosbuvir, Velpatasvir, Sofosbuvir, Velpatasvir, Voxilaprevir
Infectious Disease - HIV	Abacavir, Abacavir, Dolutegravir, Lamivudine, Abacavir, Lamivudine, Abacavir, Lamivudine, Zidovudine, Atazanavir, Cobicistat, Bictegravir, Emtricitabine, Tenofovir Alafenamide, Cabotegravir, Cobicistat, Darunavir, Cobicistat, Darunavir, Emtricitabine, Tenofovir Alafenamide, Cobicistat, Elvitegravir, Emtricitabine, Tenofovir Alafenamide, Dolutegravir, Dolutegravir, Lamivudine, Dolutegravir, Rilpivirine, Doravirine, Doravirine, Lamivudine, Tenofovir Disoproxil, Emtricitabine, Emtricitabine, Rilpivirine, Tenofovir Alafenamide, Emtricitabine, Rilpivirine, Tenofovir Disoproxil, Emtricitabine, Tenofovir Alafenamide, Emtricitabine, Tenofovir Disoproxil, Etravirine, Lamivudine, Lamivudine, Zidovudine, Raltegravir, Rilpivirine, Tenofovir Alafenamide, Tenofovir Disoproxil, Zidovudine
Migraine drugs	Atogepant, Dihydroergotamine, Eptinezumab, Erenumab, Fremanezumab, Galcanezumab, Rimegepant, Rizatriptan, Sumatriptan, Zolmitriptan
MS	Cladribine, Dimethyl Fumarate, Fampridine, Glatiramer Acetate, Interferon Beta-1a, Interferon Beta-1b, Peginterferon Beta-1a

Muscle relaxant	Chlorzoxazone, Orphenadrine, Paracetamol
Musculoskeletal System - Others	Allopurinol, Ataluren, Febuxostat, Nusinersen, Risdiplam
Nervous System - Others	Acamprosate, Ambenonium, Buspirone, Cinnarizine, Dimenhydrinate, Cytisinicline, Diazepam, Disulfiram, Hydroxyzine, Idebenone, Inotersen, Modafinil, Oxazepam, Patisiran, Pilocarpine, Piracetam, Pitolisant, Pyridostigmine, Solriamfetol, Tafamidis, Varenicline, Vutrisiran
Nervous system-dementia	Donepezil, Galantamine, Memantine, Rivastigmine
NOAC	Apixaban, Dabigatran Etxilate, Edoxaban, Rivaroxaban
NSAID	Dexibuprofen, Diclofenac, Diclofenac, Misoprostol, Etoricoxib, Ibuprofen, Ketoprofen, Nabumetone, Naproxen, Piroxicam Betadex, Tenoxicam
Oncology - others	Aminolevulinic Acid, Amivantamab, Anagrelide, Atezolizumab, Avelumab, Bevacizumab, Bexarotene, Blinatumomab, Brentuximab Vedotin, Busulfan, Cabazitaxel, Capecitabine, Carboplatin, Carfilzomib, Cemiplimab, Cetuximab, Chlorambucil, Chlormethine, Cytarabine, Daratumumab, Dostarlimab, Durvalumab, Elotuzumab, Enfortumab Vedotin, Epirubicin, Eribulin, Estramustine, Etoposide, Fludarabine, Fluorouracil, Fluorouracil, Salicylic Acid, Gemtuzumab Ozogamicin, Gimeracil, Oteracil, Tegafur, Idarubicin, Inotuzumab Ozogamicin, Ipilimumab, Irinotecan, Isatuximab, Ixazomib, Melphalan, Mercaptopurine, Methyl-5-Aminolevulinic Acid, Mitotane, Mogamulizumab, Niraparib, Nivolumab, Obinutuzumab, Olaparib, Paclitaxel, Panitumumab, Panobinostat, Pegaspargase, Pembrolizumab, Pertuzumab, Polatuzumab Vedotin, Ramucirumab, Rituximab, Sacituzumab Govitecan, Sonidegib, Sotorasib, Tafasitamab, Talazoparib, Talimogene Laherparepvec, Tebentafusp, Temozolomide, Tioguanine, Tipiracil, Trifluridine, Topotecan, Trabectedin, Trastuzumab Deruxtecan, Trastuzumab Emtansine, Trastuzumab, Tremelimumab, Treosulfan, Venetoclax, Vinorelbine, Vismodegib
Oncology - protein kinase inhibitor	Abemaciclib, Acalabrutinib, Afatinib, Alectinib, Alpelisib, Asciminib, Axitinib, Binimetinib, Bosutinib, Brigatinib, Cabozantinib, Capmatinib, Ceritinib, Cobimetinib, Crizotinib, Dabrafenib, Dacomitinib, Dasatinib, Encorafenib, Entrectinib, Erlotinib, Everolimus, Fedratinib, Gefitinib, Gilteritinib, Ibrutinib, Idelalisib, Imatinib, Lapatinib, Larotrectinib, Lenvatinib, Lorlatinib, Midostaurin, Neratinib, Nilotinib, Nintedanib, Osimertinib, Palbociclib, Pazopanib, Pemigatinib, Ponatinib, Pralsetinib, Regorafenib, Ribociclib, Ruxolitinib, Selpercatinib, Selumetinib, Sorafenib, Sunitinib, Tepotinib, Tivozanib, Trametinib, Tucatinib, Vandetanib, Vemurafenib, Zanubrutinib
Ophthalmologicals	Acetazolamide, Aflibercept, Apraclonidine, Betaxolol, Bimatoprost, Bimatoprost, Timolol, Brimonidine, Brimonidine, Brinzolamide, Brimonidine, Timolol, Brinzolamide, Brinzolamide, Timolol, Brolucizumab, Chloramphenicol, Dorzolamide, Dorzolamide, Timolol, Faricimab, Latanoprost, Latanoprost, Netarsudil, Latanoprost, Timolol, Nepafenac, Ranibizumab, Tafluprost, Tafluprost, Timolol, Timolol, Timolol, Travoprost, Tobramycin, Travoprost, Verteporfin, Voretigene Neparvec
Opioid addiction	Buprenorphine, Buprenorphine, Naloxone, Levomethadone, Methadone
Osteoporosis	Alendronic Acid, Alendronic Acid, Calcium, Colecalciferol, Burosumab, Clodronic Acid, Denosumab, Dibotermine Alfa, Pamidronic Acid, Risedronic Acid, Romosozumab, Teriparatide
Others	Abaloparatide, Abiraterone Acetate, Niraparib, Acetylsalicylic Acid, Caffeine, Citric Acid, Codeine, Sodium, Albutrepenonacog Alfa, Alogliptin, Angiotensin 2 (Human), Anifrolumab, Asparaginase Escherichia Coli, Asparaginase, Atidarsagene Autotemcel, Autologous Cd34+ Cells, Dipeptidyl Peptidase-4, Autologous Limbal Stem Cells, Avacopan, Avapritinib, Axicabtagene Ciloleucel, Baricitinib, Belimumab, Bempedoic Acid, Bempedoic Acid, Ezetimibe, Betula Alba, Birch Triterpenes,

	Brexpiprazole, Brexucabtagene Autoleucl, Caffeine, Orphenadrine, Propyphenazone, Canagliflozin, Metformin, Cedazuridine, Decitabine, Cenegermin, Chenodeoxycholic Acid, Chondrocyte, Ciltacabtagene Autoleucl, Cytarabine, Daunorubicin, Daridorexant, Darvadstrocel, Dasabuvir, Deferasirox, Deferiprone, Deferoxamine, Delafloxacin, Delamanid, Deucravacitinib, Difelikefalin, Dihydroergotamine, Etilefrine, Duvelisib, Eculizumab, Efgartigimod Alfa, Elacestrant, Eladocagene Exuparvovec, Elosulfase Alfa, Elranatamab, Epcoritamab, Eravacycline, Etranacogene Dezaparvovec, Evinacumab, Factor X, Filgotinib, Fingolimod, Fosdenopterin, Fosnetupitant, Palonosetron, Futibatinib, Ganaxolone, Glasdegib, Glofitamab, Glucarpidase, Idecabtagene Vicleucl, Inebilizumab, Inhaler Device, Isavuconazonium, Ivosidenib, Ketorolac, Phenylephrine, Lasmiditan, Lebrikizumab, Levosulpiride, Linzagolix, Lisocabtagene Maraleucl, Lonafarnib, Lonapegsomatropin, Loncastuximab Tesirine, Lumasiran, Lusutrombopag, Lutetium (177Lu) Vipivotide Tetraxetan, Maralixibat, Mecillinam, Mirikizumab, Mitapivat, Mosunetuzumab, Na, Naloxone, Natalizumab, Nivolumab, Relatlimab, Ocrelizumab, Ofatumumab, Olipudase Alfa, Ombitasvir, Paritaprevir, Ritonavir, Onasemnogene Abeparvovec, Oritavancin, Osilodrostat, Ospemifene, Ozanimod, Padeliporfin, Palopegteriparatide, Patiromer Calcium, Pegcetacoplan, Pegunigalsidase Alfa, Pegvaliase, Pegzilarginase, Pertuzumab, Trastuzumab, Pirtobrutinib, Polystyrene Sulfonate, Ponesimod, Pretomanid, Quizartinib, Ranolazine, Ravulizumab, Retigabine, Rezafungin, Ripretinib, Ritlecitinib, Rucaparib, Sebelipase Alfa, Selinexor, Sevelamer, Siponimod, Sirolimus, Somapacitan, SuCroferric Oxyhydroxide, Sugammadex, Sutimlimab, Tabelecleucl, Tagraxofusp, Talquetamab, Tasimelteon, Teclistamab, Tecovirimat, Teriflunomide, Tirbanibulin, Tisagenlecleucl, Tislelizumab, Tofacitinib, Ublituximab, Upadacitinib, Vadadustat, Valoctocogene Roxaparvovec, Vamorolone, Vedolizumab, Velmanase Alfa, Vestronidase Alfa, Volanesorsen, Vosoritide, Zilucoplan
Otologicals	Ciprofloxacin, Flucinolone Acetonide, Clioquinol, Flumetasone
Parkinson	Apomorphine, Benserazide, Levodopa, Biperiden, Carbidopa, Entacapone, Levodopa, Carbidopa, Levodopa, Foscarbidopa, Foslevodopa, Opicapone, Pramipexole, Ropinirole, Rotigotine, Safinamide, Selegiline, Tolcapone
Respiratory system- others	Acetylcysteine, Dornase Alfa, Gefapixant
Selected biological, anti-inflammatory compounds	Abatacept, Abrocitinib, Anakinra, Apremilast, Benralizumab, Bimekizumab, Brodalumab, Dupilumab, Guselkumab, Ixekizumab, Mepolizumab, Omalizumab, Reslizumab, Risankizumab, Sarilumab, Secukinumab, Tezepelumab, Tildrakizumab, Tocilizumab, Tralokinumab, Ustekinumab
Selected biological, TNF-inhibitor	Adalimumab, Certolizumab Pegol, Etanercept, Golimumab, Infliximab
Sex hormones - others	Choriogonadotropin Alfa, Chorionic Gonadotrophin, Corifollitropin Alfa, Cyproterone, Estradiol, Follitropin Alfa, Follitropin Beta, Follitropin Delta, Prasterone, Testosterone, Ulipristal Acetate, Urofollitropin
sex hormones- estrogen	Conjugated, Bazedoxifene, Estrogenic Substances, Estradiol, Medroxyprogesterone, Estradiol, Norethisterone, Norethisterone, Progesterone
Systemic antibacterials	Amikacin, Amoxicillin, Amoxicillin, Clavulanic Acid, Ampicillin, Avibactam, Ceftazidime, Aztreonam, Cefiderocol, Ceftazidime, Ceftolozane, Tazobactam, Ceftriaxone, Cilastatin, Imipenem, Relebactam, Ciprofloxacin, Clindamycin, Colistin, Dalbavancin, Doxycycline, Flucloxacillin, Fusidic Acid, Levofloxacin, Linezolid, Lyme cycline, Meropenem, Vaborbactam, Methenamine, Nitrofurantoin, Norfloxacin, Penicillin V, Pivmecillinam, Tedizolid, Teicoplanin

Systemic Anti-infectives - Others	Aminosalicic Acid, Amphotericin B, Bedaquiline, Ethambutol, Fluconazole, Isavuconazole, Isoniazid, Posaconazole, Rifabutin, Rifampicin, Voriconazole
Systemic anti-virals	Adefovir Dipivoxil, Baloxavir Marboxil, Bulevirtide, Entecavir, Famciclovir, Fostemsavir Trometamol, Lenacapavir, Letemovir, Maribavir, Nirmatrelvir, Ritonavir, Ribavirin, Valaciclovir, Valganciclovir, Zanamivir
Systemic Hormonal Preparations - Others	Betamethasone, Cetrorelix, Cinacalcet, Desmopressin, Dexamethasone, Estradiol, Norethisterone, Relugolix, Etelcalcetide, Fludrocortisone, Ganirelix, Glucagon, Hydrocortisone, Ketoconazole, Lanreotide, Lidocaine, Methylprednisolone, Mecasermin, Nafarelin, Octreotide, Parathyroid Hormone, Paricalcitol, Pasireotide, Pegvisomant, Prednisolone, Somatogon, Somatropin
Thyroid disease	Levothyroxine Sodium, Thiamazole
Urologicals	Alfuzosin, Alprostadil, Aviptadil, Phentolamine, Finasteride, Sildenafil, Tadalafil, Terazosin