

A photograph of a pharmacist in a red uniform with 'Apotheek' written on it, wearing glasses and smiling while talking to a customer. The background shows shelves stocked with various pharmaceutical products. A large white 'SFK' logo is overlaid on the left side of the image.

SFK

Facts and figures 2014

On pharmaceutical care in The Netherlands

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Introduction

Foundation for Pharmaceutical Statistics

The Foundation for Pharmaceutical Statistics (Stichting Farmaceutische Kengetallen (SFK)) has been collecting, monitoring and analysing detailed data on the use of medicines in the Netherlands since 1990. SFK obtains its information from a panel of pharmacists who currently represent 95% of all community pharmacies in the Netherlands. National figures based on the data provided by the panel are calculated using a stratification method developed by SFK, which incorporates both data supplied by SFK-affiliated pharmacies and available data on non-affiliated pharmacies and takes into account factors such as the size of the patient population and the location of the pharmacy. Every time a pharmacy dispenses a prescription, SFK gathers and records data on the dispensed medicines and/or materials, the dispensing pharmacy, the reimbursing (or non-reimbursing) health care insurer, the prescribing doctor and the patient for whom the prescription was issued. The quality and representativeness of SFK data is assured by thorough validation procedures and tried and tested statistical methods. As a result, SFK possesses the most comprehensive and up-to-date data on pharmaceutical statistics in the Netherlands.

The collected data serves to support pharmacy practice and is also used for scientific research. SFK publishes the most important statistics and news in its annual Facts and Figures (Data en feiten) report and in the Pharmacy in Figures (Farmacie in cijfers) section of Pharmaceutisch Weekblad (PW), a weekly journal for pharmacy professionals. The Royal Dutch Pharmacists Association (Koninklijke Nederlandse Maatschappij ter bevordering der Pharmacie (KNMP)) and the Dutch Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport (VWS)) frequently employ SFK data on the use of medicines.

Privacy

In recording data on medicine use SFK takes the utmost care to protect the privacy of everyone involved. Strict privacy policy maintains the anonymity of the participating pharmacies. In line with this policy, SFK only discloses to third parties data that can be traced to individual pharmacies if the pharmacist in question has issued express permission in writing. When releasing data at a national or regional level, the information disclosed to third parties is monitored by a Supervisory Board consisting of pharmacists who work in community pharmacies.

SFK only collects anonymised patient data. The identity of the patient is always concealed from SFK, because SFK uses the patient serial number issued by the pharmacy. It is not possible for SFK to link these serial numbers to individual patients. Naturally, pharmacies are aware of the identity of their patients, but this data is not disclosed to SFK.

SFK membership

SFK membership is free of charge and is open to all community pharmacists in the Netherlands. Pharmacists who supply SFK with data can access online detailed up-to-date data on the use of medicines dispensed by their own practice. They can use this data as management information for their own pharmacy and to support patient care. To facilitate the monitoring of the effectiveness of medicine use

and to support practice-based programmes in the area of pharmacy patient care and the pharmacotherapy consultation SFK produces reports on specific themes that are customised for individual pharmacies or a particular pharmacotherapy consultation. SFK produces these customised reports in association with KNMP and IVM (the Dutch Institute for Rational Use of Medicine) among other parties. SFK's online report generation tool, SFK Select, also enables participating pharmacies to view existing reports and compile their own reports.

About this report

The figures published in this report show national use of medicines dispensed by community pharmacies. This report does not provide information on the use of medicines supplied by dispensing general practitioners. In thinly populated areas, where it is not economically viable to operate a community pharmacy, pharmacy care is provided by dispensing general practitioners who, between them, serve just under eight percent of the population. This report does not provide information on the use of medicines in hospitals or institutions that provide care under the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten (AWBZ)).

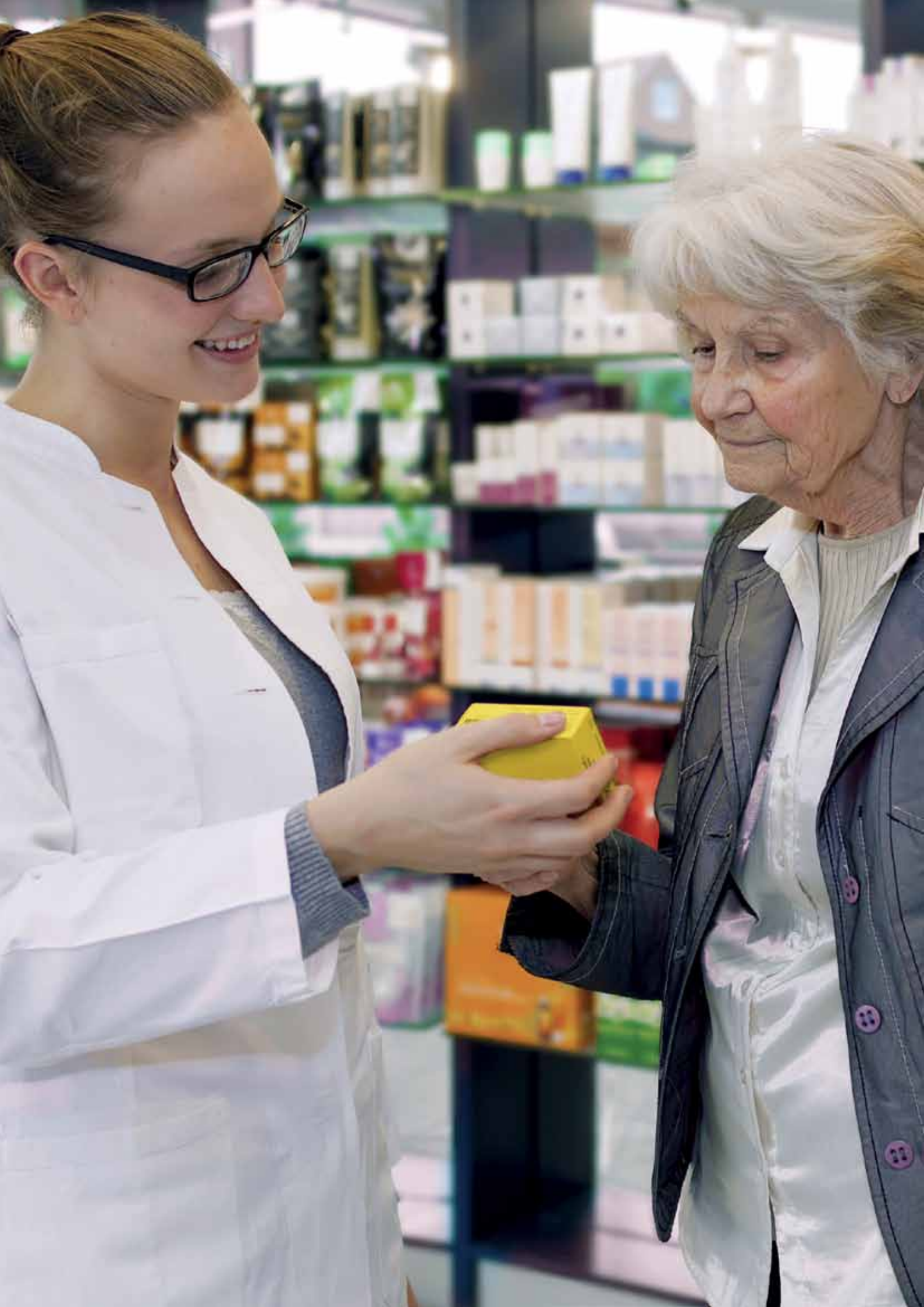
From 2012, SFK bases expenditure on pharmaceutical care on invoices submitted to health care insurers by pharmacies. Up until 2011 SFK based expenditure on pharmaceutical care on the maximum prices set by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit (NZa)) and the pharmacy purchase prices of the medicines, minus the statutory clawback.

With the introduction of deregulated prices on 1 January 2012, health care insurers and pharmacists now have to agree the reimbursement for pharmaceutical care between them. The amounts paid to pharmacists by insurers in accordance with contractual agreements may differ from the cost of medicines specified in the invoices submitted to health care insurers by the pharmacies. SFK is not privy to these agreements.

Within the context of this report, 'cost of medicines' means either the pharmacy reimbursement price (for prescription-only medicines) or the pharmacy purchase price (for non-prescription-only medicines). The cost of medicines includes the patient contributions required by the Drug Reimbursement System (Geneesmiddelenvergoedingssysteem (GVS)).

'Expenditure on medicines' refers to the cost of medicines specified in invoices submitted to health care insurers by the pharmacies plus pharmacy fees, and also includes the patient contributions required by the GVS.

All figures in this publication pertain to the statutorily insured drug package. Unless otherwise indicated, none of the amounts stated include VAT. (Prescription medicines are subject to 6% VAT in the Netherlands.)



Facts and figures in brief

Expenditure on medicines continued to fall

Expenditure on the statutorily insured drug package fell by 7% in 2013 to € 4,088 million. This reduction in expenditure was largely due to the transfer of the funding of oral oncology drugs and growth hormones to the hospital budget from the start of 2013, even if these drugs are used outside a hospital setting. (The funding of TNFalpha inhibitors was previously transferred in the same way.) The lower expenditure was a welcome development for the government and a substantial gain, given that in the budget the government allowed for an increase of almost 6%. The difference was due to lower medicine use at lower prices and the fact that the government also anticipated an increase in fees. However, in real terms, reimbursement for services provided by community pharmacies is still below the level of 2011. And since the extent to which health care insurers have contracted pharmacies to provide the new non-dispensing-related care services is very limited, pharmacies have considerably less scope for innovation than the government envisaged when determining the premiums paid to insurers.

Increase in medicine use was less than expected

In terms of defined daily doses, medicine use increased by 1.1% in 2013. This increase was considerably lower than is usually the case. In the last 10 years the rise in medicine use has ranged from 4 to 8% per year. The combination of population growth and population ageing alone would be expected to account for a 1.9% increase in medicine use in 2013. Yet the actual rise in medicine use was considerably lower. The higher excess payable by insured persons aged 18 and older may have been a contributing factor.

Even fewer pharmacies

Despite the slight increase in demand for care there was a drop in the number of community pharmacies for the second year in a row. At the end of 2013 there were 1,974 community pharmacies in the Netherlands: seven fewer than the year before. The opening of 29 new pharmacies was outweighed by the definitive closure of 36 pharmacies. It is notable that more than the half of the pharmacies that closed only opened this century. These relatively new pharmacies clearly found it impossible to operate at a profit. Despite the decrease in the number of pharmacy outlets in 2013, there was, nevertheless, a 1% increase in the number of active community pharmacists. In contrast, there was a marked decline in the number of pharmacy assistants.

Pharmacy fees remained below 2011 level

In 2013 the average community pharmacy received fee revenues of € 627,000 for the dispensing of prescription and non-prescription medicines included in the statutorily insured drug package. This was 2% more than in 2012. This can be accounted for by the somewhat higher fees paid by health care insurers for pharmaceutical care services, combined with the slight increase in medicine use and the lower number of pharmacies. Yet even with this 2% increase, pharmacy fees for the dispensing of medicines remained well below the level of 2011 (the last year in which pharmacy fees were set by NZa). Lower revenues from medicines due to lower prices, lower margins on medical devices and agreements stipulated by insurers, including clawback provisions, lowest price guarantees and historic prices, put considerable pressure on the financial position of pharmacies.

Share of generics continued to increase

In line with the trend in recent years, the proportion of generic medicines among the total number of prescription medicines dispensed by pharmacies increased to 70% in 2013. Yet generic medicines accounted for just 16% of the costs of all medicines. Partly due to the influence of insurer preference policies, generic medicines are usually low priced. In 2013, on average, treatment with a generic medicines cost just over € 2 per month. Yet the low price of generic medicines also has its drawbacks. In an average of 4.3% cases, pharmacists dispensing prescriptions had to seek a non-preferred alternative because the preferred medicine specified by the health care insurer was not available.

Significant changes in the top 10

In relation to 2012, there were significant changes in the top 10 statutorily insured drugs that accounted for the highest expenditure in 2013. There were four newcomers, with two making a re-entry: simvastatin, which last appeared on the list in 2007, and omeprazole, which was only absent from the list for a year. Methylphenidate, which is used to treat ADHD and Insulin aspart (an insulin analog marketed as NovoRapid) were genuine newcomers. With the funding of somatropin (used to treat growth problems) having been transferred to the hospital budget, the drug disappeared from the list because it no longer forms part of pharmacy care expenditure through community pharmacies. There was little change in the top 10 statutorily insured drugs with the highest number of users in relation to the previous year. The top 10 medicines included four used to treat chronic conditions. The remaining six are generally prescribed for occasional use. As in 2012, Diclofenac was the statutorily insured drug with the largest number of users, though the number of users fell by almost 8%.

Cardiovascular drugs used by 1 in 4

Drugs used in cardiovascular risk management (CVRM), medicines prescribed for diabetes, asthma/COPD and depression are among the most commonly prescribed drug groups, with CVRM drugs at the top of the list. In 2013 community pharmacies in the Netherlands dispensed one or more medicines

designed to prevent cardiovascular disease such as heart failure, angina pectoris and cardiac arrest or ischemic stroke to 4.3 million people. This means that CVRM medication is now being prescribed for more than one in four inhabitants of the Netherlands. In the last five years, use of this medication has increased at an average rate of 3.5% per year.

During the same period use of cholesterol-lowering drugs among this group has increased at twice the average rate. In 2013 Dutch pharmacies dispensed a medicine prescribed to treat asthma and/or COPD 7.1 million times to 1.6 million people. Use of these drugs fell for the first time, by approximately 3%, in 2013. In 2012 use remained more or less on a par with 2011.

There was a slight (1.5%) increase in the use of antidepressants in 2013: half the average annual growth rate in the last ten years. Every year approximately 1.1 million people take an antidepressant for a short or longer period. With the share of generic antidepressants having increased to more than 80%, this is usually a non-brand-name drug. In 2013 community pharmacies dispensed diabetes medication to approximately 890,000 patients. 584,000 were prescribed an oral antidiabetic only, 163,000 were prescribed both an oral antidiabetic and insulin, and 143,000 only used insulin. DPP4 inhibitors and GLP-1 agonists play a relatively minor role in the treatment of diabetes type 2 yet there was a sharp increase in the costs of these new types of diabetes medication. In 2010 these drugs accounted for 30% of the costs, in 2013 this increased to 68%.

Per capita expenditure fell further below the Western European average

In 2012 the average per capita expenditure on medicines in the Netherlands was € 322, which was 10% less than the previous year. Hence the Netherlands has fallen further below the Western European average of € 385. The reduced per capita expenditure is accounted for by the transfer of funding of expensive drugs to the hospital budget, lower medicine prices and lower fees for pharmacy services.

In immediate neighbouring countries, per capita expenditure is considerably higher at € 524 in Germany and € 404 in Belgium.

In 2012 expenditure on medicines as a percentage of the total cost of health care in the Netherlands fell from 9.6% to 8.4%. This puts the Netherlands among the top three Western European countries with the lowest expenditure on medicines as a share of the total cost of health care. The other two countries where the percentage share of the cost is even lower are the UK (7.5%) and Denmark (4.9%). At the top of the list are Portugal and France, where expenditure on medicines accounts for 17.5% of the total expenditure on health care.



The Netherlands

1.1 Pharmaceutical care in the Dutch health insurance system

Government no longer sets prices

Most pharmaceutical care in Netherlands is covered by compulsory basic health insurance. In 2012 the pharmacy sector was deregulated. In theory this means pharmacies are free to set their own prices and fees for medicines and pharmacy services. Yet, in practice, all of the measures designed to control expenditure remain in place

Everyone who lives or works in the Netherlands is legally required to take out basic health insurance. The content of the basic health insurance package is determined by the government and is the same for everyone. The majority of the overall cost of health care is covered by basic health insurance and financed by fixed health insurance premiums paid by everyone over the age of 18. While these premiums differ slightly from one insurer to another, they are the same for everyone insured by a particular insurer, irrespective of age, income or state of health. People on a low income may be eligible for a government allowance to help cover the cost of health insurance. No premium is required for children up to the age of 18.

Health care insurers are obliged to accept all applications for insurance and are not permitted to discriminate on the basis of health risk factors. Health insurance premiums are supplemented by income-related contributions withheld at source by employers, which are paid to the government together with payroll tax. The Dutch Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport (VWS)) delimits health care-related costs in terms of ministerial responsibility in accordance with the budgetary framework established for health

care (Budgettair Kader Zorg (BKZ)). (Potential) health care budget overruns are offset by targeted spending cuts, which may be achieved by restricting the statutorily insured drug package for example. In 2014, everyone aged 18 or older is required to pay a general policy excess of € 360 per person for health care provided as part of the statutorily insured package (with the exception of general practitioner, midwifery and obstetric care). In addition to basic health insurance people can choose to take out supplemental insurance that covers health care not included in the statutorily insured package. Insurers are permitted to determine that applications for supplemental insurance will be accepted subject to medical approval.

Drug Reimbursement System

The government determines which medicines are allowed onto the market and which medicines are included in the Drug Reimbursement System (Geneesmiddelenvergoedingssysteem (GVS)). Medicines that have more or less the same effect are grouped in clusters. A reimbursement limit based on the average price is set for each cluster. If the cost of a medicine exceeds the reimbursement limit, the patient is required to pay the difference.

The GVS was introduced in 1991 and reimbursement limits have only been revised once (in 1999). Since most drug manufacturers do not want the users of their medicines to have to pay part of the cost, there are relatively few medicines for which a patient contribution is required. No reimbursement limits are set for medicines that cannot be clustered.

Pricing Act

The Dutch Minister of Health, Welfare and Sport sets maximum prices for medicines twice a year in accordance with the Medicine Prices Act (Wet Geneesmiddelenprijzen (WGP)). The maximum price is the average price of a medicine in Belgium, Germany, France and the UK. The price charged for a medicine may not exceed the maximum price. Since the Act was introduced in 1996, it has been the government’s main means of price control. Implementation of the Act has caused the price level of medicines to fall at an average annual rate of 3 to 4% in recent years.

Preference policies

Since 2003, health insurers have been permitted to impose preference policies that restrict an insured person’s entitlement to one medicine per active ingredient. Prior to that, insured persons had the right to be prescribed any version of a drug included in the GVS. The restriction on entitlement does not apply if treatment with a preferred medicine is not medically advisable (medical necessity). There are two ways in which insurers designate preferred medicines. Some base their designation of a preferred product on the (lowest) price on a public price list, which has resulted in a sharp fall in the prices of medicines for which generic equivalents are available since June 2008. Others base their designation

of a preferred product on a restricted call for tenders and then receive a discount from the manufacturer of the designated medicine, in which case the preferred medicine may also be a more expensive brand-name drug.

Freely determined prices

In 2012 the pricing of medicines was deregulated. Yet the implication that prices are freely determined is somewhat misleading given that all of the above-mentioned government regulations designed to control expenditure on medicines remain in place, together with insurer preference policies. In 2012 the government also stopped setting fees for pharmacy services, though it continues to specify services for which pharmacies can present invoices. Pharmacists are permitted to charge one basic service fee for dispensing a medicine and another for dispensing medicines in weekly medication packs. They are also allowed to add a surcharge for dispensing in the evening, during the night or on a Sunday, preparing a medicine, and dispensing a medicine that is new to the patient. (From 2014 the dispensing of a medicine that is new to the patient is invoiced as a separate service fee rather than as a surcharge.) In addition to these dispensing-related services, the government has also defined pharmaceutical care services that are not directly related to the dispensing of medicines. These services include medication review, instruction on how to use a device needed to administer a medicine, and patient guidance during admission to and discharge from hospital. However, the extent to which insurers have contracted community pharmacies to provide these new non-dispensing-related pharmaceutical care services is very limited.

1.2 Development of expenditure

Lower expenditure a welcome gain for the government

In 2013 expenditure on the statutorily insured drug package fell by 7% to € 4,088 million. The reduction in expenditure was a significant gain for the government given that the budget allowed for an increase of almost 6%.

In 2013 there was a sharp decline in expenditure on medicines for the second year in a row. Community pharmacies in the Netherlands dispensed € 4,088 million worth of medicines in the statutorily insured drug package. This meant that the level of expenditure was € 310 million lower than in 2012 and € 912 million lower than in 2011. From 2008 to 2011 drug expenditure increased at an average annual rate of 2%. In the years prior to that it increased by as much as 6% to 8%.

Hospital budget

The reduction in expenditure was largely due to the transfer of the funding of oral oncology drugs and growth hormones. In 2012 these medicines were supplied through community pharmacies and accounted for expenditure of € 181 million. In 2013 the funding of both intramural and extramural use of these drugs was transferred to the hospital budget. The funding of TNFalpha inhibitors was previously transferred in the same way. In 2011 these drugs accounted for revenues of € 373 million. In 2012 the funding of these drugs was transferred to the hospital budget. The (financial) consequences of the transfer of funding are not yet entirely clear. This is one of the reasons why, in 2014, further transfer of funding to

the hospital budget was limited to hormonal fertility drugs used in IVF treatment. Extramural use of these drugs amounted to € 30 million in 2013.

Significant difference between government-estimated and actual expenditure.

The government did not anticipate a drop in expenditure and actually budgeted for a 5.9% increase in expenditure on pharmaceutical care. The effects of the transfer of funding were factored into this estimated growth rate. The application of this growth rate to expenditure as measured by SFK – excluding the drugs transferred to the hospital budget – would have led to expenditure of € 4,466 million in 2013: € 378 million more than the expenditure actually recorded by SFK in that year.

Difference

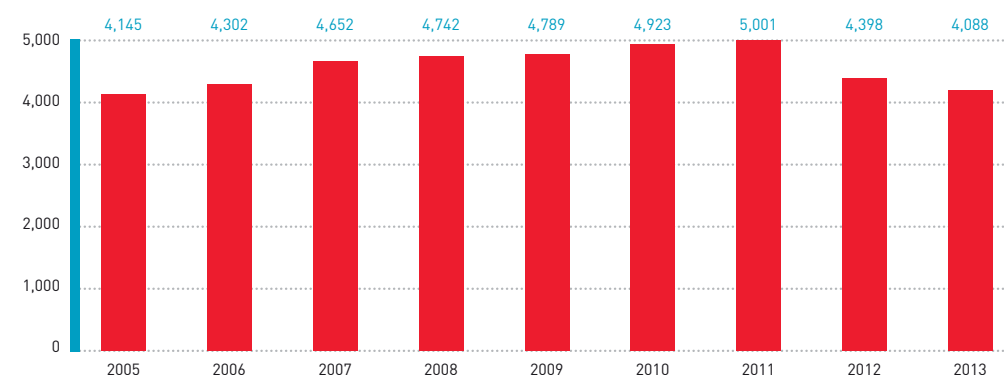
Approximately a third of this difference between projected and actual expenditure can be accounted for by the fact that drug use has lagged behind other developments in recent years. Measured in terms of the number of dispensed defined daily doses (DDDs), medicine use increased by just 1.1% in 2013. Prior to 2012, the annual rise in medicine use averaged at 6%.

Lower prices largely dictated by the Medicine Prices Act (Wet Geneesmiddelenprijzen (WGP)) are responsible for another third of the difference. The effects of patent expiry also contributed to the reduction of medicine prices.

The government also anticipated an increase in pharmacy fees. However, despite (annual) cost increases and inflation, in real terms, reimbursement for services provided by community pharmacies is still below the level of 2011.

And since the extent to which health care insurers have contracted pharmacies to provide the new non-dispensing-related care services is very limited, pharmacies have considerably less scope for innovation than the government envisaged when determining the premiums paid to insurers.

1.1 Total expenditure on pharmaceutical care provided by community pharmacies (1 = €1 million)



Expenditure on medicines fell for the second year in a row.

Source: Foundation for Pharmaceutical Statistics

1.3 Use of medicines

Increase medicine use less than expected

The 1.1% increase in medicine use in 2013 was less than might have been expected based on population growth and population ageing. Are older people healthier, or is the higher policy excess partly responsible?

In both 2012 and 2013 the increase in demand for pharmaceutical care was considerably lower than the average annual growth rate of 4 to 5% in the years prior to that.

In terms of defined daily doses (DDDs), medicine use rose by 1.1% in 2013, rather than the 1.9% that might have been expected based on population growth and population ageing. The annual increase in medicine use is largely determined by the growth of the population and the increase in the number of older people. Figures published by Statistics Netherlands (Centraal Bureau voor de Statistiek (CBS)) show that the Dutch population grew by 0.3% in 2013.

On 1 January 2014 the Netherlands had 16.82 million inhabitants, 2.92 million of whom were 65 years of age or older. That is 17.4% of the total population. In other words, the proportion of over-65s increased by 3.1% in a year. The impact of population ageing makes itself felt given that community pharmacies dispense more than three times as much medication to people in the 65-plus age group than the average Dutch person, and more than five times as much medication to people in the 75-plus age group than the average Dutch person.

Furthermore, the majority of the medicines dispensed to people in the latter age group are used chronically. Yet population growth and the increasing proportion of over-65s did not lead to the expected

rise in medicine use. One explanation might be that, on average, today's over-65s are healthier than those who reached retirement age before them.

Policy excess

The incremental increase in the policy excess payable by insured persons aged 18 and older may also be a contributing factor. Between 2009 and 2013 statutory policy excess increased from € 155 to € 350. The most recent incremental increase of € 130 in 2013 was quite considerable. This was the main reason why far more people did not exhaust their policy excess if, apart from the cost of medicines, no other care costs had to be deducted from their excess. This is making people more cost conscious in their medicine use. It may even lead some people to avoid seeking care.

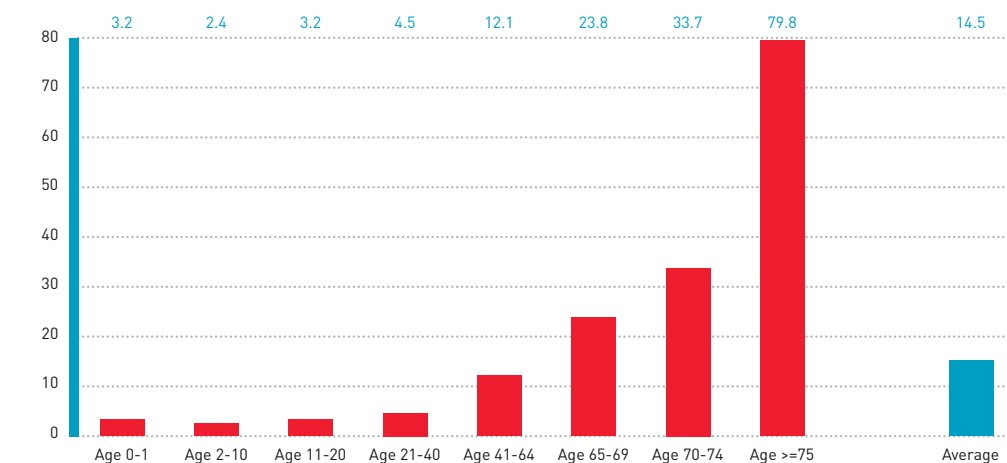
Life expectancy

According to figures published by Statistics Netherlands (Centraal Bureau voor de Statistiek (CBS)), in 2020 the number of older people in the Netherlands will have increased to 3.39 million: 20% of the total population. Population ageing is expected to peak around 2040, when 26.5% of the population will be over the age of 65. Besides the growing number of older people, life expectancy is also increasing. In the last decade life expectancy at birth has increased by 2.7 years and CBS anticipates further improvement

in life expectancy for the over-65s in years to come. Based on current medicine use and the current costs, population growth and the change in the composition of the population will lead the overall expenditure on medicines to increase by just under

2% per year until 2020. In addition to improved life expectancy, forecasts suggest that people will experience more years in good health. This will have a slight moderating effect on the anticipated demand for care.

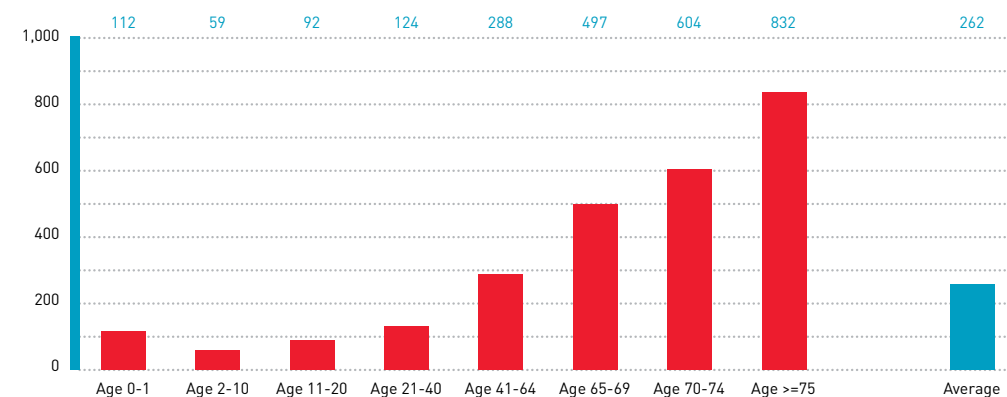
1.2 Use of medicines by age group in 2013 (in prescriptions)



Community pharmacies dispense more than five times as much medication to people in the 75-plus age group than to the average Dutch person.

Source: Foundation for Pharmaceutical Statistics

1.3 Expenditure on medicines by age group in 2013 (in €)



Higher medicine use among senior citizens correlates with proportionally higher expenditure.

Source: Foundation for Pharmaceutical Statistics

1.4 Development of medicine prices

Prices continue to fall

The combined effects of the Medicine Prices Act (Wet Geneesmiddelenprijzen (WGP)), insurer preference policies and voluntary price reductions in light of industry agreements on medicine pricing have meant that the prices of prescription medicines have more than halved since 1996. And prices continued to fall following the introduction of free price setting in 2012. However, the Medicine Prices Act is the main contributing factor.

SFK determines the development of the medicine price level by comparing the total cost of medicines dispensed by community pharmacists one month with the total cost of the same quantity of the same medicines dispensed by community pharmacists the next month. This creates a price index that is unaffected by changes in the number and nature of the dispensed medicines.

Maximum prices

Since it was introduced in 1996, the Medicine Prices Act (Wet Geneesmiddelenprijzen (WGP)) has been the government's main means of price control. In accordance with the Act, the Dutch Minister of Health, Welfare and Sport sets maximum prices for medicines based on the average price of the medicine in question in Belgium, Germany, France and the UK. The price charged for a medicine may not exceed the maximum price. The government sets maximum prices twice a year. In April 2014 the most recent set of maximum prices led to a 0.4% reduction in the price level of prescription medicines compared with March 2014 and a 3.5% reduction compared with April 2013. Two thirds of the reduction in medicine prices can be attributed to the WGP. The remaining third is mainly due to the latest round of insurer preference policies.

Industry agreements

Besides the impact of government-imposed maximum prices, industry agreements regarding the lowering of medicine prices played a significant role from 2004 to 2009. At the start of this period the Dutch Minister of Health, Welfare and Sport, KNMP, the Association of Dutch Health Insurers (Zorgverzekeraars Nederland, (ZN)), and the Association of the Dutch Generic Medicines Industry (Bond van de Generieke Geneesmiddelenindustrie Nederland (Bogin)) agreed that from 1 January 2004 the prices of generic medicines should be reduced to an average of 40% less than the list price set by the manufacturers. They also agreed that the price of new generic medicines should be at least 40% less than the price of the corresponding original brand-name medicine. Nefarma, the association for innovative medicines in the Netherlands, was party to these agreements from 1 January 2005, and the agreements made in 2006 and 2007 were renewed. In September 2007, the then Dutch Minister of Health, Ab Klink, signed a similar agreement with Bogin, KNMP, Nefarma and ZN in the form of a Transition Agreement. The lowering of maximum prices under the Medicines Prices Act and the expiry of the patents of various medicines helped ensure that the targeted spending cuts defined in the industry agreements were

achieved every year from 2005 onwards. In 2008 and 2009, partly due to the influence of health insurer preference policies, these targets were significantly exceeded.

Preference policies

At the beginning of 2008 several health care insurers (Menzis, VGZ, CZ and Agis) announced their intention to expand the implementation of their preference policies from 1 July 2008. The Association of Dutch Health Insurers (Zorgverzekeraars Nederland, (ZN)) had been experimenting with preference policies for several years, but this had had little effect at a national level. Insurers who implement a preference policy stipulate that only one or certain products within a specific group of medicines will be covered by their basic health insurance. Medicines produced by suppliers (labels) not covered by the insurer are not reimbursed. Contrary to the patient contribution regulations of the Drug Reimbursement System, this means that patients have to pay for alternative products entirely out of their own pocket. The national 'call for tenders' issued by the insurers in June 2008 sparked a real price war between suppliers of generic medicines. The prices of the main generic medicines fell by 90%. Throughout the course of the year the price war led to cost reductions of € 355 million. Earlier the same year the prices of generic medicines had already been reduced by € 125 million as a result of the Transition Agreement that Minister Ab Klink signed with the pharmacy industry. Hence revenues derived from the sale of generic medicines were reduced by half in a period of less than six months.

Concealed price policy

The Dutch Ministry of Health 'cashed in' on the effects of the price cuts by reducing the insurers' medicines budgets accordingly. Dissatisfied with this development, in 2009 health care insurer VGZ introduced a system of privately negotiated prices: a concealed price model in which the medicine supplier did not reduce the official price of a medicine, but offered VGZ a privately negotiated discount. The model met with severe criticism, because it

was not clear how the purchasing advantage gained by VGZ benefitted the insured, and also because pharmacists were obliged to supply certain generic products when cheaper versions were available. As a result, during the course of 2009, VGZ announced that medicines supplied under a concealed price policy would no longer count towards the mandatory policy excess.

Freely determined prices

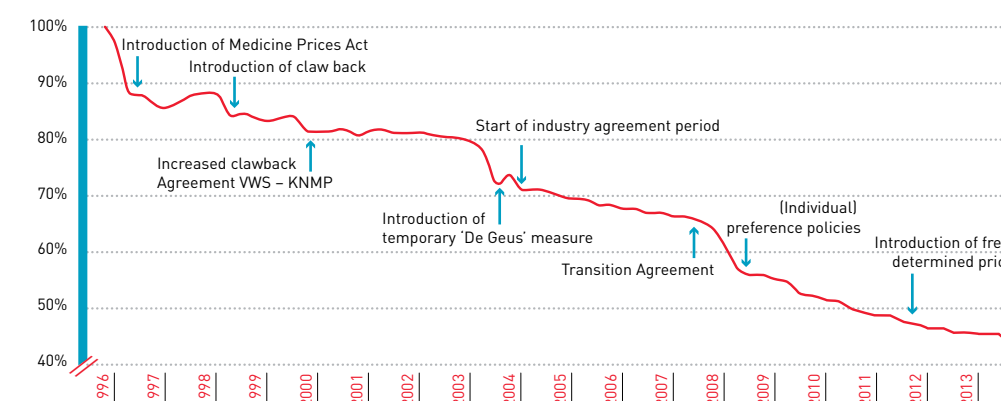
In addition to freely negotiable fees for pharmacy services, from 1 January 2012 pharmacists were free to set their own prices for medicines. Yet the implication that prices are freely determined is somewhat misleading given that most of the government regulations designed to control expenditure on prescription medicines remain in place. The provisions of the Medicine Prices Act (Wet Geneesmiddelenprijzen (WGP)) and the Drug Reimbursement System (Geneesmiddelenvergoedingssysteem (GVS)) continue to apply.

The only statutory price control mechanism that no longer applies is the clawback arrangement. This was a measure that made it compulsory for pharmacies to apply a discount to the pharmacy purchase price when presenting invoices for prescription medicines. In 2011 pharmacists were required to apply a discount of 6.82% up to a maximum of € 6.80 per prescription line. However, although the statutory basis for the clawback arrangement no longer exists, health care insurers have reintroduced the clawback in the contracts they offer pharmacies (albeit sometimes under a different name). Other contractual agreements, such as use of historically lower prices, set prices per delivered quantity and lowest price guarantees, have essentially caused the price level to decrease even more rapidly since 2012.

The price level of medicines is now 33.9% lower than in April 2007. More than half of this drop in price level is a direct result of the WGP. In other words the Act has been more instrumental in reducing Dutch medicine prices than insurer preference policies. The Minister of Health can set a maximum price for a medicine, but is not obliged to do so.

At the moment 72% of the costs of prescription medicines supplied by community pharmacies are affected by the WGP. For more than half of these medicines the difference between the pharmacy purchase price and the maximum price set for the medicines in question is less than 1%. The maximum price set for half of the medicines to which this applies was higher in April 2013 than in October 2013. The differences were relatively minor, hence the effect of the price increases introduced by suppliers was just 0.2%.

1.4 Price development of prescription medicines based on the SFK price index (January 1996 = 100)



Source: Foundation for Pharmaceutical Statistics

1.5 Market shares per product group

70% of pharmacy-dispensed medicines are generics

In 2013 Dutch pharmacists dispensed a generic medicine included in the statutorily insured drug package 151 million times. That is almost eleven million times more often than in 2012. The share of generics increased to 70%.

In line with developments in recent years, in 2013 there was an increase in both the number of pharmacy-dispensed generic medicines and the proportion of generic medicines among the total number of prescription medicines dispensed by pharmacies. The share of generics increased from 66.7% in 2012 to 69.7% in 2013. Yet generic medicines accounted for just 16% of the costs of all medicines in 2013. The total cost of generic medicines increased by € 45 million to € 415 million in 2013. Partly due to the influence of insurer preference policies, generic medicines are usually low priced. In 2013, on average, treatment with a generic medicines cost just over € 2 per month.

Patent expiries in 2013

Of the generic medicines that first became available in 2013, Zaldiar (a combination painkiller containing tramadol and paracetamol) was dispensed more than any other. Between April and the end of last year pharmacists dispensed this generic combination drug 335,000 times. This equates to a generic share of 55%. The corresponding cost of medicines amounted to € 4.3 million. This generic combination drug was only offered by one supplier in 2013 so, the introduction of the new combination painkiller

had a limited impact on the development of costs. The introduction of generic versions of the asthma drug montelukast (Singulair) in 2013 had greater financial impact. While the number of times the drug was dispensed remained more or less the same in 2012 and 2013, the costs fell by 47% to € 8.2 million. 55% of the 280,000 prescriptions for the drug dispensed by pharmacies in 2013 were filled with generics.

Patent expiries prior to 2013

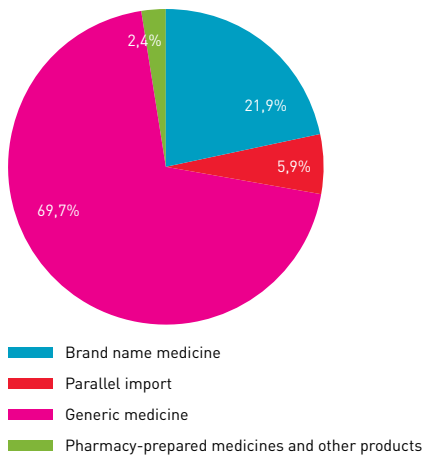
In absolute terms the cholesterol-lowering drug atorvastatin (Lipitor), which went out of patent in 2012, contributed most to the reduction of costs as a result of the increasing use of generic medicines in 2013. The costs of this drug fell by € 40 million to € 14.5 million in relation to 2012: a drop of 74%. The costs of the hypertension drug irbesartan (Aprovel) and the antipsychotic drug quetiapine (Seroquel) fell by € 15 million (65%) and € 11 million (37%) respectively as a result of generic substitution.

Ranbaxy

The low price of generic medicines also has its drawbacks. Besides frequent problems with supply, recently there have also been problems with the quality of generic drugs manufactured at Ranbaxy

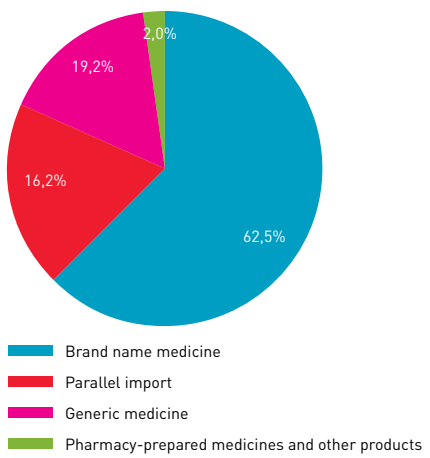
facilities. Reports about this led to a significant reduction in the number of prescriptions filled with generic drugs manufactured by Ranbaxy at the beginning of 2014. In the first weeks of this year Dutch pharmacies dispensed a Ranbaxy drug as a standard service an average of 20,500 times per week. Following the emergence of the controversy this fell to 7,500.

1.5 Use of medicines per product group: prescriptions 2013



Source: Foundation for Pharmaceutical Statistics

1.6 Use of medicines per product group: cost of medicines 2013



Source: Foundation for Pharmaceutical Statistics

1.6 Health care insurers

Just 4% of medicine users switched insurer

4% of medicine users switched insurer in 2013. Those who switch tend to be healthy. People are generally less inclined to switch to another health care insurer as medicine use increases.

The invoices submitted by community pharmacies in the first two months of 2014 suggest that 4% of medicine users switched to a different insurer at the turn of last year. This is less than the previous year when 4.7% of medicine users switched to another insurer. As medicine use increases, people are generally less inclined to switch to another health care insurer. Expenditure on medicines for those who switched insurer at the end of 2013, was, on average, 40% lower than expenditure on medicines for those who stayed with the same insurer. Those who switch are, on average, fourteen years younger.

Customer recruitment

SFK data suggests that medicine users are less inclined to switch health care insurer than the average Dutch person. In its survey of the dynamics of the health care insurance market, the research agency BS Health Consultancy concludes that 6.5% of the Dutch population switched insurer at the end of 2013. This percentage was also lower than the previous year. According to the research agency, combined expenditure on customer recruitment advertising aimed at those considering switching to another insurer increased by 15% to € 59 million. This expenditure forms part of the total acquisition costs incurred by health care insurers in seeking to attract new custom-

ers. According to the Dutch Bank (De Nederlandsche Bank (DNB)), these costs amounted to € 287 million for basic health insurance in 2012. The corresponding amount for 2013 is not yet known. At the end of last year the De Telegraaf newspaper reported an amount of € 541 million. This would mean that the recruitment costs per customer who switched were approximately half the amount collected by the insurer in the form of nominal premiums.

Market share

Despite investments in customer recruitment the switching of insurers does not appear to create much upheaval in the market. The combined market share of the four main insurers among medicine users remained virtually unchanged in 2014. In the first two months of 2014 these insurers had a combined market share of 89.7%, as opposed to 89.7% a year earlier. The market share per insurer also remained more or less the same.

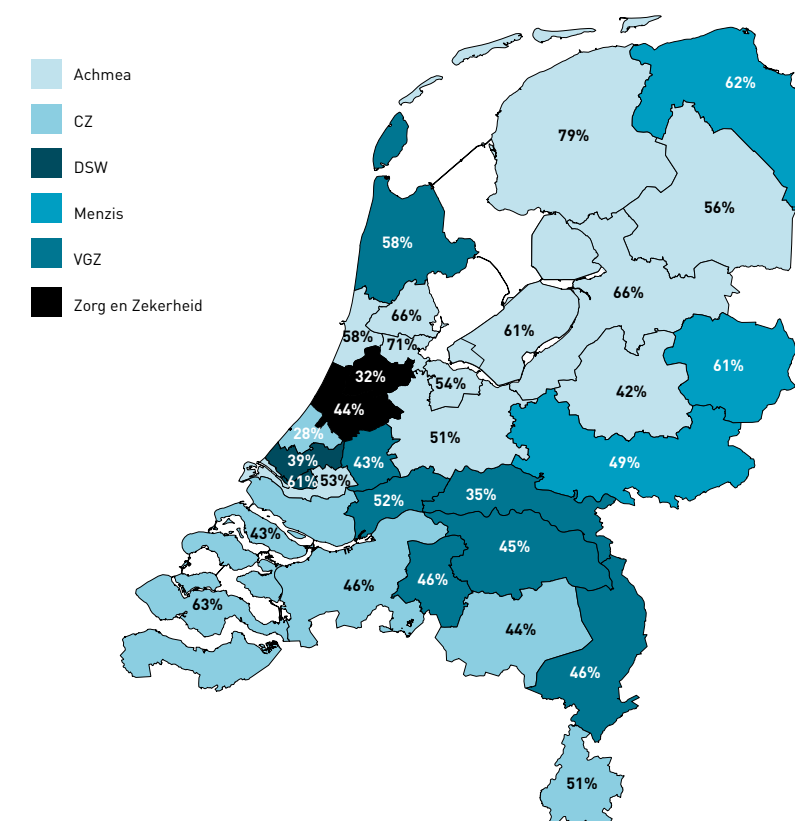
Regional

While most insurers operate at a national level they are still concentrated in particular regions. In other words, the dominant local influence of the former health insurance funds continues to make itself felt. In 2014 the main insurer in each region had

an average market share of 51%. De Friesland has the largest regional market share. Following the merger of the two health care insurers, Achmea now has a 79% shareholding in De Friesland. Achmea is also the main health care insurer in the regions of Amsterdam, Zaanstreek and Zwolle, with a market share of approximately 70%.

The concentration of the main insurer is smallest in the regions of Haaglanden (CZ), Nijmegen (VGZ), Amstelland/Meerlanden (Zorg en Zekerheid) and Delft (DSW), where the market share of the main insurer ranges from 28% to 39%.

1.7 Insurers with the largest market share per region in 2014 based on medicine users



The operating areas of the former health insurance funds are still reflected in the regional concentrations of the health care insurers.

Source: Foundation for Pharmaceutical Statistics

1.7 Availability of medicines

Still supply problems

In an average of 4.3% cases, pharmacists dispensing prescriptions in 2013 had to seek a non-preferred alternative because the preferred medicine specified by the health care insurer was not available.

The procurement contracts between health care insurers and suppliers stipulate that the preferred medicines designated by the insurer must be available throughout the period covered by the contract, yet the lack of availability of designated medicines continues to be a problem. To monitor the extent of the problem, every week the SFK receives reports from wholesalers who list all of the designated preferred medicines they were unable to supply that week. SFK then correlates the data supplied by the wholesalers with the dispensing data supplied by community pharmacies.

In combining the data SFK takes into account the market shares of the wholesalers that are having trouble supplying the drugs.

The types of contracts that pharmacists have negotiated with health care insurers are also factored into the calculations. Contracts that do not involve a preference policy are not included in the calculations. The results of these calculations provide an insight into the impact of the non-availability of preferred medicines from the wholesaler. They do not reflect non-availability from the manufacturer.

Alternative

While the extent and impact of lack of availability vary for pharmacists from one week to the next, problems with supply persist. During the period

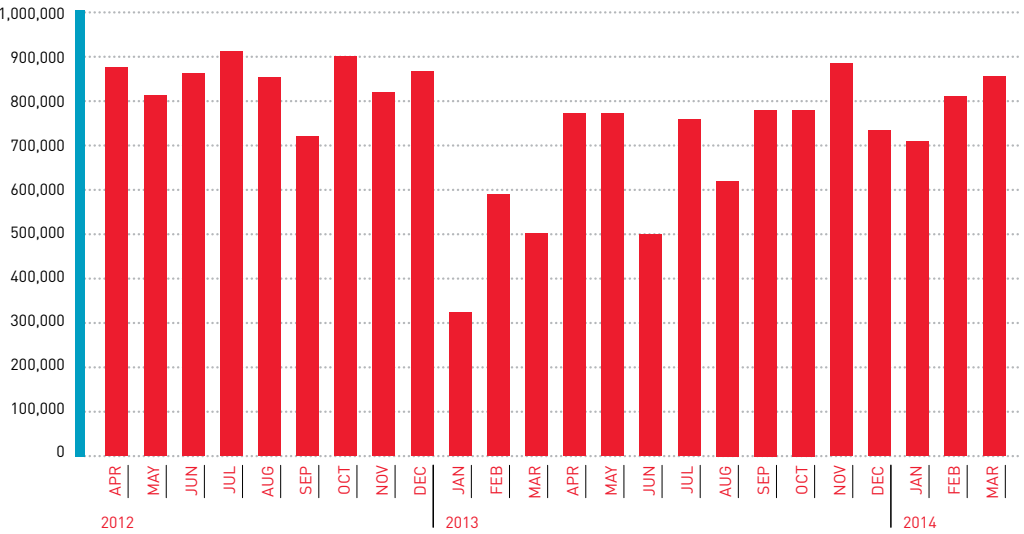
from April 2012 – the month in which SFK started monitoring supply – through to the end of March 2014, the proportion of prescribed drugs that were not immediately available ranged from 1.9% to 5.3%. During the first quarter of 2014 almost 150 medicines designated as the preferred product by health care insurers were not available on a weekly basis, to a greater or lesser extent. This meant that, on average, pharmacists had to seek an alternative for almost 800,000 prescriptions per month, which equates to almost 4.3% of all prescription medicines dispensed by pharmacists. Lack of availability of 40 mg simvastatin tablets, macrogol powder with electrolytes for mixing to a drink and 40 mg atorvastatin tablets had most impact in this respect. Problems with the supply of the latter drug resulted from import ban announced by the Dutch Health Care Inspectorate (Inspectie voor de Gezondheidszorg (IGZ)) for medicines manufactured in one of the Ranbaxy facilities in India.

Impact

Problems with supply have a considerable impact on pharmacies. If a preferred medicine is not available pharmacists have to find an alternative wholesaler or an alternative drug. They also have to bear in mind any alternatives specified by the insurer, which is complicated by the fact that insurers communicate

their preferred alternatives in different ways. And the methods they use are not always supported by software. This places a considerable administrative burden on pharmacies. The efforts made by pharmacists ensure that patients receive the medication they need. Nevertheless, patients often have to wait for their medication or use a different medicine. Pharmacists say this has led to an increase in the number of complaints about pharmacy services.

1.8 Number of pharmacy-dispensed prescriptions that could not be filled with preferred medicines due to problems with supply



Problems with supply associated with insurer preference policies differ from one week to the next.

Source: Foundation for Pharmaceutical Statistics

1.8 Medicine use in Western Europe

The Netherlands below Western European average

In 2012 the average per capita expenditure on medicines in the Netherlands was € 322. This was 10% less than the year before. Hence the Netherlands has fallen further below the Western European average of € 385.

In 2012 the average per capita expenditure on medicines (both those included and those not included in the statutorily insured drug package) in the Netherlands fell by approximately 10%. This effectively meant that the average Dutch person spent € 34 less on medicines and caused the Netherlands to fall further below the Western European average. The reduced per capita expenditure is accounted for by the transfer of funding of expensive drugs to the hospital budget, lower medicine prices and lower fees for pharmacy services.

Highest expenditure

In immediate neighbouring countries, per capita expenditure on medicines is considerably higher at € 524 in Germany and € 404 in Belgium. In Belgium per capita expenditure in 2012 remained more or less the same as in 2011. However, as a result of the reduced expenditure in the Netherlands, the difference between the two countries increased to 26%. In Germany per capita expenditure on medicines was 2% more than in 2011 and 63% higher than in the Netherlands. France, which has traditionally had the highest per capita expenditure in Western Europe, cut back considerably on medicine expenditure in 2012.

Average expenditure of € 521 per person represented a decrease of 8% in relation to 2011. As a result, France is now further down the list, behind Switzerland (€ 596) and Germany.

Lowest expenditure

The UK continues to occupy the other end of the expenditure spectrum, with per capita expenditure of € 224, which is the lowest in Western Europe. This low amount is largely accounted for by the fact that expensive medicines are dispensed by hospitals, so expenditure on expensive drugs falls outside the extramural budget. In 2012 the Netherlands started transferring the funding of certain expensive medicines to the hospital budget. Expenditure on expensive medicines that are still supplied by community pharmacies – an average of € 49 per person – is included in the Dutch figures. Countries in southern Europe have traditionally had low per capita medicine expenditure. As in 2011, Portugal (€ 239), Italy and Spain (both € 291) continued to cut back considerably on medicine expenditure in 2012.

Per capita expenditure ranged from 7% (Italy) to 12% (Portugal) in these countries.

The combined effect of all developments caused the average per capita medicine expenditure in Western European to fall by 3.8% from € 400 in 2011 to € 385 in 2012.

Population ageing

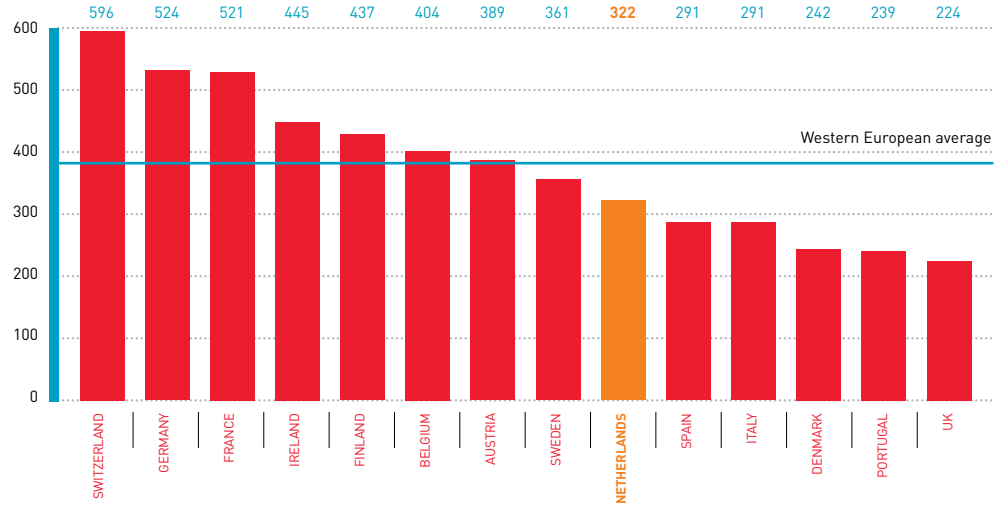
The differences in per capita medicine expenditure can be partly accounted for by population ageing. In the Netherlands people in the 65-plus age group use three times as much medication as the average person.

In 2012 16.2% of the Dutch population in the Netherlands was 65 years and older. The propor-

tion of over-65s in France, Belgium and Germany is significantly higher at 17.1%, 17.4% and 20.6% respectively.

The extent to which cheaper generics are used is also a relevant factor. In 2012 Dutch pharmacies dispensed a generic medicine in two-thirds of cases. This is comparable with the use of generics in countries such as Germany (66%) and the UK (73%). In countries such as Portugal, Italy and Belgium, generics are dispensed in approximately 25% of cases. Lastly, the conservative prescription policy adopted by Dutch doctors also contributes to the relatively low per capita expenditure on medicines in the Netherlands.

1.11 Per capita expenditure on medicines dispensed by pharmacies and general practitioners in 2012 (in €)



Dutch expenditure continues to fall further below the Western European average

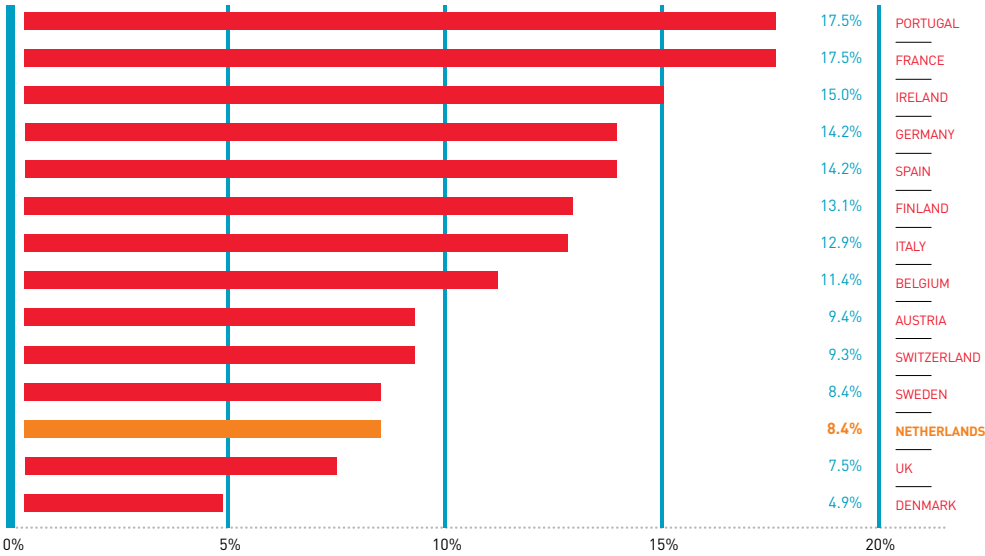
Source: Foundation for Pharmaceutical Statistics

Top 3

In 2012 expenditure on medicines as a percentage of the total cost of health care in the Netherlands fell from 9.6% to 8.4%. This puts the Netherlands among the top three Western European countries with the lowest expenditure on medicines as a share of the

total cost of health care. The other two countries where the percentage share of the cost is even lower are the UK (7.5%) and Demark (4.9%). At the top of the list are Portugal and France, where expenditure on medicines accounts for 17.5% of the total expenditure on health care.

1.12 Expenditure on pharmaceuticals dispensed by pharmacies and general practitioners as a share of the total expenditure on health care in 2012



The Netherlands is one of the three countries with the lowest expenditure on medicines as a share of the total expenditure on health care.

Source: Foundation for Pharmaceutical Statistics



Medicines

2.1 Expenditure on medicines

Seretide is back at the top of the list

Expenditure on Seretide fell by € 10 million in both 2012 and 2013. Yet Seretide still accounted for more expenditure than any other medicine in the statutorily insured drug package in 2013. Methylphenidate made its debut in the top 10.

In relation to 2012, there were significant changes in the top 10 statutorily insured drugs that accounted for the highest expenditure in 2013. There were four newcomers, with two making a re-entry: simvastatin, which last appeared on the list in 2007, and omeprazole, which was only absent from the list for a year. Methylphenidate, which is used to treat ADHD and Insulin aspart (an insulin analog marketed as NovoRapid) were genuine newcomers. With the transfer of somatropin (used for treating growth problems) to the hospital budget, the drug has disappeared from the list now that it no longer forms part of pharmacy care expenditure through community pharmacies. Because expenditure on medicines includes the cost of materials and reimbursement of pharmacy fees, the list includes both commonly used low-priced drugs and more expensive drugs that are used relatively infrequently.

Asthma/COPD drugs

Despite a € 10 million decline in expenditure on Seretide (a combination preparation containing salmeterol and fluticasone) due to lower use, the drug retained its place at the top of the expenditure list. The first generic version of the drug was brought onto the market in the autumn of 2013, hence the impact is not reflected in the expenditure in 2013. If several suppliers proceed to bring out generic

versions of the drug this year, the impact will probably show in the list for 2014. The bronchodilator tiotropium accounted for € 94 million in expenditure and remained in second place, as in 2012. Unlike in 2012, the top 3 did not include a third respiratory drug in 2013. This was due to the fact that the combination of formoterol and budesonide now has its own ATC code, whereas it previously shared a code with the combination of formoterol and beclomethasone. Without the changes in the ATC codes, the combination expenditure on the two products together amounted to € 83 million in 2013, which would have secured third place in the list.

Cholesterol-lowering drugs

The cholesterol-lowering drug rosuvastatin (+8%) just made it to third place. And simvastatin, which last appeared on the list in 2007, returned to the top 10 due to increasing use.

.....
'Cheap' simvastatin and omeprazole make
a comeback
.....

Atorvastatin disappeared from the top 10. With Lipitor having lost its patent in 2012, expenditure on the drug continued to fall in 2013 and ultimately amounted to € 27 million, a drop of 58%.

Patient contributions

Methylphenidate made its debut in the top 10 and accounted for € 43 million in expenditure, of which € 23 million consisted of GVS contributions paid by medicine users, or covered by their supplemental

insurance. The € 11.5 million paid by patients for proton-pump inhibitor omeprazole following the tightening of the reimbursement conditions in 2012 is not included.

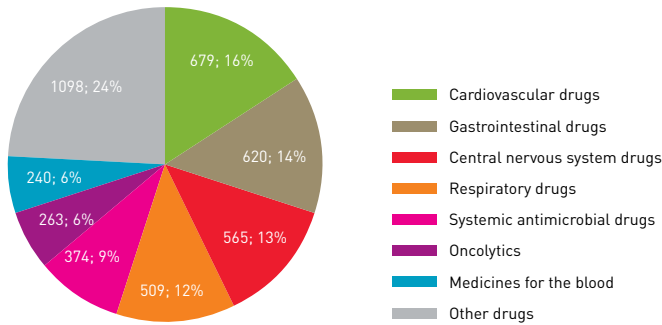
2.1 The top 10 statutorily insured drugs that accounted for the highest expenditure in 2013

	ACTIVE INGREDIENT (RANKING IN 2013)	BRAND NAME	USED TO TREAT	EXPENDITURE (MILLION €)	CHANGE IN RELATION TO 2012
1	Salmeterol with fluticasone (1)	Seretide	Respiratory diseases	108	-8%
2	Tiotropium (2)	Spiriva	Respiratory diseases	94	0%
3	Rosuvastatin (5)	Crestor	High cholesterol	61	8%
4	Formoterol with budesonide (3)	Symbicort	Respiratory diseases	61	-7%
5	Metoprolol (6)	Selokeen, Lopressor	Angina pectoris and hypertension	50	-2%
6	Insulin glargine (9)	Lantus	Diabetes	49	7%
7	Omeprazole (-)	Losec	Gastric acid disorders	47	11%
8	Insulin aspart (-)	NovoRapid	Diabetes	46	6%
9	Simvastatin (-)	Zocor	High cholesterol	44	11%
10	Methylphenidate (-)	Ritalin	ADHD	43	5%

There were four newcomers in the list of top 10 of statutorily insured drugs that accounted for the highest expenditure, including simvastatin and omeprazole, which have previously appeared on the list.

Source: Foundation for Pharmaceutical Statistics

2.2 Expenditure per medicine group in 2013
(1 = €1 million / share in %)



Source: Foundation for Pharmaceutical Statistics

2.2 Medicine users

Diclofenac had most users in 2013

Community pharmacies dispensed diclofenac to 1.5 million people in 2013. Hence diclofenac remained the statutorily insured drug with most users in 2013. In terms of DDDs, omeprazole is the most used drug.

The total number of pharmacy-dispensed prescriptions for statutorily insured drugs amounted to 228 million in 2013: an increase of 4.0% in relation to 2012. In terms of defined daily doses (DDDs), volume increased by 1.9% in 2013.

Top 10

Four of the medicines in the top 10 statutorily insured drugs with the highest number of users, are chronically (long-term) used drugs. The remaining six are generally prescribed for occasional use. There was little change in the top 10 in relation to the previous year. Doxycycline disappeared from the list and made way for acetylsalicylic acid. The fact that the antibiotics in the top 10 had fewer users than in 2012 is also notable. Fluctuations in the numbers of antibiotic users can often be traced to weather conditions, especially in autumn and winter. When it comes to the top 10 most dispensed medicines in the statutorily insured drug package, the drugs used to treat chronic conditions in the list of the top 10 most used medicines occupy the first four positions, with omeprazole in first place. These drugs also feature prominently among the top 10 statutorily insured drugs with the highest number of dispensed DDDs.

The figures for omeprazole only pertain to the part of the cost that qualifies for reimbursement. Reimbursement of proton-pump inhibitor has been restricted since 2012.

Top risers and fallers

The number of users of colecalciferol (vitamin D3, not in the top 10) almost doubled in 2013. These figures reflect changes in the management of osteoporosis in the last few years, in accordance with new guidelines on fracture prevention published by the Dutch College of General Practitioners (Nederlands Huisartsen Genootschap (NHG) at the end of 2012. There were over 450,000 users in 2013. Within the top 10, the number of users of proton-pump inhibitor omeprazole increased most (+39,000). There was also a significant increase (+50,000) in number of people using pantoprazole, another drug in the same class, which brought the total number of users to 630,000. Diclofenac, which topped the list of statutorily insured drugs with most users, saw the largest decline in the number of users (-125,000), followed by doxycycline (-80,000). Combination preparations containing codeine and paracetamol have disappeared from the lists of statutorily insured drugs, having ceased to qualify for reimbursement in 2013 (450,000 users in 2012).

2.3 Top 10 statutorily insured drugs with most users in 2013

	ACTIVE INGREDIENT (RANKING IN 2012)	USED TOT TREAT	USERS (MILLION)	CHANGE IN RELATION TO 2012
1	Diclofenac (1)	Pain and inflammation	1.47	-7.8 %
2	Amoxicillin (2)	Bacterial infection	1.14	-1.2 %
3	Simvastatin (3)	High cholesterol	1.14	+2.2 %
4	Metoprolol (4)	Angina pectoris and hypertension	1.10	-0.4 %
5	Omeprazole (5)	Gastric acid disorders	1.07	+3.8 %
6	Anesthetic dermatological agents (6)	Eczema and other skin conditions	1.00	+6.7 %
7	Macrogol combinations (7)	Constipation and intestinal ailments	0.90	+2.0 %
8	Salbutamol (8)	Respiratory problems	0.83	-2.7 %
9	Acetylsalicylic acid (11)	Blood clot-related conditions	0.79	+4.4 %
10	Amoxicillin and clavulanic acid (9)	Bacterial infection	0.77	-7.1 %

Despite the decline in the number of users, diclofenac retained its position as the drug with most users in 2013.

Source: Foundation for Pharmaceutical Statistics

2.3 Non- and conditionally reimbursed medicines

€ 185 million worth of non-statutorily insured drugs

Dutch pharmacies dispensed approximately € 185 million worth of prescription medicines that were not reimbursed as part of the statutorily insured drug package in 2013. Additionally more than € 38 million had to be paid for these medicines by the insured users.

Generally speaking, prescription medicines are included in the statutorily insured drug package in the Netherlands. However, some are excluded from reimbursement. Most prescription medicines are reimbursed if certain conditions are met. The rest are unconditionally excluded from reimbursement. Pharmacies dispensed approximately € 185 million worth of prescription medicines that were not reimbursed as part of the statutorily insured drug package in 2013, over 6 million more than in 2012. The increase was entirely attributable to combination painkillers containing paracetamol and codeine, which were added to the list of excluded medicines on January 2013. Medicine users spent € 6.7 million on these medicines out of their own pocket last year. The total amounts spent on most of the other medicine groups that are not reimbursed were more or less the same in 2012 and in 2013.

Non-reimbursed medicines

The list of non- and conditionally reimbursed medicines has increased in recent years. In 2009 reimbursement of sleep-inducing drugs and sedatives was restricted to specific situations. In 2013 medicine users coughed up € 40 million for these drugs, and health care insurers reimbursed € 27

million. In 2010, with a few exceptions, the government restricted the reimbursement of hormonal and local contraceptives to insured persons under the age of 21. In 2013, a total of € 64 million spent on these contraceptives was not reimbursed as part of the statutorily insured drug package. As of January 2012, proton pump inhibitors can only be dispensed at the expense of the health care insurers if they are prescribed for chronic use. This meant that medicine users spent € 18 million on these drugs out of their own pocket in 2013. In terms of entirely non-reimbursed medicines that accounted for most expenditure in 2013, erectile dysfunction drugs were at the top of the list (€ 19.5 million), followed by smoking cessation drugs (€ 9 million). If the latter drugs are used within the context of a smoking cessation programme, they can be reimbursed as part of the statutorily insured drug package, but not through pharmacies.

Partially reimbursed medicines

If a manufacturer sets the price of a medicine above the reimbursement limit, the patient is required to contribute towards the cost. In 2013 medicine users had to contribute a total of more than € 38 million towards the cost of partially reimbursed medicines.

Towards the cost of ADHD drugs alone € 27.5 million was contributed, of which insurers only reimbursed 23 million.

In the case of the ADHD drug atomoxetine, the difference between the amount paid by users (€ 4.0 million) and the amount reimbursed by insurers (€ 400,000) was extreme. The part of the cost that was reimbursed included the cost of pharmacy care.

Patients do not always pay these additional costs

themselves. The cost of non- and/or partially reimbursed medicines can be claimed under supplemental insurance policies. There are also so-called repayment schemes, in which manufacturers compensate medicine users because they do not want patients to bear the brunt of Dutch (price) policy. In 2013 one such repayment scheme contributed a total of € 2.1 million extra for solifenacin (Vesicare), a drug used to treat urge incontinence.

2.8 Expenditure on non-reimbursed prescription medicines in 2012 and 2013 (1 = €1 million)

	MEDICINE GROUP		2012	2013
1	Contraceptives, hormonal and local	conditionally excluded	64.5	64.2
2	Sleep-inducing drugs and sedatives	conditionally excluded	47.8	48.2
3	Erectile dysfunction drugs	unconditionally excluded	20.3	19.5
4	Proton pump inhibitors	conditionally excluded	19.7	18.4
5	Anti-malaria drugs	conditionally excluded	10.5	10.0
6	Smoking cessation drugs	unconditionally excluded	6.2	9.0
7	Paracetamol/codeine combinations	unconditionally excluded	-	6.7
8	Hair loss prevention drugs	unconditionally excluded	3.1	2.8
9	Vaccinations (national immunisation programme and prophylactic vaccinations for travellers)	conditionally excluded	2.1	1.8
10	Medicinal cannabis	unconditionally excluded	1.2	1.7

Expenditure on most medicine groups was more or less the same in 2012 and 2013.

Source: Foundation for Pharmaceutical Statistics



Pharmacies

3.1 Independent pharmacies and pharmacy chains

Even fewer pharmacies

For the second year in a row there was a decline in the number of community pharmacies. At the end of 2013 there were 1,974 community pharmacies in the Netherlands: seven fewer than the year before. The existence of fewer pharmacies is opposed to the growing demand for care. While the proportion of chain-owned community pharmacies remained the same, the proportion affiliated with a pharmacy retail formula continued to grow.

The total number of community pharmacies decreased by seven in 2013. The opening of 29 new pharmacies was outweighed by the definitive closure of 36 pharmacies. As a result, the number of pharmacies fell from 1,981 in 2012 to 1,974 in 2013. SFK only counts community pharmacies: pharmacies that carry a stock of medicines for dispensing and are open to the public. The medicines they dispense are primarily intended for home use. Hospital and institutional pharmacies differ in that they are not open to the public, hence SFK does not include these pharmacies in the count. The same applies to pharmacies that only provide support services for other pharmacies, such as compounding pharmacies, which simply produce magistral preparations for other pharmacies. SFK also excludes from the count pharmacies that specialise in central prescription filling or automated medication distribution, also known as 'Baxter' pharmacies.

It is notable that more than the half of the pharmacies that closed in 2013 only opened this century. These relatively new pharmacies clearly found it impossible to operate at a profit.

Growing demand for care

Pharmacy closures are not dictated by reduced consumer demand caused by the continuing recession or increasing numbers of people shopping online for example. On the contrary, the demand for pharmaceutical care is increasing. In terms of defined daily doses (DDDs), the demand for prescription medicines increased by 1.6% last year. Had the service offering of community pharmacies kept pace with this development, rather than decreasing, the number of pharmacies would have risen by thirty. The trend for the number of pharmacies to lag behind growing demand has been apparent for some time.

Outpatient pharmacies

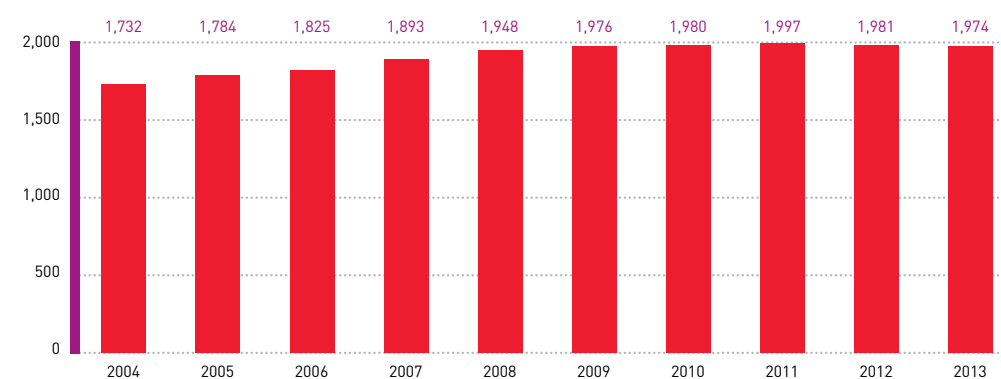
The 29 new pharmacies that opened in 2013 included a disproportionately large number of outpatient pharmacies. With more than a quarter of the new pharmacies, eight in total, being outpatient pharmacies, their number increased from 66 to 74. In many cases these public pharmacies in, or on the site of, a hospital play an important role in dispensing more expensive medicines that are funded by the hospital budget, even if they are used at home. This applies to TNFalpha inhibitors (2012), oral oncology drugs and growth hormones (2013) and drugs used in IVF treatment (2014).

Out-of-hours pharmacies

Unlike outpatient pharmacies, out-of-hours pharmacies, which are only open outside of normal pharmacy opening hours, are struggling. In the past, community pharmacies undertook to share the cost of running an out-of-hours pharmacy, but their financial position has deteriorated to such an extent that they can no longer afford to do this. In 2013 the number of out-of-hours pharmacies decreased by four, such that there are now 41. In the autumn of 2013,

the Foundation for Out-of-Hours Pharmacies in the Netherlands (Stichting Dienstapotheken Nederland (SDN)) and the Association of Dutch Health Insurers (Zorgverzekeraars Nederland, (ZN)) presented a joint proposal, recommending that, like general practices, out-of-hours pharmacies should agree fees with the main insurer and a second insurer in their region. Whether or not this proposal will put a stop to the closure of out-of-hours pharmacies will become apparent in 2014.

3.1 Number of community pharmacies 2004-2013



The number of community pharmacies reverted to the level of 2009.

Source: Foundation for Pharmaceutical Statistics

Pharmacy chains and retail formulas

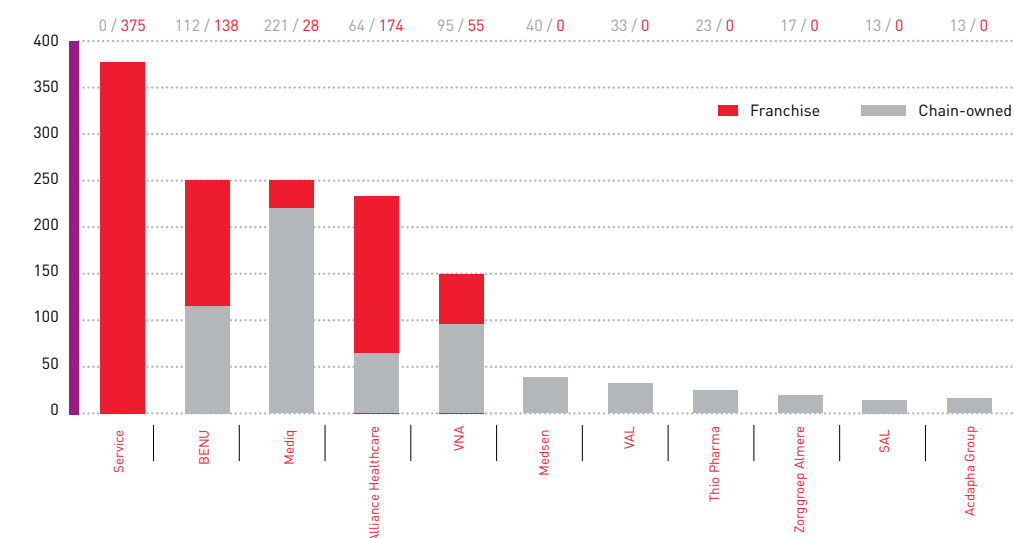
32% of all community pharmacy outlets were owned by a pharmacy chain in 2013. The proportion of chain-owned pharmacies has remained the same for years. In terms of the number of chain-owned pharmacies, Mediq remained the largest chain with 221 pharmacies. In addition to this, approximately 28 independent pharmacists run their pharmacies as a Mediq franchise. The second largest pharmacy chain in the Netherlands is BENU, which is part of the Brocacef wholesale company. In 2103 BENU owned 112

pharmacies, slightly fewer than in 2012, but the number of pharmacies run as BENU franchises increased from 124 to 138. With a total of 250 company-owned and franchise pharmacies, BENU became the largest pharmacy chain in 2013. At the end of 2013, Alliance Healthcare owned 64 pharmacies, with 39 being Kring-apotheek pharmacies and 25 following the international Boots Pharmacy concept. In addition to this, 174 independent pharmacies are run as Kring-apotheek franchises. Alliance Healthcare decided to intensify its cooperation with Alphega

Pharmacy, a leading network of independent pharmacists in Europe. Since the end of 2013 pharmacies operating under the Kring formula have been changed to Alphega pharmacies. A total of 238 pharmacies formula by operating as a franchise led to a considerable increase in the proportion of franchisees. The large pharmacy chains Mediq, BENU and Alliance Health-

care, and smaller pharmacy chains Medsen Apotheek (40 pharmacies), Thio Pharma (23), Zorggroep Almere (17) and SAL Apotheken (13), are members of the Dutch pharmacy chain association (Associatie van Ketenapotheken (ASKA)).

3.2 Number of company-owned and franchise pharmacies per chain or formula in 2013



Mediq has the largest number of chain-owned pharmacies, BENU is the largest pharmacy chain, Service is the most used pharmacy retail formula.

Source: Foundation for Pharmaceutical Statistics

3.2 Community pharmacy revenues

Slight but inadequate increase in fee revenues

In 2013, on average, community pharmacy fee revenues increased by 2% in relation to 2012. Even so, fee revenues remained well below the level of 2011 (the last year in which pharmacy fees were set by NZa). Outpatient pharmacies fared better.

In 2013 community pharmacy revenues, which consist of fee revenues and revenues from the sale of dispensed medicines, averaged at € 2.1 million. This was € 144,000 (6.5%) less than in 2012. Lower revenues from the sale of medicines, which fell by an average of € 158,000 per pharmacy, were responsible for the decline in revenues. The transfer of funding of oral oncology drugs and growth hormones to the hospital budget contributed significantly to the overall decrease in revenues. Lower prices dictated by the Medicine Prices Act (Wet Geneesmiddelenprijzen (WGP)) and the introduction of generics following patent expiries were also a contributing factor.

Fee revenues

In 2013 the average community pharmacy received fee revenues of € 627,000 for the dispensing of prescription and non-prescription medicines included in the statutorily insured drug package. This was € 14,000 (2%) more than in 2012. This can be accounted for by the somewhat higher fees paid by health care insurers for pharmaceutical care services, combined with the slight increase in medicine use. Yet even with this 2% increase, pharmacy fees for the dispensing of medicines remained well below the level of 2011 (the last year in which pharmacy

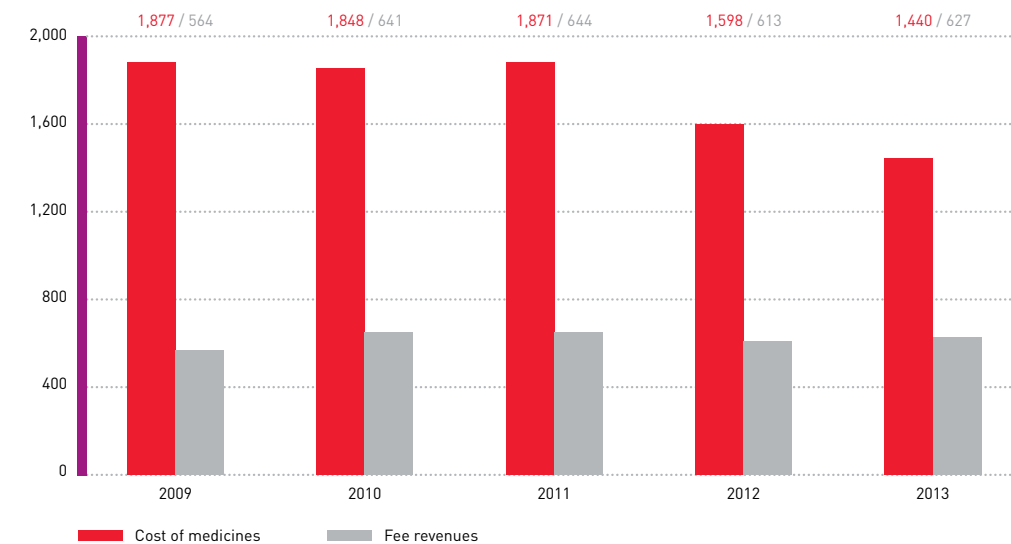
fees were set by NZa). In 2011 the average pharmacy received fee revenues of € 644,000. Since the introduction of deregulation of pharmacy fees in 2012, where pharmacists and health care insurers have to agree fees between them, community pharmacies have never obtained the revenues they earned when appropriate fees were still set by NZa. The development in fee revenues failed to keep pace with practice expenses. Among other things, the increase in pharmacy activities combined with the wage trend meant that fee revenues lagged behind practice expenses. However, the developments described above apply to the average community pharmacy. The experience of individual pharmacies may differ considerably.

Specialist segment

For pharmacies specialising in a particular segment of pharmaceutical care, such as outpatient pharmacies and out-of-hours pharmacies, the figures differed from those for the average pharmacy. Outpatient pharmacies saw an average 6% increase in their fee revenues in 2013. This was in line with the increase in the average number of dispensed prescriptions, which was also 6%.

Compared with 2012, the average out-of-hours pharmacy dispensed statutorily insured drugs

3.3 Average cost of medicines and fee revenues per pharmacy 2009-2013 (1 = €1,000)



In 2013 fee revenues remained well below the level of 2011, the last year prior to the introduction of freely determined prices and fees for medicines and pharmacy services.

Source: Foundation for Pharmaceutical Statistics

approximately 4% less often in 2013. Yet higher fees agreed by health care insurers and pharmacists for pharmaceutical care services provided in the evening, during the night and on the weekend, meant that, rather than being consistent with this reduction, the corresponding fee revenues were approximately 4% higher.

In 2014 the fee system has changed for many out-of-hours pharmacies. In line with a proposal published in the autumn of 2013, fees have been negotiated on a more individual basis. Like general practices, out-of-hours pharmacies agree fees with the main insurer and a second insurer in their region.

3.3 Community pharmacy personnel

Cutback on the hiring of pharmacy assistants

In spite of a strong inflow of recently qualified pharmacists, the number of pharmacists in the community pharmacy remained the same in 2011. In community pharmacies, the demand for pharmaceutical care nevertheless continues to increase. There seems to be a greater willingness to study pharmaceuticals.

While the number of active community pharmacists fell by approximately 20 in 2012, it rose by 30 in 2013. This equates to a increase of approximately 1%. On 1 January 2014 there were 2,868 active community pharmacists in the Netherlands. Of these, 1,974 were established pharmacists and 894 were second pharmacists. The 30 pharmacists who entered the sector in 2013 all fell within the category of second pharmacists. The number of established pharmacists decreased by 7. Unlike the decline in the number of pharmacy outlets in 2013, the rise in the number of active community pharmacists was in line with the slight increase in the demand for care.

Fewer pharmacy staff

The increase in the number of pharmacists was not accompanied by a similar rise in the number of pharmacy staff. According to information provided by the Pharmacy Assistants' Pension Fund (Pensioenfonds Medewerkers Apotheken (PMA)), on 1 January of this year 16,204 people were employed as pharmacist's assistants. This is 214 fewer (1.3%) than on 1 January 2013. In terms of FTEs, the total number of pharmacist's assistants amounted to 10,935.

This equates to a decrease of 81 (0.7%). In addition to pharmacist's assistants, community pharmacies also employed a total of 7,666 support staff, who include general support personnel, delivery staff, cleaners and administrative staff. While their number increased by 37 in 2013, their employability fell by a total of 80 FTEs (2%), which brought the number of FTEs to 4,054.

Staff levels

At the beginning of this year pharmacies employed an average of 8.2 pharmacy assistants, who worked an average of 24.3 hours per week. This equates to 5.5 FTEs per pharmacy. The average pharmacy also employs 3.9 other pharmacy staff who work an average of 19 hours per week (2.1 FTEs per pharmacy).

The net decrease in the number of pharmacy staff (161 in FTEs) is diametrically opposed to the slight increase in the demand for care mentioned earlier. It is possible that pharmacists are cutting back on pharmacy staff and compensating with more extensive automation.

Population

Just over half (54%) of established pharmacists are male, with an average age of 47. Female established pharmacists are significantly younger (with an average age of 42). When it comes to pharmacists who are also (part-)owners of a pharmacy, the gender ratio is far more skewed. As many as two-thirds of this group are male. The majority (54%) of estab-

lished pharmacists who practice their profession as paid employees are women. Unlike established pharmacists, the majority (64%) of second pharmacists are women. As is the case among established pharmacists, the average age of male second pharmacists is 47. This is higher than the average age of their female colleagues, which is 38.

3.4 Number of staff employed by community pharmacies 2009-2013

	2009	2010	2011	2012	2013
Community pharmacies	1,976	1,980	1,997	1,981	1,974
Pharmacists	2,877	2,858	2,859	2,838	2,868
Pharmacy assistants	16,548	16,203	16,368	16,418	16,204
Support staff	6,657	6,928	7,270	7,632	7,666

The decrease in the number of pharmacists in 2012 was followed by an increase in 2013.

Source: Foundation for Pharmaceutical Statistics



Key figures pharmaceutical care in 2013

provided by community pharmacies
as part of the statutorily insured
drug package

	NETHERLANDS	AVERAGE PER PHARMACY	AVERAGE PER PERSON
Pharmaceutical care revenues	€ 4,088 million	€ 2,067,000	€ 262
of which, GVS contributions	€ 40 million	€ 20,000	€ 3
Cost of medicines	€ 2,848 million	€ 1,440,000	€ 182
Prescription-only medicines (POM)	€ 2,729 million	€ 1,380,000	€ 175
Non-prescription-only medicines	€ 119 million	€ 60,000	€ 7
Pharmacy compensation	€ 1.240 million	€ 627,000	€ 80
Dispensing fee (POM)	€ 1.227 million	€ 620,000	€ 79
Margin on non-prescription-only medicines	€ 13 million	€ 7,000	€ 1
Prescriptions	226 million	114,400	14.5
Prescription-only medicines (POM)	217 million	109,800	13.9
Non-prescription-only medicines	9 million	4,600	0.6
Patients	15,6 million	7,900	-

SFK bases expenditure on pharmaceutical care on invoices submitted to health care insurers by pharmacies. With the introduction of deregulated prices on 1 January 2012, health care insurers and pharmacists now have to agree the reimbursement for pharmaceutical care between them. The amounts paid to pharmacists by insurers in accordance with contractual agreements may differ from the cost of medicines specified in the invoices submitted to health care insurers by the pharmacies. SFK is not privy to these agreements. In reality, the costs and fees listed above may be lower.

Colophon



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Compilation

A.M.G.F. Griens MSc
J. M. Janssen MSc.
J.D.L. Kroon MSc
J.S. Lukaart MSc
R.J. van der Vaart

Design

Basement Graphics, The Hague

Editorial address

Foundation for Pharmaceutical Statistics
Postbus 30460
2500 GL The Hague
T +31 (0)70 373 74 44
F +31 (0)70 373 74 45
info@sfk.nl
www.sfk.nl

