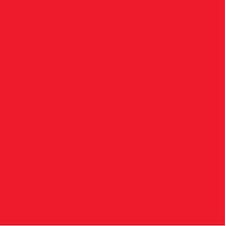


Facts and figures 2002



Contents

'Facts and Figures 2002': a brief sketch	7
Chapter 1	
Expenditure on pharmaceutical aid	11
1.1 Expenditure up 11%	11
1.2 The costs of drugs	14
1.3 Causes of structural growth	15
1.4 Good runners	23
1.5 Market shares per product group	30
1.6 Pharmacy fees	34
Chapter 2	
Cost control	37
2.1 Purple I, first social-liberal cabinet: 1994-1998	37
2.2 Purple II, second social-liberal cabinet: 1999-2002	38
2.2.1 'Claw back'	40
2.2.2 Dismantlement GVS	42
2.2.3 Incentives measure	44
2.2.4 Non-WTG	45
2.2.5 Haemostatics	46
2.2.6 SFK prognosis 2002	46
Chapter 3	
Drug consumption in a European perspective	47
Chapter 4	
The community pharmacy in figures	50
4.1 Turnover community pharmacy	51
4.2 Gross profit percentage	53
4.3 Pharmacy practice costs	54
Chapter 5	
Drug expenditure per person in 2001	61

Foundation for Pharmaceutical Statistics

Since 1990, the Foundation for Pharmaceutical Statistics (Stichting Farmaceutische Kengetallen, SFK) has been collecting and analysing exhaustive data about the use of pharmaceuticals in the Netherlands. The SFK directly gathers its data from a panel of pharmacies. At the moment, more than 1,411 of the 1,631 community pharmacies in our country are represented on this panel. The roughly 1,400 pharmacies on the panel combined serve 13 million people in the Netherlands, dispensing drugs, medical aids or bandages 120 million times a year. For each dispensation, the SFK registers information about the drug or medical aid supplied, the dispensing pharmacy, the health insurance company that either does or does not reimburse the dispensation, the prescribing doctor and the patient for whom the prescription was issued. With this, the SFK has the most elaborate collection of data in this field in The Netherlands. Thorough validation routines and well-tried statistical procedures guarantee the high quality and representativeness of the SFK-data.

The figures mentioned in this publication represent the nation-wide consumption of drugs and medical aids via community pharmacies. The figures are determined using a stratification technique developed by the SFK. This technique does not only make use of the data supplied by pharmacies that are affiliated with the SFK, but also of available information from non-participating pharmacies. The technique among other things takes into account the size of the patient population and the geographical location of the pharmacy.

Privacy

With regard to the registration of data concerning drug consumption, the SFK pays a great deal of attention to the privacy of the parties involved. Privacy regulations guarantee the privacy of the participating pharmacists. With regard to the prescribing doctor and the patient, the SFK only uses anonymously gathered data. The identity of the doctor remains hidden from the SFK through a special code that all participating pharmacies individually enter into their pharmacy computer systems.

Information from all the different doctors and pharmacies can only be linked if all parties involved authorise the SFK to do so in writing. In an increasing number of regions, the SFK supports cooperation structures of pharmacists and physicians, in which drug consumption data can be mutually exchanged via a Data Warehouse that is accessible through the SFK-intranet.

The patient's identity always remains hidden from the SFK, because the SFK uses the serial number allocated to the patient in question in the pharmacy. The SFK cannot match the numbers and the individual persons. Of course, the pharmacy knows the identity of its own patients, but this information is not passed on to the SFK.

Participation SFK

All community pharmacies in the Netherlands can participate in the SFK with no costs attached. In cooperation with the Dutch Association of Hospital Pharmacists and in consultation with the Dutch Association of Hospitals, the SFK is also working on the implementation of a nation-wide monitoring system for intramural drug dispensation via hospital pharmacies. Pharmacists who supply the SFK with information receive each quarter a written monitor report. In addition, these pharmacists can freely access up-to-date and detailed data regarding drug consumption in their own practice as management information for their own business or as 'mirror information' for pharmaco-therapeutical consultations with physicians via the SFK Data Warehouse.

In order to monitor the efficiency of drug consumption and to support practice-oriented programmes in the field of pharmaceutical patient care and the Pharmaco-Therapeutical Consultation, the SFK offers made-to-measure reports via the Internet for a fee. The SFK cooperates with the Scientific Institute of Dutch Pharmacists (Wetenschappelijk Instituut Nederlandse Apothekers, WINAp) and the Dutch Institute for Responsible Drug Consumption (Nederlands Instituut voor Verantwoord Medicijngebruik, DGV) regarding the drawing up of these 'Web reports'.

Used definitions

With the costs of drugs, the SFK means the costs at pharmacy fee price (WTG drugs) respectively the costs at pharmacy purchase price (non-WTG drugs), as registered in the G-Standard of Z-Index.

The drug expenditure entails the total drug costs and pharmacy fees.

With dispensations to private individuals, all dispensations to people who do not have National Health Insurance are meant. This means that all dispensations to people without insurance are registered as being private dispensations.

All expenditures in this publication concern the statutorily insured drug package and do not include VAT, unless stated otherwise. The VAT for prescription drugs is 6%. The amounts mentioned are in euros, unless stated otherwise.

List of used abbreviations

VAT	Value Added Tax
CBS	Central Statistical Office
CPB	Government Body for Central Planning
CTG	National Health Tariffs Authority
CVZ	Health Insurance Committee
DDD	Defined Daily Dose
FT(T)O	Pharmaco-Therapeutical (Transmural) Consultation
GVS	Drug Reimbursement System
KNMP	Royal Dutch Association for the Advancement of Pharmacy
PMA	Pension Fund Pharmacy Employees
PWC	PriceWaterhouseCoopers
RIVM	State Institute for Public Health and the Environment
SBA	Foundation Industrial Fund Pharmacies
SFK	Foundation for Pharmaceutical Statistics
VJA	Association of Young Pharmacists
VWS	Ministry of Public Health, Welfare and Sports
WINAp	Scientific Institute of Dutch Pharmacists
WTG	Health Care Charge Act
ZN	Dutch Health Insurers

'Facts and Figures 2002': a brief sketch

Drug expenditure up 11%

Through the community pharmacies, € 3,419 million was spent on drugs in 2001. This is an increase of € 327 million or 10.6% compared to 2000. The increase is predominantly attributable to cardiovascular drugs (€ 75 million), drugs concerning the central nervous system (€ 56 million), gastrointestinal drugs (€ 48 million) and drugs aimed at the respiratory system (€ 31 million).

Prognosis for 2002

The Foundation for Pharmaceutical Statistics (SFK) expects that the amount spent on drugs and medical aids through community pharmacies will increase by 9.9% to € 3,757 million in 2002. Besides structural growth factors, the adjustment of the fixed fee per prescription to € 6.00, the becoming available of a generic substitute for omeprazol and a further decreasing market share of dispensing physicians (currently 9.3%) have been taken into account in this prognosis; the introduction of the differentiated 'claw back' was not.

Causes of growth

The increase in the amount spent on drugs is a structural phenomenon, attributable to demographic factors (population growth and ageing), a shift in drug consumption towards newer, generally more expensive drugs, the admittance of new drugs to the statutorily insured drug package and the shift of care from hospitals to homes. In addition, the increased market share of community pharmacies at the expense of dispensing physicians influences the increased drug expenditure at community pharmacies.

Handing-in of purchasing advantages

Supplementary to the Long-Range Agreements with the curative sector, the Minister of Public Health in October 1999 entered into a covenant with the Royal Dutch Association for the Advancement of Pharmacy (KNMP). The main focal point within the framework of the so-called 'Basic Agreement' was the handing-in of purchasing advantages obtained by pharmacists (amounting to € 193 million in 2002) in exchange for a more cost-effective fixed fee per prescription (as much as € 50 million in 2002). This agreement has proven to be the most effective measure aimed at cost reduction in the drug dossier of the second Social-Liberal government.

Differentiated 'claw back'

In April 2002, the Ministry of Public Health, Welfare and Sports (VWS) and the KNMP agreed to use a higher 'claw back' percentage (20%) for generic drugs than for branded drugs and other drugs (5.6%). To boost price

competition between suppliers of drugs, it was also agreed to abolish the lowest price regulations for generic drugs and pharmaceutical imports. In addition, the 'claw back' disappears if a supplier of drugs charges a pharmacy purchasing price that is 20% (for generic drugs) or 5.6% (for branded drugs and other drugs) lower than the pharmacy purchasing price of the drug in question in January 2002.

Haemostatics

From the first of January 2002, the treatment of haemophiliacs has been limited to specially designated treatment centres. The extramural claim on drugs with blood coagulation factors, a subsection within the field of haemostatics, has disappeared. In 2001, community pharmacies still dispensed for € 10 million worth of haemostatics. The costs of these drugs have been part of the budget for hospital care since the first of January 2000.

At the expense of the patient

Within the framework of the Drug Reimbursement System (GVS), the Ministry of VWS clusters therapeutic drugs that are mutually interchangeable. For each cluster, the Ministry sets a reimbursement limit. If a patient uses a drug that exceeds the corresponding limit, he has to cover the price difference himself. Where necessary, most drug manufacturers adjust their prices to the lower reimbursement limits.

Because of this, it does not often occur that a patient needs to make a supplementary payment for a drug. Patients on average pay 3.4% of the total drug expenditure themselves. Besides an amount of € 100 million for drugs that are in no way eligible for reimbursement, € 18 million was paid extra as part of the Drug Reimbursement System in 2001.

Dismantlement GVS

The Ministry of VWS has the intention to transform the GVS from a system for reimbursement to a system for prescribing. Initially, the Ministry wanted to completely abolish with the system. This however entails substantial financial risks. If the GVS is abolished, it is not unimaginable that the prices of drugs will substantially go up; because drug manufacturers will raise their prices to the level of the maximum prices, this will lead to a cost increase of between € 300 million to € 400 million per year. One in three prescription drugs has no maximum price. Due to the lack of opposition, suppliers of these drugs are free to raise their prices to the level they want. According to the Ministry of VWS, the Drug Reimbursement System will continue to exist as a therapeutic reference system. From the point of view of VWS,



physicians, pharmacists and health insurance companies can use the system in the future to make agreements regarding the prescription and purchasing policy.

More generic drugs

Despite the fact that more and more generic drugs are dispensed by pharmacists (42% of all dispensations), the savings attached to this are declining. This apparent contradiction can be explained by the decreasing price difference between generic drugs and original branded drugs. Where up till some years ago a price difference of 20% between branded and generic drugs was common, the average price difference at the moment amounts to hardly 4%. The introduction of the differentiated 'claw back' will increase the price difference between branded and generic drugs, which means fresh incentives for making agreements regarding substitution.

Low drug consumption

From a European perspective, not a lot of money is spent on drugs in the Netherlands. In 2000, the Dutch spent € 231 per person on drugs (including over-the-counter sales). This amount is 25 to 40% below the spending pattern in countries such as Germany (€ 304), Belgium (€ 346), and France (€ 381).

The average pharmacy

The average community pharmacy serves a patient population of 9,000 persons. Annually, it dispenses drugs 78,000 times for a total amount of € 2,1 million.

Staff shortage

An increasing number of pharmacist's assistants prefer to work part-time. Despite the fact that the number of working pharmacist's assistants has increased by 423 to 13,023 over the last year, the staff capacity (measured in available hours) of the average pharmacy has decreased. Combined with the structural increase in drug consumption and the increase in the number of pharmacies in our country, this is one of the most important explanations for the existing shortage of pharmacist's assistants and the increasing working pressure in pharmacies.

From a historic point of view, the working pressure has never been as high as now. Several pharmacies are confronted with a substantial number of job openings that are difficult to fill. Research by the SFK has shown that 35% of community pharmacies have a vacancy for a pharmacist's assistant.



One in five job openings has been open for a year or longer. On average, it takes almost half a year for a pharmacy to find a pharmacist's assistant. One in ten pharmacies is looking for a second pharmacist.

1 Expenditure on pharmaceutical aid

1.1 Expenditure up 11%

In 2001, € 3,419 million was spent on drugs via the community pharmacies, an increase of 10.6% compared to 2000. The year before that, the increase in drug expenditure remained limited to 7.8% in our country; the Ministry of VWS was able to significantly curb the amount spent on drugs by legally compelling pharmacists to pass on more discounts in the drug prices they can charge to patients or health insurance companies.

In 2001, the 'claw back' measure still had a certain reducing effect on the amount spent, but no longer on the expenditure growth. The increase of 10.6% corresponds with the structural increase in drug expenditure. Of the expenditure growth of € 327 million, 64% can be attributed to four groups of drugs, namely cardiovascular drugs (€ 75 million), drugs aimed at the central nervous system (€ 56 million), gastrointestinal drugs (€ 48 million) and drugs aimed at the respiratory system (€ 31 million).

The relative increase in expenditure is the highest for drugs aimed at blood and blood cell producing organs. In 2001, € 105 million was spent on such drugs against € 90 million in 2000. This is an increase of € 15 million or 16.5%. This amount also includes the costs of haemostatics (€ 10 million). From the first of January 2000, claims regarding haemostatics, which are used for the treatment of haemophiliacs, fall under the law Special Medical Operations. Because of this, the amounts spent on these drugs no longer fall under the budget for drug distribution via community pharmacies and dispensing physicians, but under the budget for hospital care.

Despite this, these drugs were for the most part however still supplied by community pharmacies. According to the Health Insurance Committee (CVZ), the total costs of haemostatics in The Netherlands amounted to roughly € 35 million.

From the first of January 2002, the treatment of haemophiliacs has been limited to specially designated treatment centres. The extramural claim on drugs with blood coagulation factors, a subsection within the haemostatics, has disappeared.

Besides the above-mentioned expenditure, which solely applies to drugs that are part of the statutorily insured drug package, the community pharmacies in 2001 also supplied € 100 million worth of self-care drugs. These are drugs that are not directly eligible for reimbursement by the health insurance company (they however are sometimes reimbursable through a supplementary insurance policy). The list of drugs the patient has to pay for herself or himself is headed by the same three drugs as in

2000: the potency pill sildenafil (Viagra®) with € 8 million, the slimming product orlistat (Xenical®) with € 4 million and the anti-smoking drug bupropion (Zyban®) with € 4 million.

A surprising climber on the list of non-reimbursed drugs is the meningococcus vaccine. With € 1.8 million, it is fifth on the list of 'amounts spent in 2001'. In total, some 46,000 vaccines were dispensed. The use of the meningococcus vaccine is directly linked to the appearance of the contagious and deadly meningococcus disease in the region of West-Brabant in August of 2001.

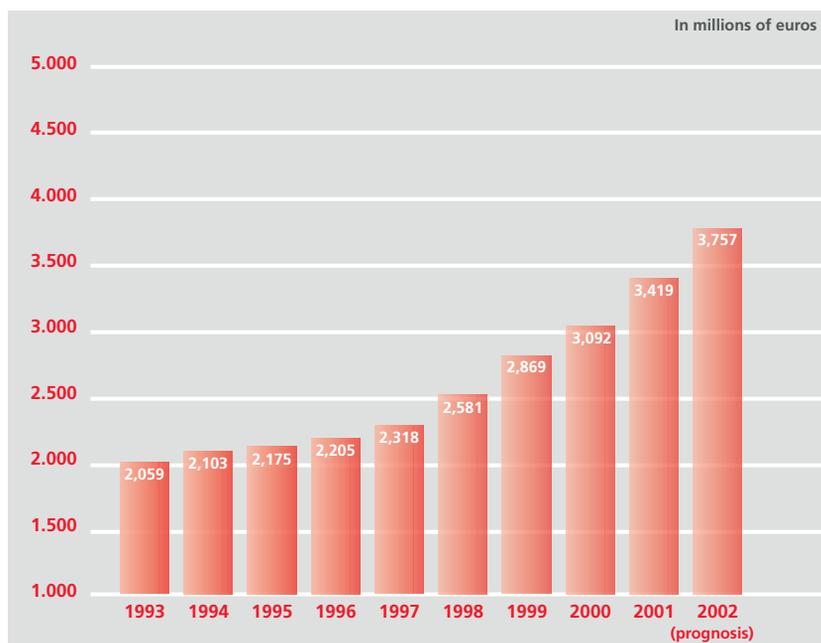
Especially in West Brabant, but also in the rest of the province North Brabant, large-scale vaccination campaigns were staged, in which more than 30,000 vaccines were dispensed by community pharmacies. The Minister of Public Health now wants to start with the vaccination of all children aged between 14 months and 18 years in June of 2002. With this, she follows the advice of the Health Council. In addition, the vaccination against meningococcus C will be part of the State Vaccination Programme from the first of September 2002. Vaccinating all 0 to 18-year-olds will expectedly cost roughly € 80 million. After that, the vaccination of young babies will cost roughly € 5 million per year. This vaccination scheme by the way does not take place via the pharmacies, but via the various Municipal Health Services (GGD).

The expenditure development in the national health insurance sector roughly runs parallel with that in the private insurance sector. In the national health insurance sector, expenditure increased by 10.5 % in the last year; for the private sector, this was 10.9%. The Health Insurance Committee registered 10,275,000 people with compulsory medical insurance in the middle of 2001.

The number of privately insured people (in the sense of non-National Health Service) amounted to 5,712,000. Of the total population, 14.5 million people (90.7%) are served by the community pharmacies. The rest of the population has to turn to dispensing physicians.

The SFK expects that the amount spent on drugs in community pharmacies will increase less in 2002 than it did in 2001. The SFK foresees an increase of 9.9% to € 3,757 million.

1.01 Total expenditure on pharmaceutical aid: community pharmacies



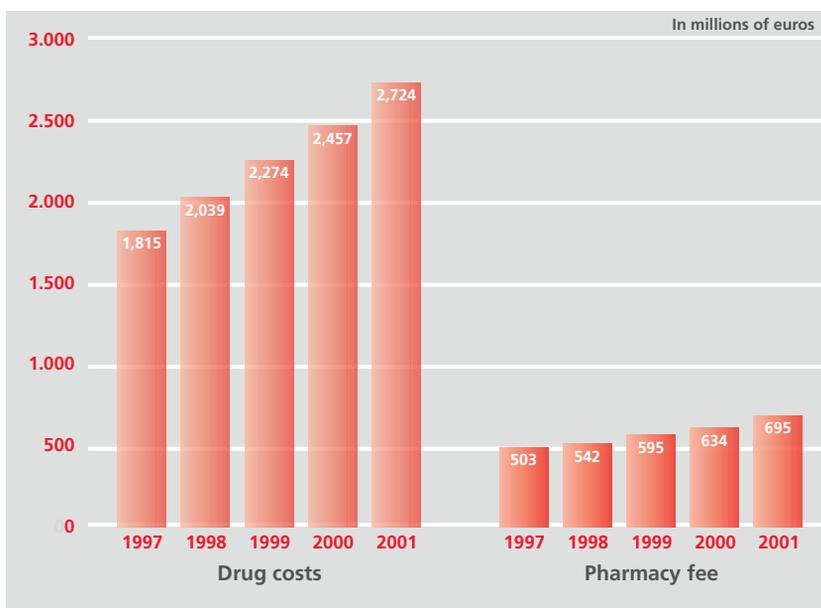
Source: Foundation for Pharmaceutical Statistics

1.2 The costs of drugs

Regarding the expenditure on pharmaceutical aid, two components can be distinguished.

- 1 The costs of drugs at pharmacy (purchase) price that may be passed on to the patient by the pharmacy.
- 2 The fee for the service of the pharmacy; this fee is closely related to the number of prescriptions.

1.02 Drug costs and pharmacy fee: community pharmacies



Source: Foundation for Pharmaceutical Statistics

With 79.7%, the costs of drugs by far account for most of the total expenditure on pharmaceutical aid. In 2001, drug costs increased by almost € 268 million to € 2,724 million; between 1996 and 2001, drug costs increased by a total of 57.9%. This corresponds with an average annual increase of 9.6%. The introduction of the 'claw back' in 1998 and the increase of this in 1999 and 2000 (price-lowering effect of 6%) have curbed the growth of drug costs in this period. In addition, the transfer of the influenza vaccination programme from pharmacies to physicians in 1997 and the fact that since 1999 self-care medication for incidental use is no longer reimbursed, resulted in limited savings on the pharmaceutical aid

budget. Without the measures mentioned above, the cost increase would have amounted to 11% per year.

The pharmacy fee amounted to € 695 million in 2001. This is an increase of € 61 million or 9.5% compared to 2000. The increase in the pharmacy fee is predominantly attributable to the 5.4% increase in the fixed fee per prescription from € 5.38 to € 5.67. This adjustment follows on the 'Basic Agreement' agreed upon by the Minister of VWS and the Royal Dutch Association for the Advancement of Pharmacy (KNMP) on the 8th of October 1999.

In relation to the raising of the discount percentage of 6.82% that pharmacists are obliged to pass on in the price of drugs (with a limit of € 6.80 per dispensed drug), this agreement entails a phased tariff increase between 2000 to 2002 (also see paragraph 1.6 and paragraph 2.2.1.).

1.3 Causes of structural growth

Without taking into account the effects of any economic measures, the amount spent on drugs structurally increases roughly 11% per year. This continuous rise in expenditure on pharmaceutical aid is mainly attributable to six structural growth factors, namely:

- growth of the Dutch population;
- ageing of the Dutch population;
- shift in health care services from the hospital to the home;
- shift in consumption pattern to newer, often more expensive drugs;
- admission of new drugs to the statutorily insured drug package;
- changed prescription and consumption behaviour.

Growth of the Dutch population

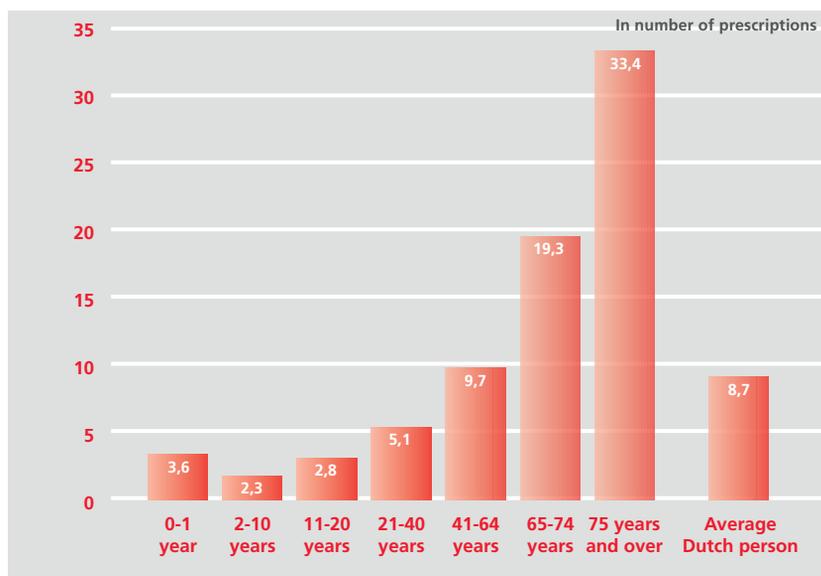
According to data by the Central Statistical Office, the Dutch population increased by 0.8% in the last year. The population grew from 15,864,000 in 2000 to 15,987,000 in 2001.

Ageing of the Dutch population

At the moment, there are 2,199,000 people aged 65 or over in The Netherlands. This corresponds with 13.7% of the total population. According to the Central Statistical Office, the number of elderly persons in our country will have risen to 2,500,000 persons by the year 2010. SFK-research shows that the ageing of the Dutch population leads to an annual increase of 0.6% regarding the amount spent on pharmaceutical aid. Dutch people aged 65 or over consume 2.9 times as many drugs as the average Dutch person. For people aged 75 or over, the consumption level even increases to fourfold the level of the average Dutchman. The higher drug consumption among the elderly is reflected in a proportionally higher drug expenditure.

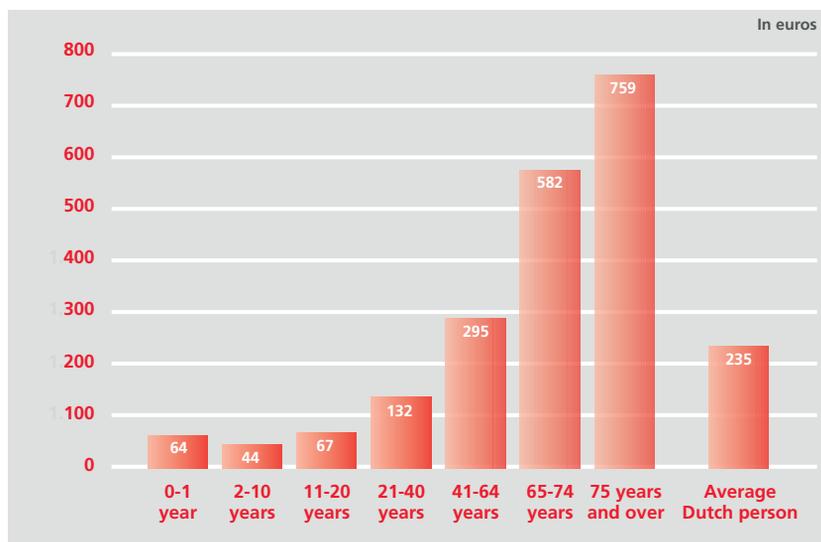
Of the € 1,308 million spent by people aged 65 or over in community pharmacies in 2001, most went to drugs for abundant acidity of the stomach, cholesterol-lowering drugs and drugs to reduce high blood pressure levels. Absolute topper is the drug omeprazol (Losec®), on which persons from the age group in question spent € 105 million. This drug is followed by simvastatine (Zocor®) with € 53 million and enalapril/enalapriilaat (Renitec®) with € 26 million. Some of the drugs most frequently used by elderly people are the sleep-inducing drug temazepam (1,3 million prescriptions), the blood-diluter acetylsalicylic acid (1,3 million prescriptions), the tranquilliser oxazepam (1,2 million prescriptions), the diuretic pill furosemide (1,2 million prescriptions) and the pain killer paracetamol (1,1 million prescriptions).

1.03 Drug consumption per age group in 2001



Source: Foundation for Pharmaceutical Statistics

1.04 Drug expenditure based on age in 2001

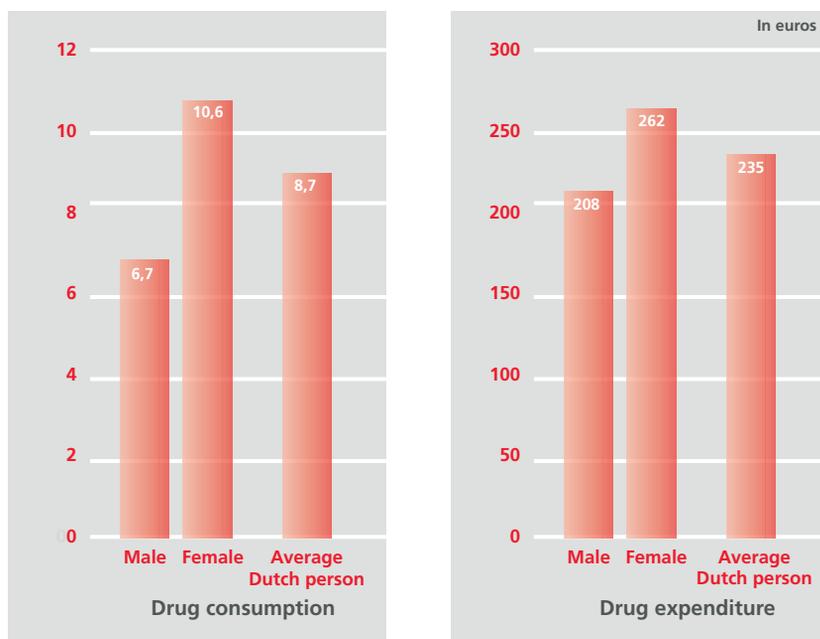


Source: Foundation for Pharmaceutical Statistics

In general, women tend to use more drugs than men. In 2001, community pharmacies dispensed 78 million times drugs to women against 48 million drugs to men. Drug consumption among women is therefore 1.6 times as high as among men. This difference can only to a very limited extent be attributed to the use of the contraceptive pill.

In 2001, community pharmacies dispensed the pill 3.9 million times. This corresponds with 5% of all dispensations to women. The fact that women have a higher life expectancy also has a limited effect. For all age groups – except for the category ‘young children’ – drug consumption among women is higher than among men.

1.05 Drug consumption (in number of prescriptions) and expenditure based on gender in 2001



Source: Foundation for Pharmaceutical Statistics

Shift in health care services from the hospital to the home

According to the Central Statistical Office (CBS), the number of hospital treatment days decreased by 609,000 days (-4.4%) to 13,332,000 in 2000. Despite an average population growth of 0.6% per annum, the total number

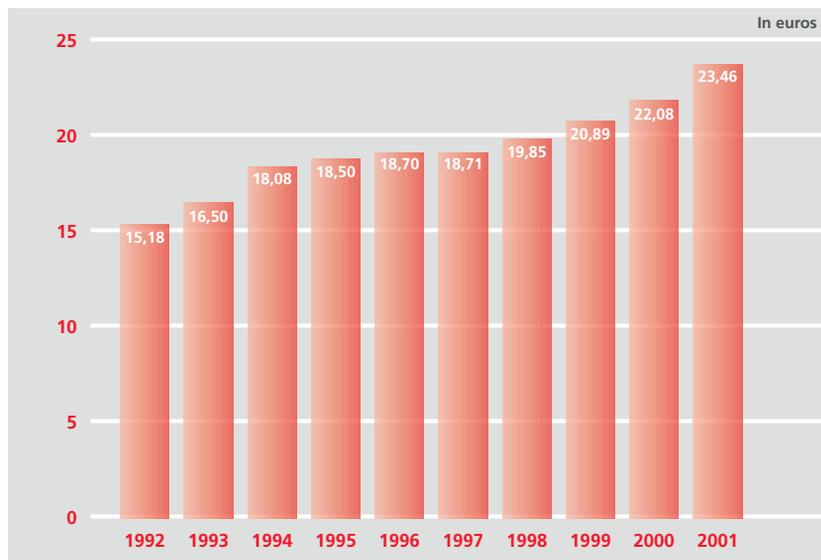
of days spent in hospital has dropped by almost 23% since 1990. More than ten years ago, the Netherlands had a hospital capacity of 47 beds per 10,000 inhabitants.

In 2000, this capacity had been reduced to 35 beds per 10,000 inhabitants. Eventually, the capacity will be further reduced to 25 beds per 10,000 inhabitants. Through longer waiting lists and a reduction of the number of admissions to hospitals (the average number of days spent in hospital has been reduced by 20% over the last ten years), this development leads towards a shift in health care from the intramural to the extramural sector. From a financial point of view, the drug sector here functions as an air valve within the health care sector: savings and cutbacks elsewhere in this sector regularly lead to more costs in the pharmaceutical sector. The effect of this shift on the increase in drug consumption in our country is estimated at some 3% per year.

Shift in consumption to new, often more expensive drugs

For WTG drugs, the drug costs per prescription have increased from an average of € 15.18 in 1992 to an average of € 23.46 in 2001. This corresponds with an average annual increase of 5.0%. In the last year, the costs per WTG prescription increased by 6.3%.

1.06 Drug costs per WTG prescription



Source: Foundation for Pharmaceutical Statistics

It has to be taken into consideration that at the pharmacies, the average price level of prescription drugs has dropped by 26% over the last five years, partly under pressure of the Drug Price Act and the introduction of the 'claw back' measure. If the measures in question had not been introduced, the average costs of a drug would not have been € 23.46 but € 29.56 in 2001. Or, in other words, without outside interference, the average costs per supplied drug would double over a ten-year period.

The increase in costs can partly be explained by the fact that drugs are supplied for an increasingly longer period of time. In 2001, patients on average received a drug supply for almost 46 days, while only an average supply for 38 days was issued in 1991. From this, the conclusion can be drawn that chronic drug consumption is on the increase. If someone is prescribed a certain drug for the first time, the average supply will last the patient 15 days. After that, the maximum dose is for 30 or 90 days (six months for contraceptives).

By far most of the prescriptions issued by physicians entail a repetition of an earlier prescription. In 68% of all cases, a drug is dispensed that was also given to the same patient by the same pharmacy earlier. Annually, this amounts to 74 million repeat prescriptions, compared to 35 million first-time dispensations. For such drugs as cholesterol reducers, beta inhibitors, antidepressants and sleep-inducing drugs, the patient is even given the same drug by the same pharmacy in 90% of all cases. These figures confirm the chronic character of many drug therapies. There is a strong link between chronic drug consumption and the age of patients. On average, roughly 50% of all dispensed drugs are used chronically in the age category up till 40 years, while among people over the age of 65 this figure has increased to 80%.

The most important explanation for the cost increase per prescribed drug is the shift in consumption towards newer, generally more expensive drugs. An example: the SFK has ascertained that drugs put on the market since 1 January 1995 accounted for 20% of the total costs of prescription drugs in 2001. Because of this, new treatment options lead to an increased expenditure on pharmaceutical aid. Developing drugs is a costly matter. That is why new drugs in general have a high cost price. With an average € 68 per prescription, the cost price of drugs introduced since 1995 is more than three times as high as the average cost price for the total group of drugs. Nevertheless, it must be taken into account that new drug therapies could lead to cost reductions elsewhere in the health care sector. Compared to other forms of health care, drug therapy is a very efficient method of treatment.



In general, medical specialists tend to prescribe more expensive drugs than physicians. In 2001, an average prescription drug prescribed by a specialist cost € 45.70 (including pharmacy fee). Among general practitioners, the average cost per prescription amounted to € 25.85. The higher costs per prescription for specialist prescriptions can partly be attributed to a difference in the number of drugs prescribed at one time.

Specialists on average prescribe 50 Defined Daily Doses (DDD) against 45 Defined Daily Doses per prescription among general practitioners. In addition, medical specialists more often prescribe recently developed drugs. New drugs are generally speaking more expensive than existing ones and because these drugs are still patented there are no cheaper alternatives available. Of all the drugs prescribed by specialists, 10.3% have been available five years or shorter in our country. Among physicians, the share of these recently introduced drugs remains limited to 5.4%. In total, 17 million WTG drugs were prescribed by medical specialists in 2001. The difference between costs per prescription is also influenced by the differences between the patient populations of general practitioners and specialists.

Admission of new drugs to the drug package

In the mid-nineties, the government decided on a restrictive policy with regard to the admittance of new drugs to the statutorily insured package of drugs. Since 1999, the Ministry of VWS has slackened the admission policy. In that year, this led to a spectacular 37% expenditure growth on drugs that are on the so-called 'Bijlage 1B' (Enclosure 1B) list. These drugs are considered therapeutically unique by the Ministry and are fully reimbursed by health insurance companies; they are often new and innovative drugs.

The year 2000 saw an increase of 23%, while in 2001 the cost increase of the 'Bijlage 1B' list remained limited to 10%. It appears that in the past two years, a certain degree of catching up has taken place. Another explanation is that new drugs were added to the package only late in the year 2001.

Regarding increased costs, the 'Bijlage 1B' list was headed by combination preparations of directly working antiviral drugs (for aids/HIV), interferon beta-1a (for multiple sclerosis), etanercept (for rheumatism) and terbinafine (for fungus on skin or nails). According to the Ministry of Public Health, the drug etanercept (Enbrel®), which was added to the legally insured drug package in 2000, was insufficiently available, which caused the expenditure in 2001 (€ 6 million) to fall behind the expected level.

Change in prescription and consumption behaviour

From a European perspective, the average Dutch person does not consume a lot of drugs (also see chapter 3). In 60% of the cases where a patient consults a general practitioner, a drug is prescribed. In Europe's more southern countries, this percentage can amount to well over 90%. From the fact that the underlying increase in the drug expenditure over the last two years has been between 11 and 12%, compared to an underlying growth of 10% in the early nineties, the SFK concludes that the prescription and consumption behaviour has changed. Perhaps the mentality of the Dutch doctor/Dutchman is shifting more towards the European pattern.

Higher market share community pharmacies

The SFK only registers the amounts spent on drugs at community pharmacies. In scarcely populated areas, where it is not economically feasible to run a community pharmacy, dispensing physicians take over the pharmaceutical care. Based on figures of the Health Insurance Committee, the conclusion can be drawn that the market share of community pharmacies is increasing at the expense of dispensing physicians.

In 1997, 89.8% of the people with National Health Insurance (ZFW) were registered at a community pharmacy. In 2001, this percentage increased to 90.7%. According to the NIVEL, the Dutch Institute for Research into the Health Care Sector, there were 578 practices with a dispensing physician in the Netherlands on the first of January 2001.

1.4 Good runners

Almost two thirds of the total amount spent on drugs in our country can be traced back to four categories of drugs:

1 Cardiovascular system (products to lower the blood cholesterol and such)	€ 733 million
2 Gastrointestinal tract (antacids and other products)	€ 603 million
3 Central nervous system (antidepressants, analgesics, sleep-inducing drugs, others)	€ 498 million
4 Respiratory system (drugs for the treatment of asthma, chronic lung disorders and such)	€ 358 million
5 Other	€ 1,227 million
Total expenditure	€ 3,419 million

Further specified at substance level, the ten drugs with the highest turnover rate in the community pharmacies account for a total expenditure of € 670 million, 21% of the total expenditure in 2001. These 10 drugs in addition account for 26% of the total expenditure growth in 2001. On average, top-10 drugs are three times more expensive than average drugs. These good runners to a great extent influence the increase in the average costs of prescription drugs from € 15.18 in 1992 to € 23.46 in 2001.

Antacids

The increasing consumption of drugs for gastrointestinal problems has over the last couple of years resulted in a substantial increase in the amount spent on drugs in our country. This year, € 331 million worth of antacids was dispensed via the community pharmacies, almost 10% of the total drug expenditure. In four years time, the costs of these drugs increased by 60%. The increased expenditure on antacids can be completely attributed to increased consumption levels. Although the number of prescriptions for these drugs did not increase as strongly, patients are given increasingly larger quantities per prescription.

For some years now, the antacid omeprazol (Losec®) has been the drug that most money is spent on in our country. This drug, produced by Swedish/British manufacturer AstraZeneca, generated a turnover of € 225 million in 2001, € 12,5 million more than in 2000. The patent on this drug will expire in 2002.

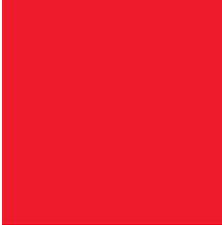
Through the introduction of the variation Losec Mups®, AstraZeneca tried to anticipate an impending loss of turnover. Because pharmacies were hardly able to obtain the original Losec® last year, 99% of users are now switched to this new variation. From the second quarter of 2002, Merck, Multipharma and Katwijk Farma among others will offer generic omeprazol. The price of generic omeprazol is 10 to 15% below the price of the original branded drug.

The antacid pantoprazol(Pantozol®) is increasing its market share at the expense of the antacid omeprazol(Losec®). Both fall in the category of protonpomp inhibitors. Omeprazol saw an increase in turnover of 6% in 2001, but this increase is in shrill contrast with the 60% increase in turnover realised by competitor pantoprazol; pantoprazol is roughly 5% cheaper per Defined Daily Dose than its big brother. More medical specialists than general practitioners prefer pantoprazol. In 2001, pantoprazol generated an annual turnover of € 33 million at the community pharmacies.

Cholesterol-lowering drugs

Of all the different kinds of drugs, the expenditure on cholesterol-lowering drugs is increasing the most. In 2001, € 253 million worth of cholesterol-lowering drugs was dispensed via community pharmacies. This is € 40 million more than last year. Expressed as a percentage, 19% more was spent on cholesterol-lowering drugs. The main reason for this increase is the fact that more people – most of them men – use cholesterol-lowering drugs. The most popular cholesterol-lowering drug is still simvastatine (Zocor®), but since the introduction of the competing drug atorvastatine, simvastatine saw its market share drop. Atorvastatine will soon be the new market leader in this segment.

Atorvastatine (Lipitor®), put on the market by the American company Parke-Davis, saw its turnover increase by € 20 million in 2001. This makes the drug the highest climber regarding expenditure in 2001, taking the first place position from omeprazol. 29% more was spent on atorvastatine, from € 68 million to € 88 million. Atorvastatine accounts for roughly fifty percent of the expenditure increase in the group of cholesterol-lowering drugs. Pravastatine (Selektine®) with an increase of € 11 million (+39%) is also a strong riser.



The Health Council mid 2000 explicitly advised the Minister of Health to stimulate the preventive use of cholesterol synthesis inhibitors (or statines) by people with a hereditary disorder of the fat-metabolism, people who suffer from cardiovascular diseases, patients with diabetes and persons with an above-average level of cholesterol in their blood. For this group, the chances of a (new) heart infarct or (a deterioration of) heart or vascular disease could be decreased by 30%. According to the Health Council, this entails some 200,000 people. Annually, this could result in € 60 million more being spent on cholesterol-lowering drugs.

Antidepressants

Antidepressants are among the most prescribed drugs in The Netherlands. In 2001, community pharmacies dispensed 4,7 million antidepressants on prescription. This entailed an amount of more than € 160 million. The SFK has ascertained that the use of these drugs has been increasing for some years now. From 1997, the number of dispensations has increased by more than 12% per year. In 2001, this increase went slightly down to 9%.

The increased consumption of the antidepressant paroxetine (Seroxat®) is representative for the growth within the total group. Seroxat® has been available in our country since 1991. Because on the one hand the number of prescriptions for Seroxat® increased by 9% and on the other hand the amount supplied per prescription rose, the turnover increased from € 64 million to € 73 million. Paroxetine can be found on the top-ten list of most dispensed drugs in 2001.

Seretide®

The most important newcomer in the top-ten of drug expenditure is the branded drug Seretide®. This is a combination of the bronchi-widener salmeterol and the locally active corticosteroid fluticasone that is used for asthma/COPD. The drug immediately took sixth position on the top-ten list for 2001.

The use of Seretide® is steadily increasing. Since it was introduced in the second quarter of 1999, the turnover of this drug has on average increased by € 1 million each quarter. In 2001, € 42 million was spent on it; € 18 million more than the previous year. The turnover increase regarding the combination preparation salmeterol/fluticasone is partly at the expense of salmeterol (-€ 2 million). Fluticasone however did realise an increase in turnover (+€ 2 million). All of these drugs are produced by drug manufacturer GlaxoSmithKline.

Oxazepam surpasses paracetamol

Based on the number of dispensations, paracetamol is no longer the most popular product in the community pharmacy. In 2001, paracetamol was dispensed 2,607,000 times at community pharmacies. The most important reason for this decline is the 'First of September measure'. From the first of September 1999, certain self-care drugs are only reimbursed by the health care insurance company if the doctor prescribes them for chronic use. With regard to incidental use, the costs are always for the patient. To be complete, it must be mentioned that the above-mentioned figures do not include the boxes of paracetamol that were paid for in cash by clients and are not registered in the pharmacy information system.

The sedative oxazepam was the most dispensed drug in the community pharmacy in 2001. In total, oxazepam was dispensed 2,812,000 times, an increase of 58,000 compared to 2000. Oxazepam slows down certain stimuli in the brain. Feelings of fear, tension, restlessness and concern decrease. If used in the evening, it benefits the sleep. Oxazepam, which has been available in our country since 1967, is mostly used by older people. In 42% of all cases, the consumer is at least 65 years old.

Vioxx®

The increase in the number of prescriptions for the drug rofecoxib (Vioxx®) is striking. In 2001, rofecoxib was dispensed 177,000 times more at community pharmacies than in 2000. This corresponds with an increase of 67%. Rofecoxib generated a turnover of € 16 million. Rofecoxib is aimed at combating pain in cases of arthrosis of hip and knee joints. The drug has been available in the Netherlands since early 2000.

In the course of 2001, the amount spent on rofecoxib more or less stabilised. The SFK does not have data at its disposal to check whether physicians stick to the registered indications for prescribing rofecoxib. According to the Dutch Institute for Research into the Health Care Sector (NIVEL) and the State Institute for Public Health and the Environment (RIVM), rofecoxib is often prescribed without the official indication – combating pain in cases of arthrosis of hip and knee joints. General practitioners are said to prescribe rofecoxib 'off label' in 86% of all cases, among other things to combat backaches, shoulder pains and arthritis (inflammation of the joints).

The aim to administer the lowest possible active dose to a patient is enfeebled by the Drug Reimbursement System. For a daily dose of 12.5 mg, the patient is charged a Drug Reimbursement System-contribution of roughly € 15 per month and for a daily dose of 25 mg there is no Drug



Reimbursement System-contribution; the purchasing price of both dosages is the same per 30.

1.07 Top-10 drug expenditure 2001

	Substance name	Brand name	Sort of drug	Expenditure (€)
1	A02BC01 Omeprazol (1)	Losec®	Antacid	225 million
2	C10AA01 Simvastatine (2)	Zocor®	Cholesterol-lowering	108 million
3	C10AA05 Atorvastatine (3)	Lipitor®	Cholesterol-lowering	88 million
4	N06AB05 Paroxetine (4)	Seroxat®	Antidepressant	73 million
5	C09AA02 Enalapril/enalaprilat (5)	Renitec®	For high blood pressure	46 million
6	A02BA02 Salmeterol (-)	Seretide®	Respiratory complaints with other CARA drugs (-)	42 million
7	C10AA03 Pravastatine (-)	Selektine®	Cholesterol-lowering	40 million
8	C08CA01 Amlodipine (10)	Norvasc®	For angina pectoris and raised blood pressure	39 million
9	A10AD01 Insulin human (8)	Various	For diabetes	37 million
10	R03BA05 Fluticason (9)	Flixotide®	Respiratory complaints	36 million

Source: Foundation for Pharmaceutical Statistics

1.08 Top-10 increase drug expenditure 2001

	Substance name	Brand name	Sort of drug	Increase in Expenditure (€)
1	C10AA05 Atorvastatine (3)	Lipitor®	Cholesterol-lowering	20 million
2	R03AK06 Salmeterol with other CARA drugs (2)	Seretide®	Respiratory complaints	18 million
3	A02BC01 Omeprazol (1)	Losec®	Antacid	13 million
4	A02BC02 Pantoprazol (7)	Pantozol®	Antacid	12 million
5	C10AA03 Pravastatine (8)	Selektine®	Cholesterol-lowering	11 million
6	N06AB05 Paroxetine (4)	Seroxat®	Antidepressant	9 million
7	C10AA01 Simvastatine (-)	Zocor®	Cholesterol-lowering	9 million
8	M01AH02 Rofecoxib (6)	Vioxx®	For rheumatism-related ailments	8 million
9	B03XA01 Epoëtine (9)	Eprex®	For special anaemia	6 million
10	L03AB07 Interferon beta-1a (10)	Avonex® Rebif®	For multiple sclerosis	5 million

Source: Foundation for Pharmaceutical Statistics

1.09 Top-10 drug prescriptions 2001

	Substance name	Brand name	Sort of drug	Prescriptions
1	N05BA04 Oxazepam (1)	Seresta®	Sedative	2,812,000
2	N02BE01 Paracetamol (2)	Various	Pain killer	2,607,000
3	M01AB05 Diclofenac (3)	Voltaren®	Combating pain	2,387,000
4	N05CD07 Temazepam (4)	Normison®	Sleep-inducing drug	2,385,000
5	A02BC01 Omeprazol (5)	Losec®	Antacid	2,031,000
6	B01AC06 Acetylsalicylic acid (6)	Aspirin®	Blood diluent	1,891,000
7	G03AA07 Oestrogen with levonorgestrel (8)	Various	Contraceptive	1,830,000
8	M01AE01 Ibuprofen (7)	Various	Pain killer	1,798,000
9	C07AB02 Metoprolol (9)	Lopresor®, Selokeen®	For migraine	1,772,000
10	N06AB05 Paroxetine (-)	Seroxat®	Antidepressant	1,707,000

Source: Foundation for Pharmaceutical Statistics

1.10 Top-10 increase drug prescriptions 2001

	Substance name	Brand name	Sort of drug	Increase Prescriptions
1	A02BC02 Pantoprazol (10)	Pantozol®	Antacid	201,000
2	M01AH02 Rofecoxib (-)	Vioxx®	For rheumatism-related ailments	177,000
3	C07AB02 Metoprolol (3)	Lopresor®, Selokeen®	For migraine	167,000
4	G03AA07 Oestrogen with levonorgestrel (8)	Various	Contraceptive	167,000
5	R03AK06 Salmeterol with other CARA drugs(4)	Seretide®	Respiratory complaints	163,000
6	C10AA05 Atorvastatine (5)	Lipitor®	Cholesterol-lowering	158,000
7	A10BA02 Metformine (7)	Glucophage®	For diabetes	153,000
8	N06AB05 Paroxetine (1)	Seroxat®	Antidepressant	140,000
9	N06AB04 Citalopram (-)	Cipramil®	Antidepressant	122,000
10	H03AA01 Levothyroxine (-)	Thyrax®, Euthyrax®, Eltroxin®	Thyroid hormone	111,000

Source: Foundation for Pharmaceutical Statistics

1.5 Market shares per product group

Among prescription drugs, these are some of the product categories that can be distinguished.

Proprietary medicinal products

Branded drugs developed by the manufacturer, that are or used to be patented.

Pharmaceutical imports

Branded drugs imported outside of the manufacturer's official channel from EU countries, where prices are lower than in the Netherlands.

Generic drugs

Drugs modelled after brand drugs of which the patent has expired; they do not carry the brand name but the name of the active ingredient.

Generic drugs can be classified into the following categories:

- Tablets and capsules
- Branded generics
- Generic drugs for which the name of the manufacturer is linked to the drug's generic name.
- Pharmaceutical preparations; generic drugs that are administered in other ways than in tablets and capsules.

Pharmacy-made products

Drugs prepared in the community pharmacy

The market share of pre-packed, unbranded drugs, so-called 'generic drugs', has been increasing considerably over the last couple of years. The market share of this group increased to 42% in 2001, while in 1995 a generic drug was dispensed in only 27.8% of all cases. In 2001, 53 million prescribed generic drugs were supplied via the community pharmacy. Compared to 2000, that is an increase of 5.6%; more than the growth of proprietary medicinal products (3.5%). In 2001, 54 million proprietary medicinal products were dispensed through community pharmacies.

In 2001, the pharmacies supplied a pharmaceutical import 9 million times. Following a period in which parallel import lost a lot of ground, 2001 saw a limited increase again in the number of dispensed pharmaceutical imports (4.1%). The parallel import of drugs peaked in the mid-nineties.

The increasing trend began in 1994, the year in which pharmacists were allowed to negotiate purchasing advantages in return for a deduction on



the fixed fee per prescription, the fixed fee pharmacists are allowed to charge within the framework of the Health Care Charge Act (WTG). The downward trend started in the second half of 1996. As a result of the introduction of legal maximum prices, the price difference between pharmaceutical imports and proprietary medicinal products became smaller. To limit the turnover reductions that followed on the capping of drug prices, a number of multinational drug manufacturers started to limit their supply per country in such a way that it became more difficult to obtain pharmaceutical imports.

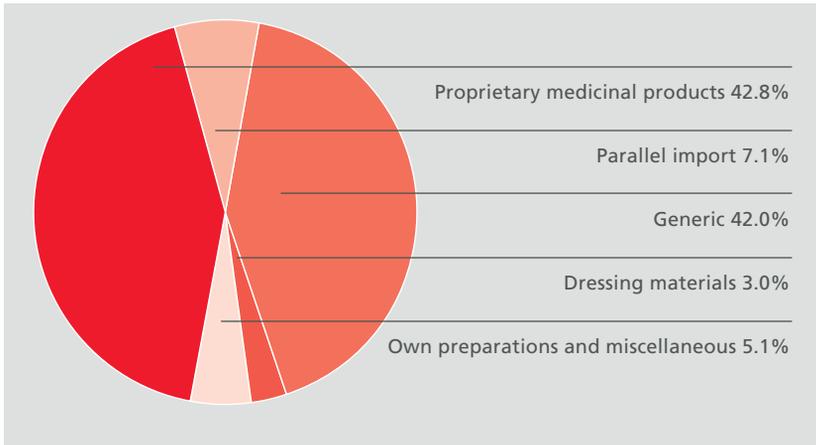
Despite the fact that pharmacists supply more and more unbranded drugs, the savings attached to this are declining. This apparent contradiction can be explained by the decreasing price difference between generic drugs and the original proprietary drugs. Where until a couple of years ago a price difference of 20% between proprietary medicinal products and generics was almost a rule, the average price difference at the moment amounts to 4%.

The number of drugs manufactured by community pharmacies themselves seems to have stabilised following a sharp drop in 2000. With 'own (pharmacy-made) preparations and other', the SFK means preparations that are in line with a national protocol of the WINAp (that in general have a national identification number) and products without a national registration number in the G-Standard of Z-Index. The last category also entails pharmacy preparations made according to own or local protocol. The number of dispensations in the category 'own preparations and other' increased from 6,4 million to 6,5 million, an increase of 1.7%.

The number of specialistic preparations such as means for parenteral pain control and methotrexate injections has significantly grown in the last couple of years. Some of the most common preparations are vitamin K drops, which are used by new-born babies in the first three months of their lives, prednisolon capsules in dosages that are not manufactured by the industry and are used to suppress immuno reactions and inflammatory-related reactions, as with some asthmatic disorders, and several skin products (neutral preparations and preparations containing corticosteroid) that are adjusted to the needs of the individual patient.

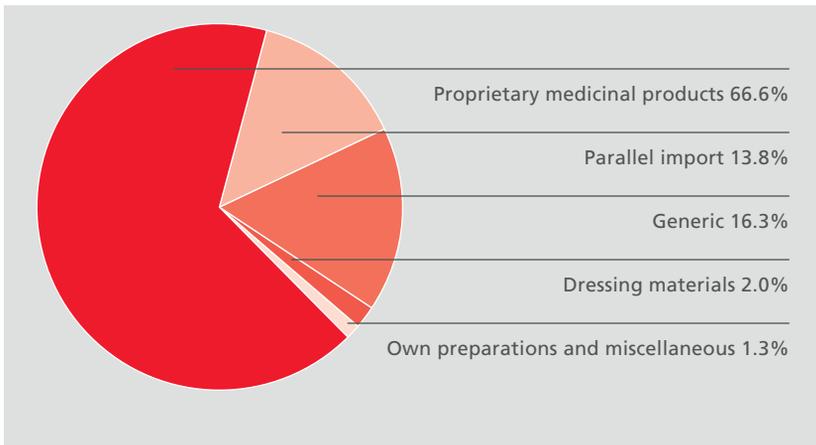
Besides drugs, the phrase 'pharmaceutical aid' also entails dressing materials. In 2001, 3,7 million dispensations were involved in this group.

1.11 Usage of drugs and dressing materials per product group: prescriptions 2001



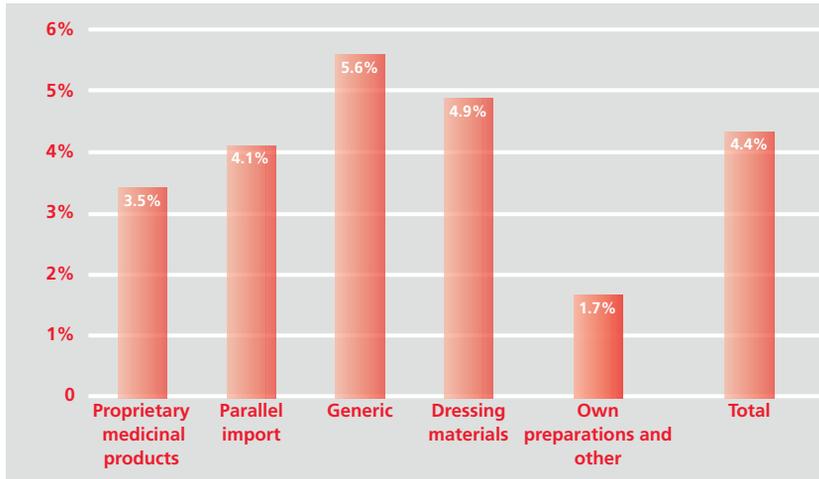
Source: Foundation for Pharmaceutical Statistics

1.12 Usage of drugs and dressing materials per product group: drug expenditure 2001



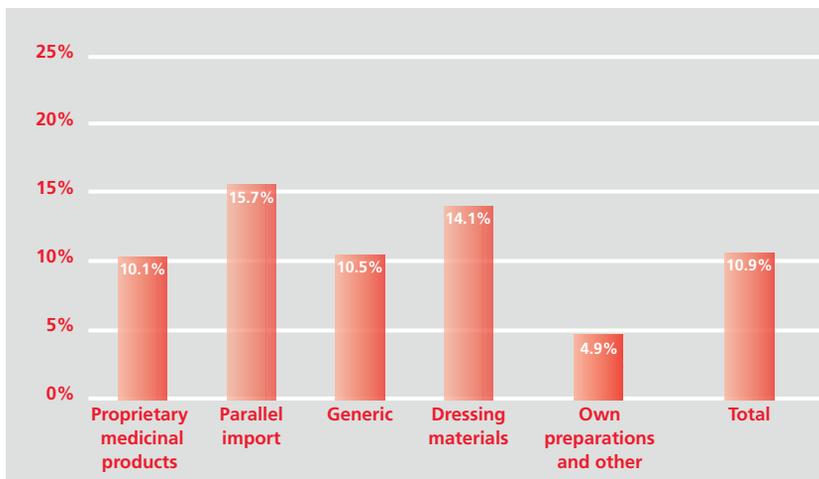
Source: Foundation for Pharmaceutical Statistics

1.13 *Development in the use of drugs and dressing materials per product group: prescriptions 2000-2001*



Source: Foundation for Pharmaceutical Statistics

1.14 *Development in the use of drugs and dressing materials per product group: drug costs 2000-2001*



Source: Foundation for Pharmaceutical Statistics

1.6 Pharmacy fees

In 2001, the community pharmacies generated € 695 million worth of fees. This amount includes the fixed fee per prescription (€ 617 million), revenues from incentive-related measures (€ 14 million) and the pharmacy margin on (self-care) drugs that are not covered by the Health Care Charge Act (€ 64 million). The increase in pharmacy fees is mainly attributable to the adjustment of the fixed pharmacy fee per prescription from € 5.38 to € 5.67 per supplied WTG drug and an increase of 4.4 % in the number of prescriptions (partly attributable to the population growth and an increased market share of community pharmacies at the expense of dispensing physicians).

Fee per prescription

The pharmacy's earnings are not in line with the costs of drugs, because the pharmacy fee for supplying a WTG drug is linked to the doctor's prescription and not to the price of the drug. WTG drugs are prescription drugs that are only available in pharmacies and have a fixed fee per prescription. The pharmacist therefore has nothing to gain from (unnecessarily) dispensing expensive drugs. Per prescription, the pharmacist receives a fixed fee, regardless of the price and the supplied quantity of the drug in question. Depending on the situation and the kind of drug, there however is a limit to the quantity supplied: for 15, 30 or 90 days. For contraceptives, the maximum delivery period is 6 months.

In 2001, the fixed fee per prescription was increased twice. The adjustment of the fixed fee per prescription follows from the 'Basic Agreement' between the Minister of VWS and the KNMP. In relation to the increase of the discount percentage of 6.82% that pharmacists are obliged to pass on in the price of drugs, this agreement entails a phased increase of the tariff between 2000 and 2002 to a more cost-effective level.

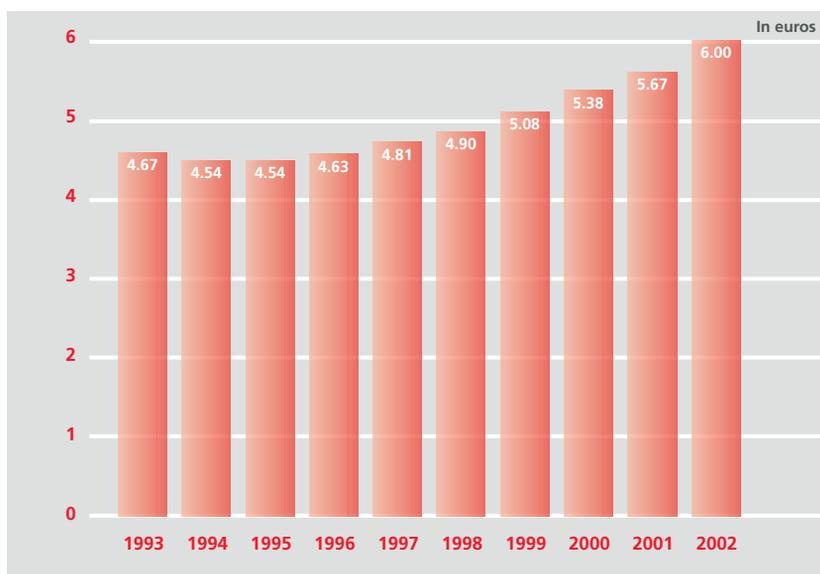
On the first of January 2001, the National Health Tariffs Authority (CTG) limited the fixed pharmacy fee per WTC prescription to € 5.65. From the first of July, this was raised to € 5.67. The increase followed on the substantial increase in the premium rate of professional disability insurances. In addition, a correction was implemented in relation to the 'interim benefit medical expenses'.

From the first of January 2002, the fixed pharmacy fee per WTG prescription was further increased from € 5.67 to € 6.00. This increase is bound by a certain condition. The KNMP reached agreement with the Dutch Health Insurers (ZN) that community pharmacies are only allowed to charge the full

fee of € 6.00 if the pharmacist in question has handed in an annual plan with the most important regional health care insurance company before the first of June 2002.

In this annual plan, the pharmacist is expected to set aims in relation to care innovations, efficiency, quality or patient-oriented care. If it turns out that a pharmacist has not met this requirement in the middle of 2002, health insurance companies are allowed to in retroaction deduct € 0.16 per prescription from this pharmacist. For the second half of 2002, these pharmacists will in addition receive a proportionally lower fixed fee per prescription.

1.15 Pharmacy fee per WTG prescription



Source: Foundation for Pharmaceutical Statistics

1.16 Total figures pharmaceutical aid via community pharmacies in 2001

	ZFW insured	Privately insured	Total
Total expenditure on pharmaceutical aid	€ 2,470 million	€ 949 million	€ 3,419 million
• Of which GVS co-payments	€ 12 million	€ 6 million	€ 18 million
Drug costs	€ 1,963 million	€ 761 million	€ 2,724 million
• WTG drugs	€ 1,847 million	€ 704 million	€ 2,551 million
• Non-WTG drugs	€ 116 million	€ 57 million	€ 173 million
Pharmacy fee	€ 507 million	€ 188 million	€ 695 million
• Fixed fee per prescription	€ 454 million	€ 163 million	€ 617 million
• Incentive revenue	€ 10 million	€ 4 million	€ 14 million
• Margin non-WTG	€ 43 million	€ 21 million	€ 64 million
Prescriptions	90 million	36 million	126 million
• WTG drugs	80 million	29 million	109 million
• Non-WTG drugs	10 million	7 million	17 million
Patients	9,3 million	5,2 million	14,5 million

Source: Foundation for Pharmaceutical Statistics

2 Cost control

Controlling the amount spent on pharmaceutical aid was one of the main themes in the care policy of the second social-liberal coalition that took office in the summer of 1998. The extra means allocated to health care by this cabinet at the start of this period of government would have been completely absorbed by the drug expenditure file, if the structural increase in the amount spent on drugs had not been curbed.

The aims the Cabinet had set itself, and with that also the sector, turned out to be unrealistic. When drawing up the drug budget for the period 1999-2002, the Cabinet allowed for an annual growth of 6 to 7%, while it has been ascertained that structural causes will lead to an annual increase of well over 11% (also see paragraph 1.3). This implied that over the last couple of years, the amount spent on drugs would have to be reduced by € 100 million to € 125 million per year. This is a more than ambitious goal.

The government acknowledged this halfway its term. Because of some fiscal windfalls, the government was able to allocate an additional one-time amount of € 180 million in May 2000 to tackle the existing drug expenditure deficit. Because pharmacists had to hand in a significant percentage of their purchasing advantages, the annual increase in the amount spent on drugs remained limited to 9.8% in the period 1998-2001.

For the coming cabinet period, the government seems to have adopted more realistic starting points in relation to the development of the amount spent on drugs. Partly based on advice of the Government Body for Economic Planning, the Ministry of Public Health and the Ministry of Finance based their policy for the coming years on a structural drug expenditure increase of 11% per year. This by the way did not stop some political parties to include substantial cost reduction aims in their party programmes.

2.1 Purple I, first social-liberal cabinet: 1994-1998

The economy measures of Purple II were initially substantiated by referring to the cabinet period of Purple I. Between 1994 and 1998, the average increase in drug expenditure remained stable at 5.3%. Then, the government managed to curb the expenditure growth by direct interventions in the price level and the composition of the drug package.

The most important measures in question were:

	Savings effect:
1995 Prolonged effect of the 5% price cutback by drug manufacturers in the middle of 1994	2%
1996 Thinning out of the drug package	1%
1996 Introduction maximum drug prices	15%
1997 Transfer of influenza vaccination program from the budget pharmaceutical aid to the budget general practitioners	0.5%
1998 Introduction of the 'claw back' percentage to compensate for the rebates of pharmacists	2%

Without the introduction of the measures mentioned, the cost expenditure increase would have been twice as high in that period. The measures have in common that they all intervene at drug expenditure level. There is no restructuring of the structural increase in drug consumption (for example by influencing the behaviour of doctors and patients).

2.2 Purple II, second social-liberal cabinet: 1999-2002

When Purple II took office, the possibilities for further price measures seemed limited and a further reduction of the statutorily insured drug package was met with too much political resistance. The Ministry of VWS therefore tried to realise the savings in this cabinet period via other ways, namely via the Long-Term Agreements with various players in the health care sector.

In relation to the 'Drug dossier', these Long-Term Agreements leaned heavily on an intensification of the cooperation between physicians and pharmacists. Through regional pilot projects, so-called 'experimental gardens', the boundaries and possibilities of such forms of cooperation were explored.

For the time being, the Ministry of VWS has concluded that more intensive cooperation between the various care disciplines holds certain possibilities for a better and more efficient level of care, but that realising such cooperation requires some time. In addition, the conclusion was drawn that there is increasing interest for monitoring prescription behaviour and carrying out effect measurements, but that the (regional) implementation of this still takes place with little structure.

Thanks to funds made available by the Ministry of VWS, the SFK over the last two years has set up a nation-wide monitoring system with which drug consumption and agreements surrounding drug consumption can be followed in each place and region by cooperation structures between pharmacists and physicians and/or health insurance companies.

Using the Internet, a secured Data Warehouse with detailed figures regarding drug consumption can be consulted on-line. In addition, the SFK makes available supplementary tailor-made reports regarding the quality and efficiency of drug provision via the web. In cooperation with DGV, the Dutch Institute for Responsible Drug Consumption, the SFK draws up comprehensive practice programmes for the Pharmaco-Therapeutical Consultation. By now, 87% of all Dutch pharmacies have been linked to the system of the SFK. One in three pharmacies exchanges information in a cooperation structure using the SFK-system. The Ministry of VWS itself uses national information regarding drug consumption from the Data Warehouse system of the SFK.

In addition to the Long-term Agreements with the curative sector, the Minister of Public Health entered into a covenant with the KNMP in October 1999. The main focus within the framework of the so-called 'Basic Agreement' was the handing-in of purchasing advantages by pharmacists (amounting to an amount of € 193 million in 2002), in exchange for a more cost-effective fixed fee per prescription (as much as € 50 million in 2002). This agreement has proven to be the most effective measure aimed at cost reduction in the drug dossier of the second social-liberal government. Agreements regarding the use of the Electronic Prescription System or the intention to make drugs that are prescribed in outpatients' clinics part of the hospital budget have as of yet hardly yielded any results, if any.

Within the drug policy of the second social-liberal cabinet, three focal points could be distinguished:

1 Improving the quality and efficiency regarding the prescription of drugs

This among other things entails protocol-based prescribing in line with agreements made in FT(T)O-context (the Pharmaco-Therapeutical (Transmural) Consultation between general practitioners, medical specialists, community pharmacies and hospital pharmacies), a better exchange of relevant data between doctors and pharmacists and also feedback regarding prescriptions to doctors by pharmacists and health care insurance companies.

II Stimulating the market mechanism regarding drug distribution

By abolishing existing rules and regulations, the government wants to stimulate competition in the field of drug distribution. The government expects that increased competition will result in lower prices. The policy is geared to the fact that from 2003 onwards, the national list of reimbursement fees for prescription drugs will have been abolished (this entails the drug prices pharmacies are allowed to charge) and the Drug Reimbursement System will have been dismantled (this system regulates the amount of reimbursement the patient is entitled to). Criticasters state that more competition in the health care sector may lead to lower prices, but not to a more efficient pattern of drug consumption.

III Transferring responsibility from the government to health insurance companies

Within the new market order, the government wants to leave the management of the sector to the health insurance companies. This change is expected to be put in effect from the first of January 2003.

2.2.1 'Claw back'

Over the last couple of years, the acceptability of rebates as pharmacy income has been the focus of long-lasting political debate. To gain more insight into the scale of the bonuses and rebates, the Ministry of VWS in the beginning of 1999 asked the accountancy firm PriceWaterhouseCoopers (PWC) to launch a large-scale investigation into the discounts. A survey among 939 community pharmacies and 276 dispensing physicians showed that they on average realised a discount of 8.9% when purchasing drugs. PWC ascertained that dispensing general practitioners realised the same level of discount as community pharmacies in relation to the size of their practices.

'Basic Agreement'

The findings of the survey mentioned above formed the basis for the 'Basic Agreement' that was signed by the Ministry of Public Health and the KNMP on the 8th of October 1999. In exchange for a phased increase of the fixed fee per prescription, it was agreed that for a period of three years, pharmacists and dispensing physicians would pass on 6.82% discount to the prices of prescription drugs with a limit of € 6.80 per dispensed drug.

The capping at € 6.80 prevents pharmacists (and patients) from getting into trouble regarding the dispensation of very expensive drugs such as AIDS drugs and interferon beta, for which no discounts can be obtained. It was agreed that the so-called 'claw back' measure had to result in an increasing

cost reduction of € 159 million in 2000 and € 175 million in 2001 to ultimately € 193 million in 2002.

Besides the 'claw back' the agreement anticipated an increase of the fixed fee per prescription. Research by accountancy firm Ernst & Young in 1997 showed that the then applicable fixed fee per prescription was not cost-effective. In the end, the fixed fee per prescription was raised in phases from € 5.08 in 1999 to € 6.00 in 2002. An inflation correction was taken into account regarding this adjustment, as was the increase in drug consumption and the corresponding additional prescriptions. Each year, the fixed fee per prescription is adjusted for this purpose. An increase in the use of prescription drugs is passed on for 60% in the height of the fixed fee per prescription. This system on the one hand prevents pharmacists from earning 'too much' when drug consumption increases, but on the other hand also makes sure that pharmacists are compensated for the extra work and costs as a result of more prescriptions and patient contacts.

Differentiated 'claw back'

Over the last years, pharmacies have dispensed an increasing number of generic (unbranded) drugs. This is partly caused by the expiration of the patent of a number of often-used branded drugs. Research by the Retail Wholesale Group (RWG) in 1994 already showed that pharmacists were able to negotiate higher discount rates for generic drugs than for proprietary medicinal products. When the Minister of VWS encountered problems regarding the funding of care for the homeless in the beginning of 2002, these elements were used to eliminate this budget deficit.

In April 2002, the Ministry of VWS and the KNMP agreed to use a higher 'claw back' percentage (20%) for generic drugs than for branded drugs and other drugs (5.6%). To boost price competition between suppliers of drugs, it was also agreed to abolish the lowest price regulations for generic drugs and pharmaceutical imports. In addition, the 'claw back' will disappear if a supplier of drugs charges a pharmacy purchasing price that is 20% (for generic drugs) or 5.6% (for branded drugs and other drugs) lower than the pharmacy purchasing price of the drug in question in January 2002. The Minister of Health has asked the CTG for advice regarding the introduction of the differentiated 'claw back'.

2.2.2 Dismantlement GVS

The Drug Reimbursement System (GVS) dates from 1991. Within the framework of this system, the Ministry of VWS clusters therapeutic drugs that are mutually interchangeable. Per cluster, the Ministry establishes a maximum reimbursement limit. If a patient uses a drug with a higher price than the maximum reimbursement level in question, he or she has to bear the price difference.

Since 1994, the prices of drugs have dropped roughly 20%. Until January 1999, the reimbursement limits were based on the higher price level of 1991. The GVS's impact on the cost level was therefore very limited. On the first of February 1999, the Ministry of VWS updated the reimbursement limits based on the then relevant prices. The SFK has ascertained that the adjustment of the GVS-limits results in an annual reduction of € 72 million (including VAT) of the amount spent on drugs. This reduction can be predominantly attributed to the drug manufacturers.

Veiled price law

The lower reimbursement limits lead to a price adjustment by the drug manufacturers. In real-life, the GVS more influences the behaviour of the supplier than that of the patients. In fact, there is a veiled price law. The Drug Price Act limits the maximum price of a prescription drug in our country to the average price of that same drug in surrounding countries: Belgium, Germany, France and Great Britain. The supplier is legally bound to this maximum price. If in addition the reimbursement according to the GVS is lower than the maximum price in question, most drug manufacturers bring their prices in line with this lower reimbursement limit. In this way, it is hoped that an impending loss of market share can be avoided. Dutch patients are not accustomed to (co)financing prescription drugs themselves and are not easily persuaded to do so either.

Limited own risk for patients

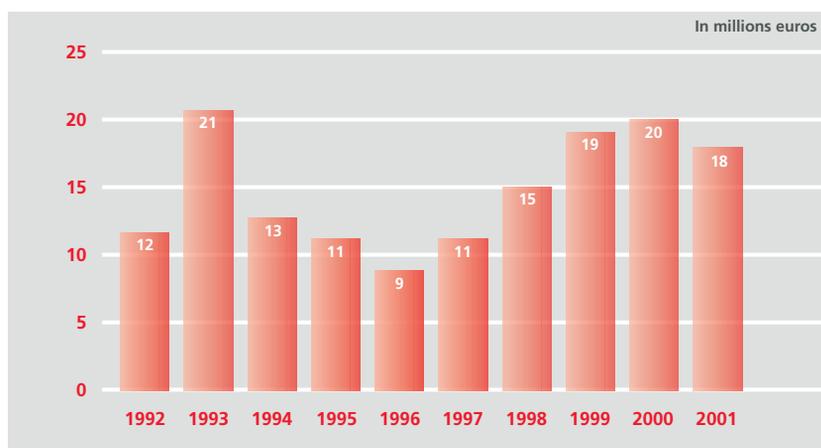
Dutch patients on average pay for 3.4% of the total amount spent on drugs out of their own pockets. Besides an amount of € 100 million for drugs that are not eligible for any reimbursement whatsoever, an additional € 18 million was paid within the framework of the Drug Reimbursement System (GVS) in 2001. Besides various contraceptive pills (GVS-contribution of € 8 million), additional payments were involved for the drug tolterodine (GVS-contribution € 1.7 million, brand name Detrusitol®), to be used for incontinence problems caused by tension.

The GVS as prescription system

The Ministry of VWS has the intention to transform the Drug Reimbursement System (GVS) from a system for reimbursement to a system for prescribing. Initially, the Ministry wanted to completely do away with the system. This however entails substantial financial risks. If the GVS is abolished, it is not unimaginable that the prices of drugs will substantially go up. If drug manufacturers will raise their prices to the level of the maximum prices, this will lead to a cost increase of between € 300 million to € 400 million per year. One in three prescription drugs has no maximum price. Due to the lack of counterbalance, suppliers of these drugs are free to raise their prices to the level they want.

To explore the consequences of dismantlement of the GVS, the Ministry of VWS wants to experiment with the abolition of reimbursement limits for cholesterol-lowering drugs and antacids in 2003. This experiment will however not result in a good indication of the risks involved. The risk of price increases is minimal for cholesterol-lowering drugs and antacids because most drugs are priced according to or slightly under the legal maximum. According to the Ministry of VWS, the Drug Reimbursement System will continue to exist as a therapeutic reference system. From the point of view of the Ministry, physicians, pharmacists and health insurance companies can use the system in the future to make agreements regarding the prescription and purchasing policy.

2.01 Total GVS-contribution via community pharmacies

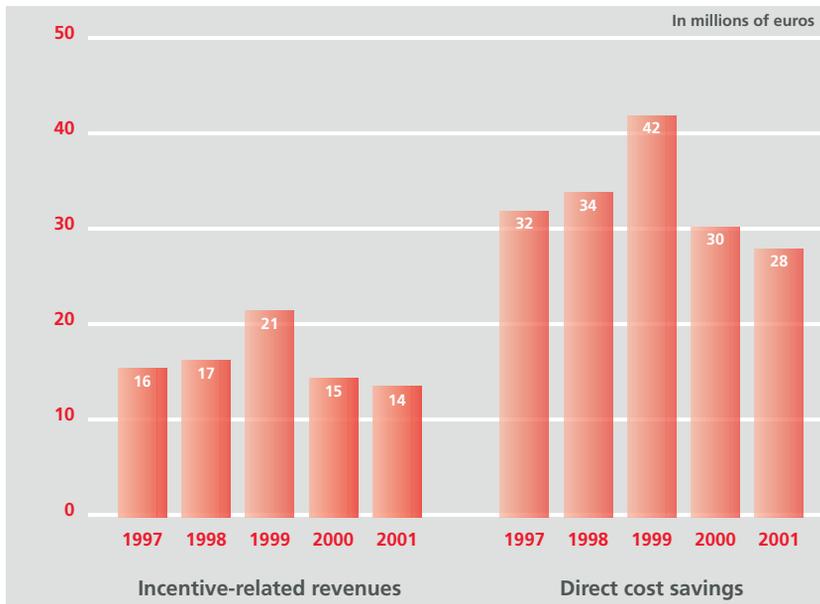


Source: Foundation for Pharmaceutical Statistics

2.2.3 Incentives measure

The aim of the incentives measure that was introduced in 1988 is to persuade pharmacists to dispense generic (unbranded) drugs or pharmaceutical imports instead of generally more expensive original drugs. For this, the drugs have been classified based on generic name, pharmaceutical form, method of administration and strength. Based on the CTG-guidelines, a reference price is determined per group each month. If the pharmacist supplies a drug with a lower price than the reference price of the group in question, the pharmacist as an incentive may keep a third of the price difference. In the past, incentive-related revenues were considered as extra income for the pharmacies. At the end of 1999, the Ministry of VWS decided that the incentive-related revenues should be considered regular pharmacy revenues in relation to establishing the fixed fee per prescription. From the first of January 2002 the pharmacy tariff has been cut by € 0.14. This annually results in a cost reduction of € 16 million at community pharmacies.

2.02 Generic substitution by community pharmacies



Source: Foundation for Pharmaceutical Statistics

Since the introduction of legal maximum prices in 1996 and the introduction and increase of the 'claw back', substitution-related savings as a result of price levelling have decreased. Pharmacists do dispense more generic drugs (see paragraph 1.5), but because the mutual price differences between trademarked drugs and generic drugs and pharmaceutical imports is becoming smaller and smaller, substitution-related savings for the patient and health insurance company are diminishing just the same.

For drug manufacturers, there are hardly any incentives to compete with each other regarding drug prices. Certain legal price rules are more restricting than stimulating in relation to price competition. This among other things results in the fact that the price difference between branded and generic drugs over the last couple of years has decreased from 20% to 4%. As a consequence, the dispensation of generic drugs results in less cost savings.

If the differentiated 'claw back' (see paragraph 2.2.1) is actually implemented, the price difference between branded drugs and generic drugs will be restored to former proportions. Because of this, the importance of substitution will significantly increase from a cost reduction point of view. In addition to the introduction of the differentiated 'claw back', there are also plans to abolish the legally binding price rules that hinder price competition regarding generic drugs (and pharmaceutical imports).

2.2.4 Non-WTG

Of all prescription drugs dispensed by community pharmacies, 80.5% falls under the Health Care Charge Act (WTG). These drugs are only available on prescription in pharmacies. For these drugs, a fixed fee per dispensed drug applies (€ 6.00 in 2002). Some other (self-care) drugs can sometimes also be obtained outside of the pharmacy, at the chemist's or supermarket.

In 2001, these kinds of drugs generated an amount of € 310 million at community pharmacies with a total of 26 million dispensations. Of the amounts spent on self-care drugs, 77% is eligible for reimbursement through health insurance companies.

'First of September'-measure

Since 1 September 1999, self-care drugs are only reimbursed by the health insurance company if the physician prescribes the drug for chronic use. Physicians have to underline this on the prescription with the letters 'c.u.' (chronic use). Various players within the health care sector have criticised this economy measure.

The criticism was on the one hand aimed at the feasibility and verifiability of the measure. On the other hand, the degree of realism of the expenditure cut entailing € 66 million (including VAT) attached to this measure by the Ministry of VWS, was questioned. By shifts in the consumption of drugs, the exact cost-saving effect of the measure is hard to establish. For many of the non-WTG drugs that are no longer reimbursed, there is an alternative within the WTG-segment that is reimbursed.

According to the SFK, the long-term cost-saving effect of this measure does not exceed € 21 million. The Commission De Beer recently concluded that the measure entails the necessary administrative burdens for pharmacies and dispensing physicians.

2.2.5 Haemostatics

From the first of January 2000, claims regarding haemostatics, which are used for the treatment of haemophiliacs, fall under the law Special Medical Operations. With this, the government has shifted the costs of use of these drugs from the pharmaceutical aid budget to the budget for hospital care. In spite of this, these drugs were for an important part still dispensed by community pharmacies in 2001.

According to the Health Insurance Committee, the total costs of haemostatics in the Netherlands amount to roughly € 35 million. In 2001, community pharmacies dispensed for at least € 10 million worth of haemostatics. These costs are included in the figures published by the SFK regarding drug expenditure via community pharmacies. The Ministry of VWS is also considering to shift the expenditure on AIDS and HIV inhibitors to the hospital budget.

From the first of January 2002, the treatment of haemophiliacs has been limited to specially designated treatment centres. The extramural claim on drugs with blood coagulation factors, a subsection within the field of haemostatics, has disappeared.

2.2.6 SFK prognosis 2002

The Foundation for Pharmaceutical Statistics (SFK) expects that the amount spent on drugs and medical aids through community pharmacies will increase by 9.9% to € 3,757 million in 2002. Besides structural growth factors, the adjustment of the fixed fee per prescription to € 6.00, the becoming available of a generic substitute for omeprazol and a further decreasing market share of dispensing physicians (currently 9.3%) have been taken into account in this prognosis; the introduction of the differentiated 'claw back' was not.

3 Drug consumption in a European perspective

Compared to most Europeans, the Dutch on average spend less money on drugs. This has been the case for some years now. In 2000, the Dutch on average spent € 231 per person on drugs in community pharmacies (or at dispensing physicians). Non-reimbursable (self-care) drugs are included in this amount. This figure is 25 to 40% below the expenditure pattern in countries such as Germany (€ 304) Belgium (€ 346), and France (€ 381, situation 1999).

In the United Kingdom, an average of € 206 per person was spent on drugs. This amount however solely encompasses drugs that are reimbursed by the National Health Service.

The differences are to some extent attributable to the degree of ageing of the population in the various countries. In the Netherlands, 13.6% of the population was aged 65 or over in the year 2000. In countries such as France and Germany, this was 16%. The latter corresponds with the average for the European Union.

3.01 Drug expenditure via pharmacies and dispensing physicians per head of the population in 2000



* Figures 1999

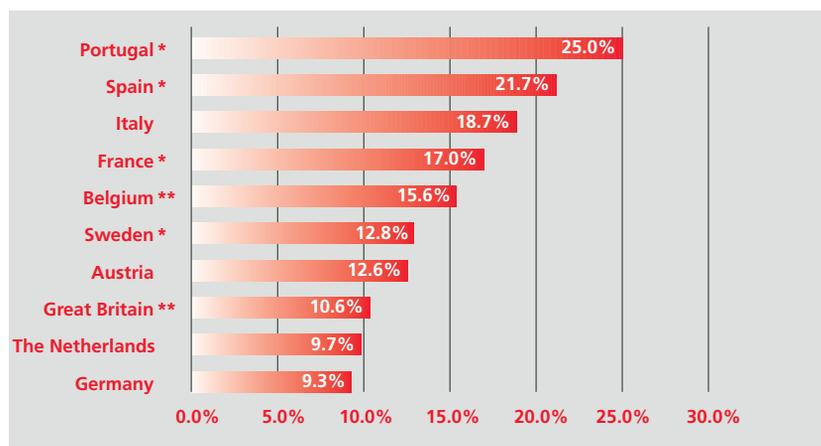
** Solely public expenditure

Source: Foundation for Pharmaceutical Statistics

If one relates the (extramural) expenditure on pharmaceutical aid to the

total health care costs, the Netherlands again occupies a modest position among the countries of Western Europe. In 2000, 9.7% of the total costs of health care in the Netherlands was related to expenditure on pharmaceutical aid. The Netherlands together with Germany and Great Britain forms the European 'tail group'. Generally speaking, the following conclusion can be drawn: the more southern the country is situated, the higher the expenditure on pharmaceutical aid is.

3.02 *Percentage spent on pharmaceutical aid in relation to the total expenditure on health care in 2000*



* Figures 1999

** Solely public expenditure

Source: Foundation for Pharmaceutical Statistics

Compared to most other European countries, a lot of generic (unbranded) drugs are consumed in the Netherlands. In 42% of all cases, Dutch pharmacies dispense generic drugs. In Belgium and Italy, for example, generic drugs are not or hardly used. In Germany, a generic drug is involved in 49% of all drugs dispensed. Here, it must however be noted that Germans use significantly more self-care drugs than the Dutch. In England, the market share of generic drugs is also higher than in our country (52% of dispensations); doctors prescribe using the substance name in 71% of all cases (figures for the whole of Great Britain are not known).

Pharmacy size

The average Dutch community pharmacy has a patient population of 9,000. In Belgium (2,000 patients), France (2,500 patients), Germany (4,000 patients) and Great Britain (5,000 patients), the pharmacies have a significantly smaller patient population. In the Netherlands, 9% of the population has to use a dispensing physician. In Great Britain, this is 6%. In Germany, no drugs are dispensed via physicians.

4 The community pharmacy in figures

The last year, the number of community pharmacies increased significantly. At the end of 2001, there were 1,629 community pharmacies in the Netherlands, 27 more than a year earlier. In 2001, 37 pharmacies opened their doors for the first time. Two of those had to close down again after a couple of months. In addition, eight more community pharmacies closed down.

Over the last couple of years, legislation surrounding the exploitation of a pharmacy has become more relaxed. Certain requirements made of pharmacies in the past are no longer applicable. These requirements were among other things related to the round-the-clock availability of pharmacies and the facilities for own pharmacy preparations.

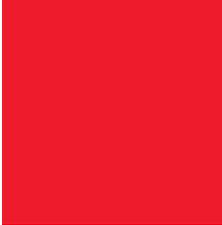
Since early 1999, it has been considerably more easy for non-pharmacists to run pharmacies. This among other things has resulted in the fact that (international) wholesalers such as OPG (Mediveen), Alliance Unichem (De Vier Vijzels) and Gehe are trying to strengthen their market position by acquisition of existing pharmacies. The supplying of drugs by the way (still) has to take place under the supervision of a pharmacist.

OPG aims to own 150 pharmacies by the end of 2002. 'De Vier Vijzels' owned 27 pharmacies at the end of 2001 and wants to expand this number to 100 pharmacies in the next three years. At the end of 2001, Gehe owned 11 pharmacies; it wants to build a chain of 200 to 250 pharmacies within three to five years. If it is up to the wholesalers, the pharmacy market will drastically change in the next couple of years. At the moment, 80% of all pharmacies is still owned by independent pharmacists.

With this forward integration, pharmaceutical wholesalers try to strengthen their negotiation position in view of the changing role of health insurance companies.

By relaxing legislation, the government aimed to stimulate the competition between pharmacies. The adjustments however seem to mostly have a positive effect on the mutual cooperation between pharmacies. Six 'service pharmacies' opened their doors last year, for example. These are pharmacies that are opened in the evening and on weekends. The associated pharmacies do no longer handle these uneconomic shifts independently, but come together in a joint service.

Besides these newly established service pharmacies, there are also cooperation structures where existing pharmacies offer a round-the-clock service.



The market share of community pharmacies last year again increased at the expense of dispensing physicians. At the moment, 9.3% of the population has to turn to a dispensing physician for pharmaceutical care. Three years ago, this was still 10% of the population. According to the NIVEL, the Dutch Institute for Research into the Health Care Sector, there were 578 practices with a dispensing physician on the first of January 2001.

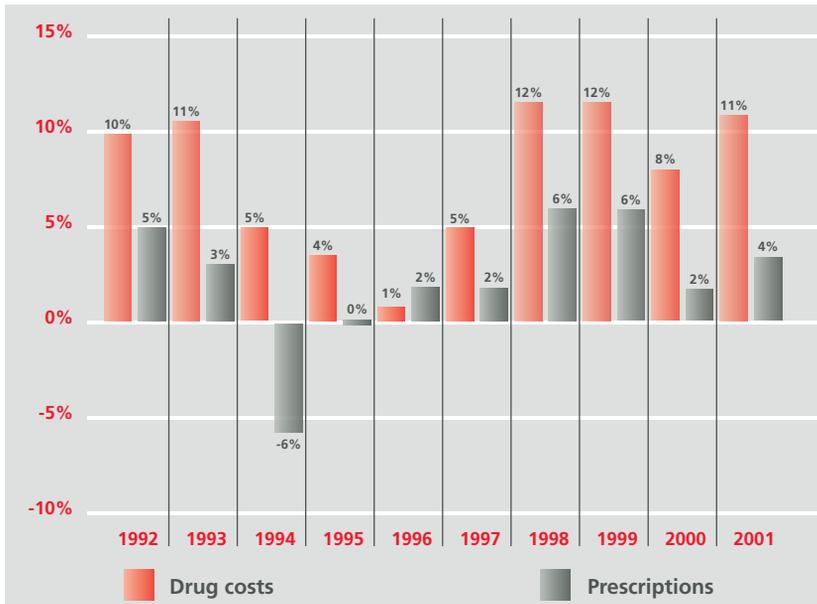
4.1 Turnover community pharmacy

The average community pharmacy serves a patient population of 9,000 persons. Compared to most other European countries, the patient population of a Dutch pharmacy can be called sizeable. In Germany, an average pharmacy serves 4,000 patients, whereas in France some 2,500 patients are served. In Belgium, the population is as low as 2,000 patients per pharmacy.

In 2001, the average community pharmacy dispensed 78,000 prescription drugs. These drugs entailed a turnover of € 2,116,000. Of this total turnover, 20.3% or € 430,000 was earmarked as fee for the pharmacy. The costs of materials for drugs amounted to € 1,686,000. The main source of income for the pharmacy is the fixed fee per prescription (€ 382,000 on average). This entails the fixed pharmacy fee the pharmacist may charge for supplying a WTG drug (drugs only available on prescription in pharmacies).

For 2001, this fixed fee was established at € 5.67. Since the first of January 2002, the fixed fee has been € 6.00, providing the pharmacist in question has handed in an annual plan containing aims in relation to care innovations, efficiency, quality or patient-oriented care with the most important regional health care insurance company before the first of June 2002.

4.01 Development drug costs and number of prescriptions



Source: Foundation for Pharmaceutical Statistics

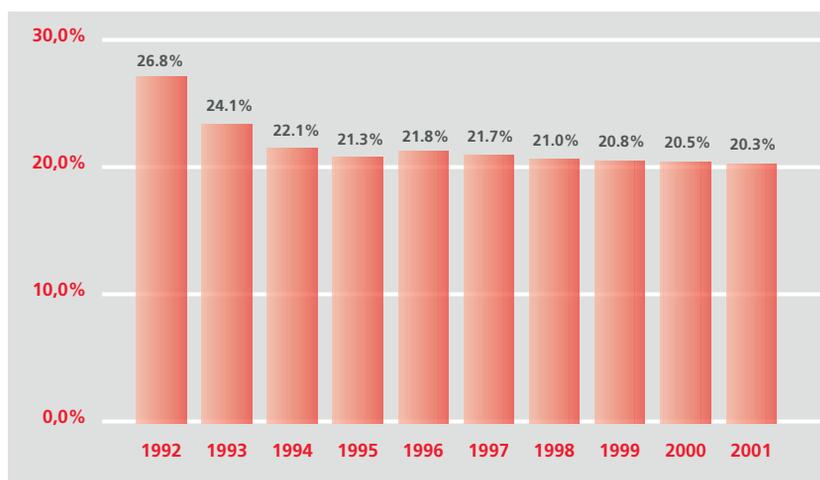
The turnover of a pharmacy in itself does not serve as a reliable indication regarding its profitability. The revenues of the pharmacy to a great extent is determined by the number of fixed fees per prescription. A more expensive WTG drug does not automatically mean more revenue for the pharmacy. Because the drug turnover with a structural growth of 11 to 12% in general increases more than the number of prescribed drugs (structural growth between 4 and 5%), the share of pharmacy fees in general decreases over time.

Between 1993 and 1997, the number of prescriptions increased by less than 5% per year through several measures by the government:

- no longer reimbursing homeopathy (1993);
- no longer reimbursing various self-care drugs (1994);
- further thinning out of the drug package (1996);
- transfer of the flu vaccination program to general practitioners (1997).

During the period 1996-2001, the share of the pharmacy fee stabilised through several price measures initiated by the government, such as the introduction of maximum drug prices and the introduction of the 'claw back'-percentage.

4.02 Stake of pharmacy fees in the expenditure on pharmaceutical aid



Source: Foundation for Pharmaceutical Statistics

4.2 Gross profit percentage

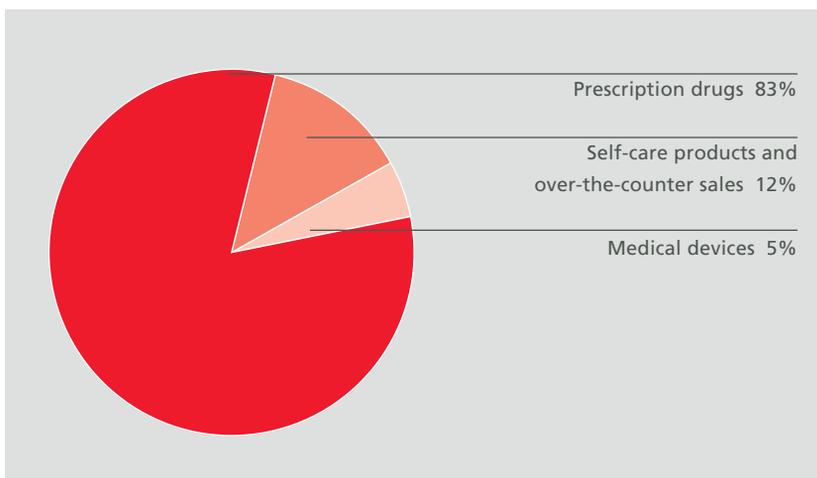
By order of the Ministry of Public Health, the accountancy and advice firm PriceWaterhouseCoopers (PWC) in 1999 looked into the rebate advantages realised by pharmacists in addition to the above-mentioned pharmacy fee. The results of this survey show that pharmacists and dispensing physicians then on average realised an 8.9% rebate on the purchase value of drugs. This percentage consists of all forms of rebates measurable in money.

In 2001, the pharmacists handed over € 93,000 per pharmacy via the 'claw back'. Assuming the average 8.9% of purchase rebates established by PriceWaterhouseCoopers, a mere 3% of net purchasing advantages remains for the pharmacy. If these net purchase rebates are added to the total of the pharmacy fee, an average gross profit percentage of 23% follows. In Europe, an average gross profit percentage of 25% is usual among pharmacies. The SFK has no insight in the actual rebate advantages of pharmacies.

4.3 Pharmacy practice costs

In principle, pharmacists have to finance the costs of their practice and their income through the fixed fee per prescription that applies to WTG drugs. When determining the height of the fixed fee per prescription, the revenues from pharmaceutical aids, non-WTG drugs and other over-the-counter products are taken into consideration. It is a widespread (political) misconception that the other (trade)activities of the pharmacy are subsidised from the fixed fee per prescription. In practice, the opposite in fact applies, because the revenues generated by this are deducted from the fixed fee per prescription.

4.03 Pharmacy turnover per product category, 2001



Source: Foundation for Pharmaceutical Statistics

In line with the three-year agreement signed by the KNMP and the Minister of Public Health on the 8th of October 1999, the pharmacy practice cost reimbursement rate was increased to € 456,000 from the first of January 2002. The norm income for the owner of the pharmacy, € 91,000, is included in this amount. The norm income also entails matters such as social taxes, disability insurance and pension contributions.

The norm income for owners of pharmacies corresponds with a gross annual income of € 65,000. In the adjustment of the fixed fee per prescription from the first of January 2002, an increase in the number of prescriptions as a result of increasing drug consumption in our country has been taken into

consideration. In line with the conclusions drawn by the SFK, the norm practice size has been adjusted from 73,600 prescriptions to 75,400 prescriptions.

Due to an increase in the premium for disability insurance, the CTG decided to raise the norm income with € 1,621 to € 92,999 from the first of July 2002. This entails an increase in the fixed fee per prescription of € 0.02. Because of legally binding rules regarding the rounding-off of amounts (within the WTG, it was decided that amounts between € 2 and € 50 will be rounded off to 10 euro cents), this increase will have no effect on the fixed fee per prescription that can be billed. This fee was already rounded off (or actually rounded up) to € 6.00 on the first of January 2002.

4.04 Build-up fee for costs of pharmacy practice from 1 January 2002

	Fee for costs of pharmacy practice (€)	Fixed fee per prescription (€)
Staff costs	215,036	2.85
Housing costs	53,147	0.70
General costs	49,052	0.65
Computer costs	15,635	0.21
Interest	14,237	0.19
Deprecations	11,939	0.16
Motor car costs (deliveries and such)	5,443	0.07
Norm income	91,378	1.22
Total fee	455,867	6.05
Deduction incentive revenues	-10,437	-0.14
Deduction due to revenue		
AWBZ institutions	-2,147	-0.03
Adjustment 2001		0.09
Rounding-off rule CTG		0.03
Fixed fee per prescription		6.00

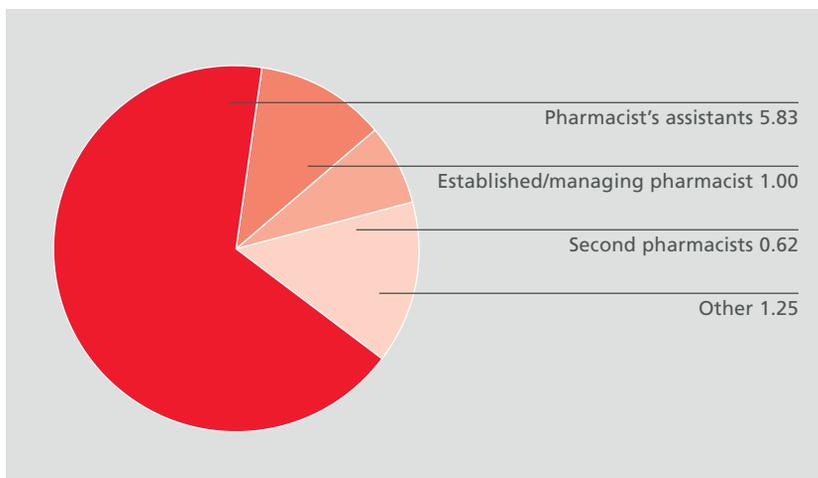
Source: Foundation for Pharmaceutical Statistics

4.05 Number of persons employed in community pharmacies

	1996	1997	1998	1999	2000	2001	Annual increase
Pharmacies	1,530	1,547	1,571	1,588	1,602	1,629	1.2%
Pharmacists	2,319	2,381	2,439	2,472	2,611	2,636	2.6%
Pharmacists' assistants	11,239	11,589	11,931	12,189	12,600	13,023	3.0%
Other	2,042	2,123	2,280	2,549	3,080	3,845	13.5%

Source: Foundation for Pharmaceutical Statistics

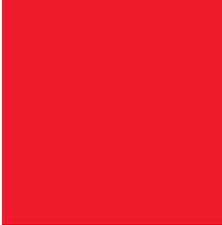
4.06 Number of employees in an average pharmacy in 2001



Source: Foundation for Pharmaceutical Statistics

Shortage of pharmacist's assistants

According to the Pension Fund Pharmacy Employees, 13,023 persons were active as pharmacist's assistant in a community pharmacy on the first of January 2002. Compared to the previous year, this is an increase of 423 persons (+3.4%). This increase is however compromised by the fact that more and more pharmacist's assistants prefer working part-time. Together with the structural increase in the level of drug consumption and the increase in the number of pharmacy branches in our country, this is one of the main explanations for the existing shortage of pharmacist's assistants and the increasing working pressure in pharmacies.



Historically speaking, the working pressure has never been as high as at the moment. Currently, pharmacies have a great number of vacancies that are difficult to fill. A survey carried out by the SFK by order of the Foundation Industrial Fund Pharmacies shows that 35% of all community pharmacies are looking for a pharmacist's assistant. One in five job openings has been open for a year or longer. On average, it takes almost half a year for a pharmacy to find a pharmacist's assistant.

Not all pharmacies encounter difficulties in finding enough pharmacy staff. Repeated research by the SFK has shown that 45% of all pharmacies did not encounter any substantial problems regarding the staffing of assistants.

A lot of part-timers

A full-time pharmacist's assistant has a 36-hour working week. The average working week of pharmacist's assistants in 2001 amounted to 26.3 hours per week. Converted to full-time units, an average community pharmacy has 5.83 pharmacist's assistants. Compared to a year earlier, this is a drop of 1%. Pharmacist's assistant is a typical female profession. There are only 118 male pharmacist's assistants in the Netherlands.

Of all pharmacist's assistants, a mere 34.3% works full-time. Two years ago, this was still 42.1%. Mostly younger pharmacist's assistants up to 28 years of age work full-time. More than 70% of pharmacist's assistants aged 33 or over work three days or less. It does not look as if the influx of pharmacist's assistants over the coming years will be sufficient to meet the current and future demand for pharmacist's assistants. The limited interest in the study for pharmacist's assistant points more towards an expected increase in the shortage of pharmacist's assistants.

Processing rate

The processing rate, the number of prescriptions in relation to the number of pharmacist's assistants (converted to full-time units), is a good criterion to establish whether the number of staff members corresponds with the working pressure in the pharmacy. In 2001, the average processing rate increased to 14,454 prescriptions per full-time pharmacist's assistant. This is an increase of 3.7% compared to 2000. When calculating the processing rate, the starting point is the number of supplied WTG drugs and non-WTG drugs, regardless of whether they are reimbursed by the health insurer. Medical aids such as stoma- and incontinence materials and pure over-the-counter articles that can also be freely purchased at chemists and supermarkets (and are not registered via the pharmacy information system) are not taken into account for determining the processing rate.

Not an absolute norm

Although the national processing rate gives a good indication of the productivity development within the community pharmacy, this figure may not indiscriminately be used as an absolute standard for judging the situation in the own pharmacy. The number of dispensations per pharmacist's assistant may vary considerably from pharmacy to pharmacy.

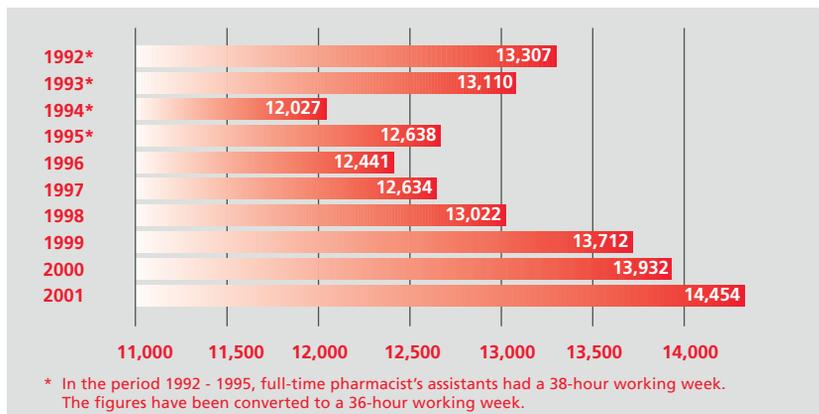
Traditionally, pharmacies in rural areas have a higher processing rate. The main explanation for this phenomenon is the fact that rural pharmacies encounter a more limited group of prescribers. This better enables pharmacists to make agreements with the general physicians in question regarding the used formula and the advanced passing on of prescriptions via the fax or computer. In 2001, the processing rate in rural areas was still 2% higher than the national average.

It however is striking that the processing rate in big cities (more than 100,000 inhabitants) increased strongly over the last year. The processing rate there has by now increased to 11% above the national level. Supposedly, there is an even greater shortage of pharmacist's assistants in the big cities.

Some other factors influencing the processing rate are the way in which evening and weekend shifts are organised and the extent to which pharmacy preparations are provided. Increasingly, community pharmacists decide to mutually cooperate regarding these uneconomic aspects of pharmacy service rendering, such as evening/weekend shifts and pharmacy preparations (see introduction chapter 4).

In the early nineties, pharmacist's assistants had an average 38-hour working week. In the middle of 1996, their working week was shortened to 36 hours. For a historically correct perspective on the development of the processing rate, the figures in the accompanying graphic have been adjusted for a 36-hour working week. The graphic clearly illustrates that the processing rate in the last decade has never been as high as right now.

4.07 Development processing rate



Source: Foundation for Pharmaceutical Statistics

The decrease of the processing rate in the mid nineties was caused by package measures by the government: no longer reimbursing certain drugs. As a result, the demand for those drugs dropped. The market can only react to such measures with a certain delay. After all, in practice, it is not possible to immediately adjust the number of employees.

Pharmacists

The number of students graduating as pharmacists is strongly diminishing. In 2001, 155 persons successfully passed the pharmacy exam. In 2000, this were still 192 graduating persons. Of the graduates, roughly 110 pharmacists will opt for a function within the community pharmacy sector.

On balance, the increase in the number of active pharmacists in the community pharmacy sector last year amounted to only 25 pharmacists. This means that in 2001, there was a strong outflow of pharmacists of roughly 85 persons. Among them are many pharmacists who sold their pharmacy to a wholesaler and then said goodbye to the community pharmacy.

As a result of the limited net influx, vacancies for the function of second pharmacist are becoming harder and harder to fill. One in ten pharmacies has a vacancy for a second pharmacist. At the moment, each community pharmacy on average has 0.62 second pharmacist.

Larger pharmaceutical chains encounter problems in finding pharmacists for the pharmacies they own. For British pharmacy chain Boots, this was even reason to stop their activities in our country. A survey carried out by the SFK among members of the Association of Young Pharmacists shows that 60% prefers the independence within an own pharmacy over being in the employ of a pharmacy chain of a pharmaceutical wholesaler.

Interest for the study pharmacy has been waning over the last couple of years. In 2001, a mere 182 new students enrolled, whereas in 1997 this number was still 349. The decrease is related to a widening of the 'numerus fixus' for the study medicine. Many students who in the past were eliminated by lottery for the study medicine alternatively opted for the study pharmacy.

4.08 Core figures expenditure on pharmaceutical aid per pharmacy in 2001

	ZFW insured	Privately insured	Total
Total expenditure on pharmaceutical aid	€ 1,529,000	€ 587,000	€ 2,116,000
• Of which GVS-contributions	€ 8,000	€ 3,000	€ 11,000
Drug costs	€ 1,215,000	€ 471,000	€ 1,686,000
• WTG drugs	€ 1,143,000	€ 436,000	€ 1,579,000
• Non-WTG drugs	€ 72,000	€ 35,000	€ 107,000
Pharmacy fee	€ 314,000	€ 116,000	€ 430,000
• Fixed fee per prescription	€ 281,000	€ 101,000	€ 382,000
• Incentive revenue	€ 6,000	€ 2,000	€ 8,000
• Margin Non-WTG	€ 27,000	€ 13,000	€ 40,000
Prescriptions	55,900	22,100	78,000
• WTG drugs	49,500	17,800	67,300
• Non-WTG drugs	6,400	4,300	10,700
Patients	5,800	3,200	9,000

Source: Foundation for Pharmaceutical Statistics

5 Drug expenditure per person in 2001

ZFW insured

	Prescriptions	Costs per prescription (€)		Expenditure per person (€)
WTG	8.59	Material costs	23.09	248
		Fixed fee per prescription	5.67	
		Incentive	0.13	
		Total	28.89	
Non-WTG	1.10	Material costs	11.29	17
		Pharmacy margin	4.23	
		Total	15.52	
Total	9.69			265

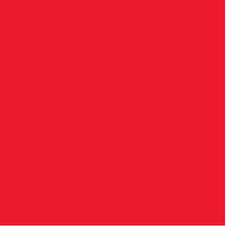
Privately insured

	Prescriptions	Costs per prescription (€)		Expenditure per person (€)
WTG	5.49	Material costs	24.50	166
		Fixed fee per prescription	5.67	
		Incentive	0.13	
		Total	30.30	
Non-WTG	1.35	Material costs	8.16	15
		Pharmacy margin	2.96	
		Total	11.12	
Total	6.84			181

Average

	Prescriptions	Costs per prescription (€)		Expenditure per person (€)
WTG	7.47	Material costs	23.46	219
		Fixed fee per prescription	5.67	
		Incentive	0.13	
		Total	29.26	
Non-WTG	1.19	Material costs	10.02	16
		Pharmacy margin	3.72	
		Total	13.74	
Total	8.66			235

Source: Foundation for Pharmaceutical Statistics



Colophon

Facts and Figures 2002 is a publication of the Stichting Farmaceutische Kengetallen (Foundation for Pharmaceutical Statistics, SFK).

Reproduction of data from this brochure is allowed provided that the source is fully acknowledged as follows: Stichting Farmaceutische Kengetallen (Foundation for Pharmaceutical Statistics), May 2002.

Editing

drs. J.L. Tinke

drs. A.M.G.F. Griens

Lay-Out

2D3D, Den Haag

Printing

Zwaan offset, Wormerveer

Editorial address

Foundation for Pharmaceutical Statistics

P.O. Box 30460

2500 GL The Hague

The Netherlands

Telephone (+31) (0)70 3737444

Fax (+31) (0)70 3737445

E-mail info@sfk.nl

Website www.sfk.nl

