MedicinesUK®

Biosimilar prescribing and substitution: A comparative study

A report from Medicines UK

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Introduction

Medicines UK has analysed European healthcare systems that have implemented INN [1] (or generic name) prescribing of biosimilars, or automatic substitution of biosimilars in community pharmacy.

This short study comes at an important time, as NHS England's biosimilar programme is delivering tangible successes, with one of the highest uptakes in Europe now consistently being achieved. High uptake levels are to be welcomed, and it is right to recognise the political and NHS system leadership, as well as the significant work done by health service colleagues at all levels, to enable the NHS to capitalise on biosimilar competition. NICE has identified £1.2bn in savings over the next 5 years from the NHS's use of biosimilars while simultaneously widening patient access. At a time when the NHS is evolving and efficiencies are being sought, this is an opportunity not to be missed.

We are therefore delighted that NHSE has committed to earlier horizon-scanning and communication about the tendering process, as well as to running tenders earlier so that awards are typically made six months before the start date for biosimilar market entry. This builds on MHRA's commitment to license new biosimilars within 180 days and NICE's resolution to support biosimilar (and generic) patient access. NHSE is now looking at how to build on this success, and INN prescribing of biosimilars is one option being considered. To inform these considerations, Medicines UK has looked at the extent to which this occurs across Europe.

This report, based on our findings, is intended to provide readers with a quick comparative overview to inform UK policymaking, rather than an exhaustive account of biosimilar prescribing. In February and March 2026, we conducted structured interviews [2] with representatives of the generic and biosimilar trade associations covering Denmark, Finland, France, Germany, Greece, the Netherlands, Norway and Poland – nations that practise biosimilar INN prescribing or retail pharmacy substitution according to the 2025 review of the biosimilar medicines markets by Medicines for Europe [3].

Wider comparative analyses of biosimilar policies and uptake across Europe are available, most notably the AUGMENT European Commission study [4].

[1] International Nonproprietary Names.
[2] Interviews were conducted in English, written up, and verified with the interviewees.
[3] https://www.medicinesforeurope.com/wp-content/uploads/2025/06/Biosimilars-Market-Review-2025.pdfa
[4] Capacity building to support the uptake of biosimilars in a multistakeholder approach', published November 2025.

Report contributors

We wish to thank the following individuals and trade associations for their time and insights, which we were instrumental in preparing this report.

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Common features / lessons

Across the eight interviews we conducted for this report, there were several common features and interesting findings that are relevant to the considerations for the UK market which we summarise here.

Some European healthcare systems prescribe more biosimilars in hospitals, and some in a community setting, depending on where care and treatment specialists are located. Hospital biosimilar supply is universally tendered, with contracts usually lasting for 1-2 years. Here, substitution is effectively practised when supply begins, following the award of tenders. Supply then shifts to the company that wins the tender. In some countries, like Denmark, this shift is near instantaneous and total; in other countries it is less pronounced but still significant.

In community pharmacy, automatic substitution – where it is allowed – is often nascent. Even in those countries where it is practised, it seldom occurs or is only implemented annually, and in some cases it requires clinician consent. Therefore, the impact of automatic substitutability appears limited, or it is only effective in conjunction with other policies.

In primary care, switching sometimes does not occur due to contractual supply arrangements or a lack of incentives for health systems to switch (after the initial best-value biologic selection following originator loss of exclusivity). More often, however, it is because of clinical hesitancy to do so. In Greece, a distinction is made between patients already on a biologic treatment when the loss of exclusivity occurs (who are maintained on the originator brand) and new patients (who receive the biosimilar).

In some nations, co-payment exists (Denmark, Finland, Norway). In Denmark and Finland, patients are financially incentivised to use cost-effective versions, and biosimilars are a popular choice. France is introducing co-payment this year. In several European nations, particularly those where biosimilars offer 80%-plus discounts compared with the originator brand prior to loss of exclusivity, the sustainability of low pricing is being questioned, as well as whether this – together with tender structures that concentrate supply – will ultimately limit domestic market attractiveness. This is particularly the case given the number of biologics losing exclusivity over the next 5 years.

Finally, value-based procurement operates in Denmark and Norway, which appears to contrast with the price-driven approach elsewhere. Notably, these nations still achieve significant price erosion. Along with Finland (and the UK), they appear to have the greatest biosimilar uptake (commonly 80% or higher) among the European markets assessed. Among the countries valuing bids other than simply by lowest price, Denmark focuses on supply continuity, while Norway prioritises supply continuity alongside a strong environmental sustainability focus. NHSE is planning to adopt value-based procurement in secondary care generic tenders and potentially also for biosimilars.

Specific lessons to be drawn from this comparative analysis

· In secondary care tenders, the awarding of contracts, alongside clinician and health system acceptance to ensure adherence, appears to be the most significant driver of biosimilar uptake.
· Although automatic substitution could reduce NHS administration in switching (by not needing to notify the patient), we would argue that patients should be informed before taking a new brand of biologic, particularly after loss of exclusivity, when a switch is likely to occur for the first time. Patient reassurance is most likely to be required in new therapy areas.
· In primary care, automatic substitution is possible and is being introduced or scaled up in most of the countries we examined. But switching is happening on an irregular basis, often in recognition that biosimilars should not be treated as standard generics for clinical reasons.
· It is also important to note the different commercial drivers behind community pharmacy in the UK. Here, pharmacies are financially incentivised to choose the most affordable version. This dynamic is absent or less relevant in many of the other nations analysed, for example, because pharmacies pay the same, irrespective of the brand dispensed.
· As such, the use of INN prescribing in primary care – particularly in the UK's highly price-driven, competitive retail pharmacy market with regular generic switching – could lead to uncontrolled biosimilar switching. The experiences of denosumab, a biologic that lost exclusivity in November 2025, will be interesting, since it is a rare example of a biologic which patients are maintained on in primary care.

Our position on INN prescribing of biosimilars

Medicines UK supports the retention of brand prescribing of biosimilars because we believe that branding of biosimilar medicines is central to patient safety and acceptance.

We note that MHRA guidance clearly states that although biosimilars and their reference products are interchangeable, “the decision rests with the prescriber in consultation with the patient, in line with the principles of shared decision making; both need to be aware of the brand name of the product received” [5]. MHRA adopts this stance for certain types of products where there are clinical reasons and switching needs to be managed carefully.

Around 20% of patients do not respond to biologic medicines, including biosimilars [6]. A brand name makes tracing much easier for non-responders, in the case of adverse events, or when switching a patient back to a previous brand for clinical reasons. Indeed, MHRA states: “Accurate traceability of biosimilars by brand name and batch number must be assured in the post-marketing setting.” [7]

We also believe it is important for UK market attractiveness, both at the launch of a medicine and throughout its lifecycle, that biosimilars continue to be prescribed by brand.

[5] https://www.gov.uk/government/publications/guidance-on-the-licensing-of-biosimilar-products/guidance-on-the-licensing-of-biosimilar-products
[6] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807157
[7] https://www.gov.uk/government/publications/guidance-on-the-licensing-of-biosimilar-products/guidance-on-the-licensing-of-biosimilar-products

Denmark summary

Country	Type of health system	How are biosimilars supplied and dispensed?	Rate of biosimilar uptake
Denmark	Denmark provides free healthcare in public, regionally run hospitals, including the cost of medicines. In pharmacy, patients must pay up to a capped amount (ca. £500 per year), unless they tell the pharmacist they do not want the most cost-effective version.	Biosimilars have been tendered and supplied in hospitals for 10 years, based on a national recommendation for biosimilars to be used as equivalent therapeutic options and for both naive patients and those in established treatments to be normally treated with a biosimilar. These tenders are for one-year contracts, usually with two winners. Price is the predominant factor, but security of supply is also valued. The contracts determine which companies supply products. In 2025, the Danish medicines agency decided to start substituting biosimilars in community pharmacies to enhance competition and reduce the cost of biological medicines. So far, this has only applied to teriparatide, but insulin glargine and adalimumab are currently being considered.	In hospitals, uptake following contract changeover to the biosimilar is very high – over 90% within several weeks. Competition has resulted in 80%+ savings compared with the originator prior to loss of exclusivity. For primary care biosimilars, the market is in its infancy. Substitution is expected to be slower and more limited than is typical for generics.

Finland summary

Country	Type of health system	How are biosimilars supplied and dispensed?	Rate of biosimilar uptake
Finland	Finland's social security covers outpatient care. Pharmacies are reimbursed for the medicines they dispense on a sliding scale, with patients paying the remainder. Hospitals are state-financed, with two-year tenders for biosimilars.	Most biosimilars are prescribed in primary care, including those for rheumatoid arthritis, with hospitals providing infusions, such as to treat cancer. Biosimilars in hospitals are substitutable, with the switch occurring at contract changeover. Following low uptake, biosimilar retail substitution has been phased in since 2024. This started with enoxaparin for patients over 18 and now includes nearly all biosimilars (excluding short-acting insulins). Pens and injectables are not substitutable with each other. Doctors are required to prescribe the most affordable version of a medicine, which patients generally accept if they are co-paying. Assuming the prescriber has not blocked substitution for a clinical reason, pharmacists can dispense and substitute based on the brands they have purchased, but they must inform the patient of the most affordable option. Switching in primary care can occur every six months, though most patients are switched less frequently. These tenders are for one-year contracts, usually with two winners. Price is the predominant factor, but security of supply is also valued. The contracts determine which companies supply products. In 2025, the Danish medicines agency decided to start substituting biosimilars in community pharmacies to enhance competition and reduce the cost of biological medicines. So far, this has only applied to teriparatide, but insulin glargine and adalimumab are currently being considered.	The Finnish generic and biosimilar association believes that substitution, allied with co-payment and the forced reduction of prices based on the cheapest on the market, has led to some originators exiting. This has subsequently increased biosimilar uptake rates. Biosimilar outpatient uptake is thought to be around 80%. The association is expected to have more conclusive views on the success of substitution by the end of 2026. For example, substitution only started for rheumatoid arthritis medicines in April 2025.

France summary

Country	Type of health system	How are biosimilars supplied and dispensed?	Rate of biosimilar uptake
France	France's public health insurance system covers a large share of healthcare costs, reimbursing around 70% of outpatient care and 80% of hospitalisation costs, based on regulated tariffs. In some situations, such as for long-term chronic conditions, pregnancy, or low-income individuals, up to 100% of costs may be covered. Remaining costs are usually partly or wholly covered by complementary private health insurance ("mutuelle"), which is often provided to employees through employers but can also be purchased individually. Hospital care in France is mainly delivered by public hospitals, complemented by a substantial network of private hospitals and clinics.	Where possible, patient care and, consequently, biosimilar prescriptions are administered in the community. Medicines are tendered in secondary care, with a free market and short-term pricing in community pharmacy. Biosimilar substitution was introduced in 2022 for a few products and extended in 2025. Additional biosimilar treatments can be added to the substitutable list after one year of biosimilar availability (starting in 2026). Doctors can forbid pharmacy substitution. However, from late 2026, doctors will have to prescribe by INN and justify decisions to forbid a switch from the originator. Patients will not have to pay and will be reimbursed for biosimilars (payments will be managed away from patients). Biosimilar manufacturers can offer pharmacists discounts of up to 20% (up to 40% for generics) to promote product stocking. A 2023 European Medicines Agency report stating that there is no loss of efficacy or safety from using biosimilars compared with the reference product has proved influential in pushing these changes.	The long-term aim of the government has been to reach 80% biosimilar penetration. However, in 2024 (the most recent data), average biosimilar uptake was 47% (90% in hospitals, 34% in retail). To approach this target, substitution policies are being enacted in 2026, along with enforced price cuts. As a result, annual savings of €100m are targeted from biosimilar use. The priority is to encourage biosimilar switching from the originator, rather than seeking savings from subsequent tenders later in the lifecycle.

Germany summary

Country	Type of health system	How are biosimilars supplied and dispensed?	Rate of biosimilar uptake
Germany	Germany operates a health insurance policy system split between public and private insurance. Insurers, known as sickness funds, cover all prescription medicine costs with a small fixed co-payment charge. Generic and biosimilar drug companies supply medicines mostly through tenders and open contracts operated by the sickness funds.	More care and treatments are delivered and prescribed in the community than in the UK, owing to the location of clinicians in community care settings. Biosimilars are given in hospitals, but patients are swiftly moved to community settings, and so the treatment cost also follows. Biosimilar substitution at the pharmacy level has been mandatory since 1 April 2026 (including for parenteral treatments since mid-2024). There is a focus on both improving biosimilar uptake following loss of exclusivity and extracting more value from mature biosimilar markets.	While competition has resulted in 80%+ savings in some markets compared with the originator prior to loss of exclusivity, the rate of biosimilar uptake varies considerably with the treatment area. Overall, average biosimilar uptake in December 2025 was 30-40% over multiple biosimilars [8]. Although substitution facilitates switching from the originator to biosimilars, the rate of follow-on switching to other biosimilars is limited. [8] IQVIA, 2025.

Greece summary

Country	Type of health system	How are biosimilars supplied and dispensed?	Rate of biosimilar uptake
Greecee	Most hospitals in Greece are government-run, with the state authority buying medicines on behalf of the country's ca.120 hospitals. Primary care is funded through social security contributions, while private healthcare insurance is also available.	No biosimilar substitution is recommended in Greece, although it occurs in hospitals, such as for injections (where hospitals may have several brands for supply security reasons). Most biosimilars are dispensed by government pharmacies (subcutaneous drugs and those administered in primary care). They are purchased through an agreement between pharmaceutical companies and the social security fund. Patients are usually maintained on the brand they first receive and cannot be switched if the prescription is branded. Pharmacies distribute biosimilars to new patients. The market uptake of denosumab, set to be the first biosimilar available for private pharmacies, will be instructive.	Biosimilar uptake is thought to be around 50%, excluding several biosimilar molecules that the originator decided not to tender for.

The Netherlands summary

Country	Type of health system	How are biosimilars supplied and dispensed?	Rate of biosimilar uptake
The Netherlands	The Netherlands operates mandatory healthcare insurance, which covers citizens for essential care. In primary care, the GP is the point of entry and referral. Hospitals are semi-privately run, but not for profit, and are also supported by the health insurance system.	Health insurers reimburse medicines at the lowest price. Pharmacists are only reimbursed (by health insurers) for dispensing the medicines. The 110 hospitals in secondary care form buying groups to run tenders. Biosimilars are usually only available through hospital pharmacies. Biosimilars are regarded as substitutable in secondary care. In practice, hospitals buy from the contracted winner of the tender. The government is planning to reform the regulated pharmacy market for primary care by 2030.	In hospitals, uptake following contract changeover to the biosimilar is very high – over 90% within several weeks. Competition has resulted in 85%+ savings compared with the originator prior to loss of exclusivity.

Norway summary

Country	Type of health system	How are biosimilars supplied and dispensed?	Rate of biosimilar uptake
Norway	Norway has a state-run hospital system with medicines wholly paid for by the government. Citizens pay a nominal sum to access primary care, such as appointments with GPs. Prescription medicines are largely reimbursed by the state, but there is a co-payment element.	The hospital sector is the largest purchaser of biosimilars (but patients can collect them from community pharmacies). This approach is working smoothly, in large part driven by the authorities strictly applying MEAT [9] criteria. In Norway, 25% of the award is based on price, 30% on environmental factors and 45% on security (MEAT was first applied to antibiotics). Substitution is made at contract changeover. Norway has implemented substitution in primary care alongside a stepped three-stage discount process. Products can be substituted, but this is rare since manufacturers and wholesalers tend to establish long-term contracts. Clinicians nearly always prescribe the originator, but wholesalers stock the biosimilars since pharmacies have to provide the patient with them. Patients who want the originator must pay the price uplift. [9] Most economically advantageous tender.	Biosimilar switching in hospitals is 95-97%. Biosimilar uptake in primary care is very high (often 90% within three months). Competition is limited, partly due to a stepped and significant discount system. Overall, the stepped discount system reduces prices by 80-90% compared with pre-loss of exclusivity. This system is being reviewed to establish whether it is supporting competition and long-term market sustainability.

Poland summary

Country	Type of health system	How are biosimilars supplied and dispensed?	Rate of biosimilar uptake
Poland	Poland operates a statutory health insurance model, with citizens automatically contributing through wage deductions to the National Health Fund (NFZ) overseen by the Ministry of Health. Municipalities oversee primary care, with different levels of regional authorities managing larger and smaller hospitals. The constitution guarantees equal access, though private healthcare can be used to bypass waiting times, especially for outpatient care.	Following specialist-led prescribing and hospital or pharmacy dispensing, the NFZ reimburses the use of biosimilars. Most biosimilars in Poland are only administered at hospitals and are supplied through lowest-price, single-winner tenders organised at hospital or regional level. Biosimilar supply is therefore closely linked to tendering outcomes: the company winning the tender becomes the primary supplier for that hospital or programme (including outpatient specialist clinics attached to hospitals and NFZ drug programmes with strict eligibility criteria). Some biosimilars – particularly insulins, hormones, and less complex biologics – are dispensed through retail pharmacies. These products follow the same rules as generics: pharmacists can dispense reimbursed products according to NFZ pricing and substitution rules. However, automatic substitution for biologics is not regularly practised, and switching decisions are typically made by specialists within hospital programmes.	Poland's biosimilar uptake is low compared with other European countries. However, uptake has translated into major savings and expanded access. Variation persists in newer or more complex biologics, where clinician confidence and tender dynamics play a larger role than substitution freedom.

Medicines UK represents the interests of UK-based manufacturers and suppliers of generic and biosimilar medicines. We promote the development and understanding of this vital sector, which supplies four out of five NHS prescription medicines.
Find out more at www.medicinesuk.com or contact us at info@medicinesuk.com

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