



# **Facts and Figures 2000**

## Colophon

Facts and Figures 2000 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), September 2000.

### Compiled by

drs. J.L. Tinke

### Editorial address

Foundation for Pharmaceutical Statistics  
P.O. Box 30460  
2500 GL The Hague  
The Netherlands  
Telephone: +31 70 37 37 444  
Fax: +31 70 37 37 445  
E-mail: info@sfk.nl

## Contents

'Facts and Figures 2000': a brief sketch	6
<b>Chapter 1</b>	
Expenditure on pharmaceutical aid	10
1.1 Expenditure up 11%	10
1.2 The costs of drugs	12
1.3 Causes of structural growth	14
1.4 Good runners	20
1.5 Market shares of product categories	24
1.6 Pharmacy fees	28
<b>Chapter 2</b>	
Cost control	31
2.1 First social-liberal government: 1994-1998	31
2.2 Cost control in 1999-2000	31
2.2.1 Updating GVS	33
2.2.2 Non-WTG	35
2.2.3 'Claw back'	36
2.2.4 Incentives measure	38
2.2.5 Approach good runners	39
2.2.6 SFK-prognosis 2000	40
2.3 Long-term policy	40
<b>Chapter 3</b>	
Drug consumption in a European perspective	42
<b>Chapter 4</b>	
The community pharmacy in figures	45
4.1 Turnover community pharmacy	46
4.2 Gross profit percentage	48
4.3 Costs of pharmacy practice	49
<b>Chapter 5</b>	
Expenditure on pharmaceutical aid per person 1999	55

## Foundation for Pharmaceutical Statistics

Since 1990, the Foundation for Pharmaceutical Statistics (Stichting Farmaceutische Kengetallen, SFK) has been collecting exhaustive data about the use of pharmaceuticals in the Netherlands. The SFK directly gathers its data from a panel of pharmacies; 1,160 of the 1,600 community pharmacies in our country are represented on this panel. The 1,160 pharmacies on the panel combined serve 10 million people, dispensing drugs or medical aids some 80 million times per year. For each dispensation, the SFK registers information about the drug supplied, the dispensing pharmacy, the health insurance company that does or does not reimburse the remedy, 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-trying statistical procedures guarantee the high quality and representativeness of the SFK-data.

### Privacy

With regard to the registering 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, which all participating pharmacies individually enter into their pharmacy computer systems. Information about 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 aimed at the mutual exchange of drug consumption data.

The patient's identity always remains hidden from the SFK, because the SFK uses the serial number allocated to the person 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.

*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).*

*The drug expenditures entail the total drug costs and the pharmacy fees.*

*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%.*

### List of used abbreviations

VAT	Value Added Tax
CBS	Central Statistical Office
CTG	National Health Tariffs Authority
CVZ	Committee for Health Insurances
FT(T)O	Pharmaco Therapeutical (Transmural) Consultation
GVS	Drug reimbursement system
KNMP	Royal Dutch Association for the Advancement of Pharmacy
PGEU	Pharmaceutical Group of the European Union
PWC	PriceWaterhouseCoopers
SFK	Foundation for Pharmaceutical Statistics
VWS	Ministry of Health, Welfare and Sports
WTG	Health Care Changes Act

## 'Facts and figures 2000': a brief sketch

### Drug expenditure up 11%

Through the community pharmacies, NLG 6,303 million was spent on drugs in 1999. This is an increase of NLG 616 million or 10.8% compared to 1998. The increase is predominantly attributable to cardiovascular drugs (NLG 121 million), drugs concerning the central nervous system (NLG 119 million), gastrointestinal drugs (NLG 107 million) and drugs for the respiratory system (NLG 51 million).

### Prognosis for 2000

The Foundation for Pharmaceutical Statistics (SFK) expects the increase of the amount spent on drugs to remain limited to 7% in 2000. This percentage is perfectly in line with the growth margins of 6 to 7% generally strived for by the Ministry of VWS in its budget. The temporary adjustment of the expenditure growth is mainly due to an increased 'claw back'-percentage from 3.5% to 6.82% from the first of January 2000. The 'claw back'-percentage is the rebate percentage that pharmacists are legally compelled to pass on to the prices of prescription drugs. The SFK estimates that this measure will have a cost-saving effect of NLG 370 million on the drug expenditure in the year 2000. That is NLG 20 million more than originally anticipated. The SFK expects that the Cabinet for the years 2001 and 2002 will have to allocate additional funds to the drug expenditure in order to get the budget more in line with the realistic expectations regarding the expenditure growth.

### 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 the hospital to the home setting. In addition, the increased amounts spent at community pharmacies are also influenced by the increased market share of community pharmacies at the expense of the market share of dispensing physicians.

### Over-optimistic assessment

Besides the 'claw back'-measure, the Ministry of Health was over-optimistic regarding the cost-saving effects of a number of expenditure cuts. This especially is the case for the adjustment of the drug reimbursement system and the no longer reimbursing of self-care drugs for incidental use.

### Revision GVS

Within the framework of the GVS, the Ministry of VWS clusters therapeutic drugs that are mutually interchangeable. Per cluster, the Ministry sets a reimbursement limit. If a patient uses a drug that costs more than the corresponding limit, he has to cover the price difference himself. Up till January 1999, the reimbursement limits were based on the price level of 1991. Among other things through the introduction of legal maximum prices, the prices of drugs have decreased by well over 20% since then. On the first of February of 1999, the Ministry of VWS updated the reimbursement limits based on the actual prices at that time. According to the SFK, the cost-saving effect of this adjustment amounts to NLG 158 million (include VAT). The Ministry of VWS had aimed at saving NLG 255 million (include VAT). The revision of the reimbursement limits only had a marginal effect on the patient contributions, because most drug manufacturers adjusted their prices to the lower reimbursement limits where necessary.

### Self-care drugs on prescription

Since 1 September 1999, prescribed self-care drugs are only eligible for reimbursement by the health insurance company if the doctor prescribes the drugs for chronic use. The government has set the cutback aims for this measure at NLG 145 million (include VAT). According to the SFK, the above-mentioned measure will maximally lead to NLG 70 million less being spent on drugs. The cost-raising effects caused by the switching behaviour of doctors has not been taken into account. According to a survey among general practitioners, the University of Nijmegen states that 28% of general practitioners is willing to switch to a (possibly more expensive) prescription drug that is fully reimbursed.

### **Approach good runners**

For two years now, the Ministry of VWS has been announcing it wants to take measures to consequently curb the use of antacids as well as cholesterol-lowering drugs. Although VWS in its 2000 budget has incorporated a budget cut of NLG 90 million (include VAT) to tackle the high consumption levels of these good runners, it up till now has not yet taken any concrete steps in this direction. In 1999, antacids and cholesterol-lowering drugs contributed NLG 113 million to the increase in the amount spent on drugs. In contrast, the Health Council however plead for an intensification of the preventive use of cholesterol-lowering drugs.

### **Three-year agreement**

The three-year agreement the minister of Health reached with the KNMP on the 8th of October 1999 put an end to a long-lingering political discussion surrounding the acceptability of purchasing rebates as pharmacy income in addition to the regular fixed fee per prescription. As an argument against the pruning away of the purchasing rebates, the pharmacists stated that the fixed fee per prescription is not sufficient to cover the pharmacy practice costs. Parties found each other in a phased approach. Pharmacists and dispensing physicians are compelled by law to consecutively save NLG 350 million, NLG 385 million and ultimately NLG 425 million (all figures include VAT) by passing on a statutory discount of 6.82% to the prices of prescription drugs (with a maximum of NLG 15 per dispensed drug) between 2000 and 2002. To compensate for the handing in of the purchasing rebates, the fixed fee per prescription will be raised in phases. On the first of January 2000, the fixed fee per prescription was increased from NLG 11.20 to NLG 11.85.

Outside of the three-year agreement, the minister of VWS at the end of 1999 decided that the yields from the incentives policy (the reward for supplying cheaper drugs and pharmaceutical imports) would in the future be taken into account for determining the fixed fee per prescription. The incentive bonus remains in effect as a measure, but from the first of January 2000 the fixed fee per prescription has been reduced by NLG 0.32. With this, the minister saved an additional NLG 35 million on the pharmacy fee.

### **Low drug consumption**

From a European perspective, less money is spent on drugs in The Netherlands. In 1998, the Dutch spent NLG 421 on drugs (including over-the-counter sales). This amount is 30 to 45% below the spending pattern in countries such as Belgium (NLG 600), Germany (NLG 618) and France (NLG 750).

### **The average pharmacy**

The average community pharmacy serves a patient population of 9,000 persons. Per year, it supplies 75,000 drugs worth a total amount of NLG 4 million. The average gross profit percentage amounts to roughly 23% (including purchasing rebates).

### **Staff shortage**

At the moment, roughly half of all the pharmacies is understaffed. In total, there are some 900 vacancies for pharmaceutical technicians. In addition, 15% of the community pharmacies is looking for a second pharmacist. The staff shortage leads to high levels of work pressure in the pharmacy.

## 1 Expenditure on pharmaceutical aid

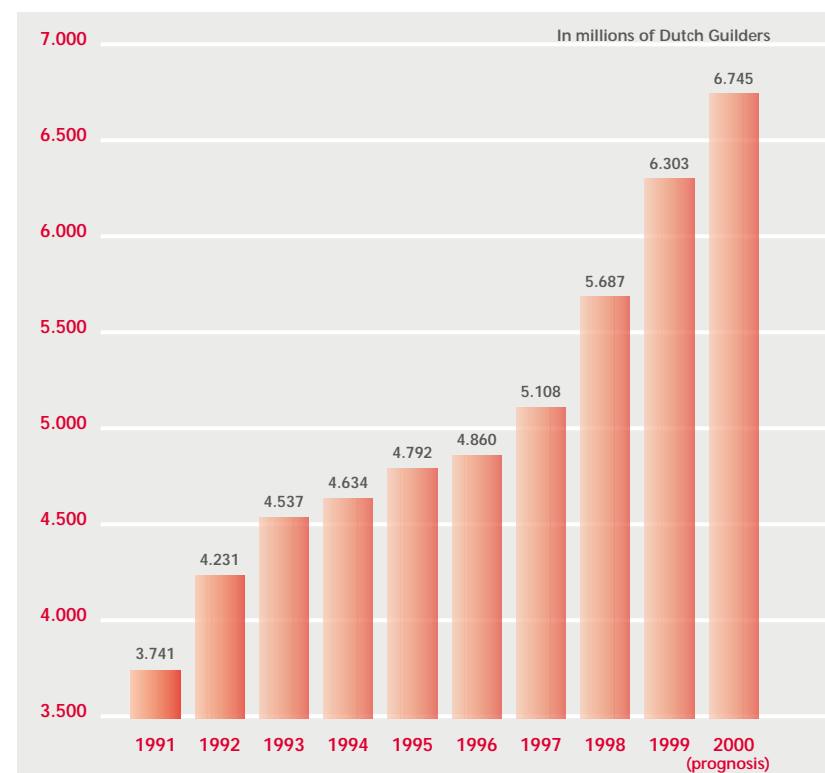
### 1 Expenditure up 11%

In 1999, NLG 6,303 million was spent on drugs via the community pharmacies. That is an increase of 10.8% compared to the previous year. Regarding scale, the increase is comparable to that of 1998. Two-thirds of the increased expenditure of NLG 616 million is attributable to four groups of drugs: cardiovascular drugs (NLG 121 million), drugs aimed at the central nervous system (NLG 119 million), gastrointestinal drugs (NLG 107 million) and drugs aimed at the respiratory system (NLG 51 million). The relative increase is the highest for drugs aimed at the central nervous system; 15.6 % more was spent on these drugs.

Besides the above-mentioned expenditure, which solely applies to drugs that are part of the statutorily insured drug package, the community pharmacies in 1999 also supplied NLG 143 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 himself is headed by the potency pill sildenafil (Viagra®) with NLG 12 million, the slimming product orlistat (Xenical®) with NLG 8 million and xylometazoline, nose drops for a clogged-up nose, with NLG 4 million.

The Foundation for Pharmaceutical Figures (SFK) expects that the amount spent on pharmaceutical aid in community pharmacies will in the year 2000 accumulate to NLG 6,745 million. This corresponds with an increase of 7%. This is in line with the growth margins of 6 to 7% the Ministry of Health generally strives for in its budget (also see chapter 2).

1.01 Total expenditure on pharmaceutical aid: community pharmacies



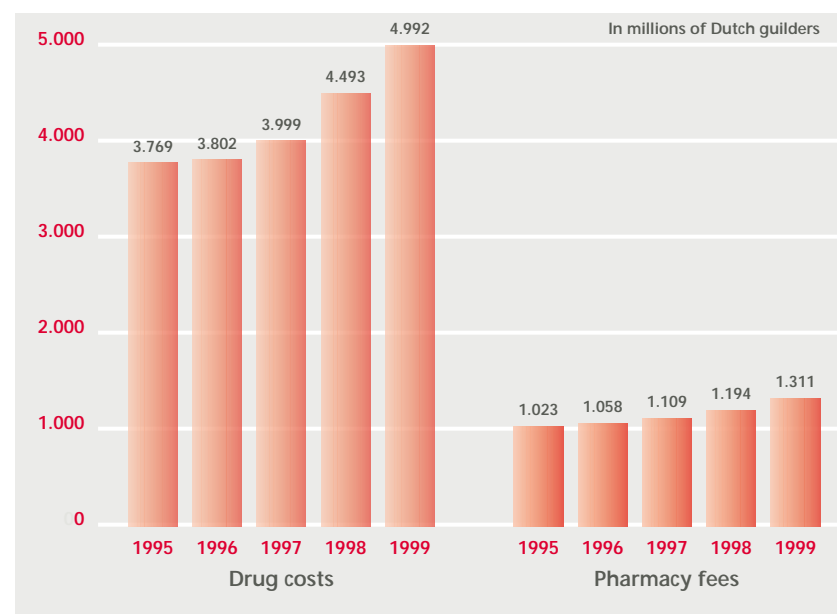
Source: Foundation for Pharmaceutical Statistics

## 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 fees: community pharmacies.



Source: Foundation for Pharmaceutical Statistics

With 79.2%, the costs of drugs by far account for most of the total expenditure on pharmaceutical aid. In 1999, drug costs increased by half a billion guilders to NLG 4,992 million; over the last five years, drug costs increased by a total of 38.2%. This corresponds with an average annual increase of 6.7%. The last two years, the increase in drug costs with an average 11.7% was way above this figure. The reason for this sizeable difference lies in the fact that between 1994 and 1997, drastic economic measures were implemented, such as the general price reduction of 5% in 1994, the thinning out of the statutorily insured drug package in 1994 and 1996 and also the introduction of the Drug Price Act in 1996 (price-lowering

effect of 15%). The measures in question mostly influenced the level of the amount spent on drugs. There has been no change in the trend regarding drug consumption or the amount spent on drugs.

This is the most important explanation for the fact that the expenditure growth since 1998 has almost fallen back to the structural level. In 1998 and 1999, the government only managed to realise marginal savings on the drug costs. Government measures in 1998 remained limited to the introduction of the 'claw back'-measure, which allowed the community pharmacies to pass on NLG 100 million of purchasing rebates through lowering the prices of drugs. In 1999, the minister of Health adjusted the 'claw back'-aim from NLG 100 million to NLG 150 million. After drug manufacturers in 1998 benefited from an increase of the maximum drug prices at the end of 1997 (the increase was the result of a stronger British pound), the lowering of the reimbursement limit within the framework of the Drug Reimbursement System (GVS, also see chapter two) in the spring of 1999 brought the price level of drugs back down to the level of 1997.

For the year 2000, the SFK anticipates that the increase in drug costs with 7% will again be in line with the average increase over the last five years. This controlled cost development is mainly attributable to the implementation of the three-year agreement ratified on the 8th of October 1999 by the minister of Health and the Royal Dutch Association for the Advancement of Pharmacy (KNMP), the professional association of pharmacists. Following this agreement, pharmacists as from the first of January 2000 pass on a 6.82% discount to the prices of prescription drugs (with a maximum of NLG 15 per supplied drug).

### 1.3 Causes of structural growth

Without taking into account the effects of any economic measures, the amount spent on drugs structurally increases 11 to 12% 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 new, often more expensive drugs;
- admission of new drugs to the statutorily insured drug package;
- changed prescription and consumption behaviour.

#### Growth of the Dutch population

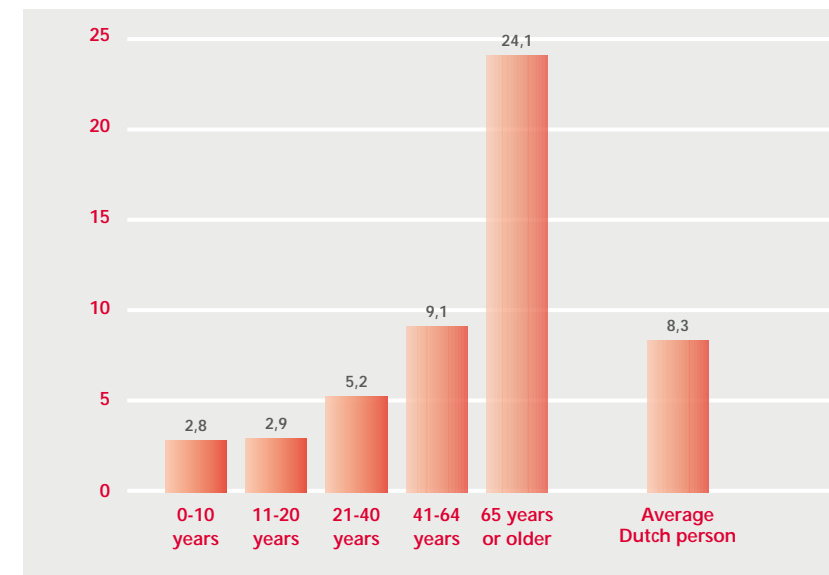
According to data by the Central Statistical Office, the Dutch population grows by 0.7% per year.

#### Ageing of the Dutch population

At the moment, there are 2,155,000 people aged 65 or over in the Netherlands. This corresponds with 13.6% of the total population.

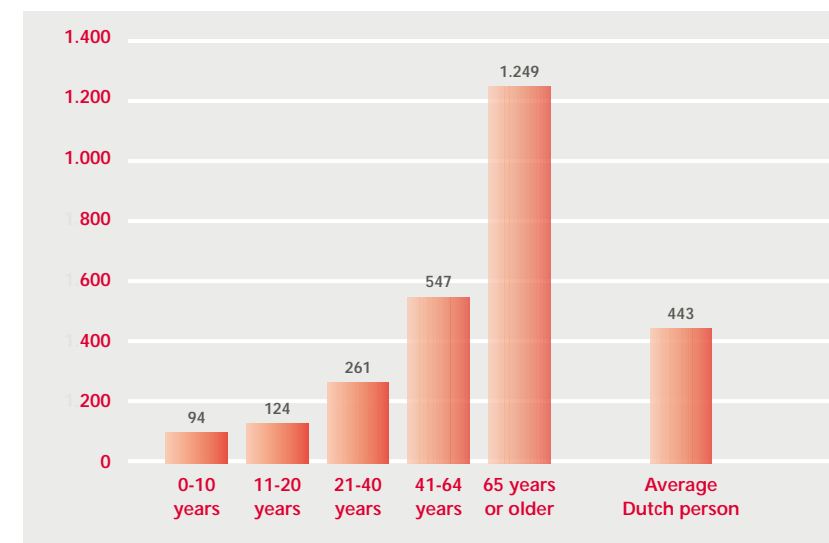
According to the Central Statistical Office, the number of elderly persons in our country will have risen by 310,000 persons in the year 2010. SFK-research shows that the ageing of the Dutch population leads to an annual increase in the amount spent on pharmaceutical aid of 0.6%. Dutch people aged 65 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 average. The higher drug consumption among the elderly leads to a proportionally higher drug expenditure. Of the NLG 2,370 million spent by people aged 65 or over in community pharmacies in 1999, 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 NLG 190 million. This drug is followed by simvastatine (Zocor®) with NLG 100 million and enalapril/enalapriilaat (Renitec®) with NLG 84 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 (1.2 million prescriptions), the pain killer paracetamol (1.2 million prescriptions), the diuretic pill furosemide (1.1 million prescriptions) and the tranquilliser oxazepam (1.1 million prescriptions).

1.03 Drug consumption per age group in prescriptions in 1999



Source: Foundation for Pharmaceutical Statistics

1.04 Drug expenditure based on age in NLG in 1999



Source: Foundation for Pharmaceutical Statistics



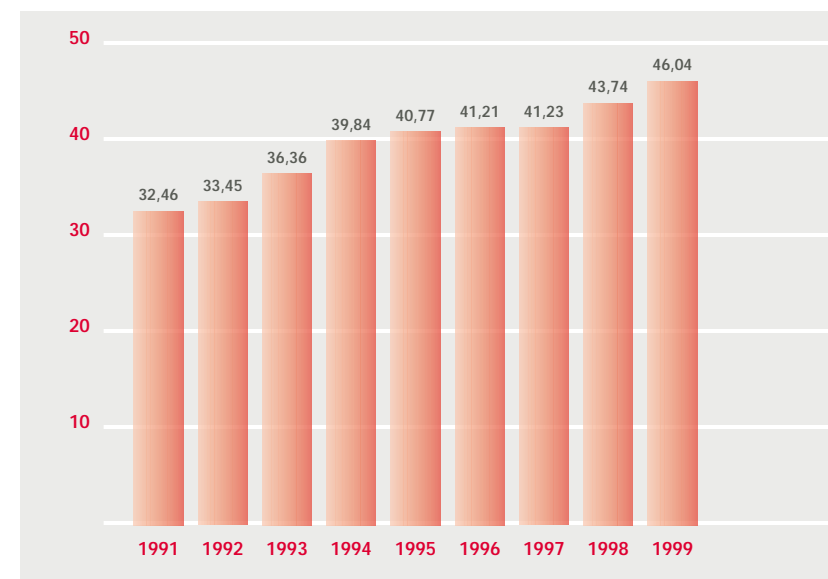
### Shift in health care services from the hospital to the home

According to the Central Statistical Office (CBS), in 1998 there were 369,000 less hospital treatment days (2.4%) compared to the previous year. Despite a population growth of 0.7% per annum, the total number of days spent in hospital has dropped by 15% since 1990. More than ten years ago, The Netherlands had a hospital capacity of 47 beds per 10,000 inhabitants. This capacity has by now been reduced to 36 beds per 10,000 inhabitants. Eventually, the capacity will be further reduced to 25 beds per 10,000 inhabitants. Compared to the situation in the early eighties, the intramural capacity has been reduced by 50%. Through longer waiting lists and shorter hospital admissions (the average duration of treatment over the last ten years was reduced by 20%), this development leads to a shift within the health care sector 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 of drug consumption in our country is estimated at some 3% per year. Although the Ministry of VWS acknowledges this trend, it does not sufficiently take it into consideration when drawing up the drug budget. This to a very great extent explains the fact that overspending is a returning item in the drug file.

### Shift in consumption to new, often more expensive drugs

For WTG-drugs, the drug costs per prescription have increased from an average NLG 32.46 in 1991 to an average of NLG 46.04 in 1999. This corresponds with an average annual increase of 4.5%.

1.05 Drug costs per WTG-prescription in NLG



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 23% over the last four 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 NLG 46.04 but NLG 56.63 in 1999. Or, in other words, without outside interference, the average costs per supplied drug 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 1999, patients on average received a drug supply for 43 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).

However, the most important explanation for the cost increase per prescribed drug is the shift in consumption towards new, generally more expensive drugs. An example: the SFK has ascertained that drugs put on the market since 1 January 1995 by now account for 16% of the total costs of prescription drugs. New treatment options because of this 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 NLG 161 per prescription, the cost price of drugs introduced since 1995 is three and a half 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 elsewhere in the health care sector could lead to cost reductions. Compared to other forms of health care, drug therapy is a very efficient method of treatment.

#### **Admission of new drugs to the drug package**

Over the last couple of years, the government has embarked on a restrictive course with regard to the admittance of new drugs to the statutorily insured package of drugs. Last year, the Ministry of VWS slackened the admission policy. This among other things led to a spectacular 37% expenditure growth on drugs on the so-called 'Bijlage 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 37% expenditure increase on 'Bijlage 1B' corresponds with 3.5% of the total amount spent on drugs. Half of the explosive surge is attributable to an actual increased consumption of the drugs in question. The growth is further explainable by the admittance of new drugs to the statutorily insured drug packet and the shifting of drugs in the packet from 'Bijlage 1A' (drugs with a reimbursement limit) to 'Bijlage 1B' and vice versa.

#### **Changed 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 drug expenditure 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 Committee for Health Insurances (CVZ), 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 a ZFW-insurance were registered at a community pharmacy. In 1999, this percentage increased to 90.3%.

## 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)	NLG	1,351 million
2 Gastrointestinal tract (antacids and other products)	NLG	1,141 million
3 Central nervous system (antidepressants, analgesics, sleep-inducing drugs, others)	NLG	884 million
4 Respiratory system (drugs for the treatment of asthma, chronic lung disorders and such)	NLG	694 million
5 Other	NLG	2,233 million
Total expenditure	NLG	6,303 million

Further specified at substance level, the ten drugs with the highest turnover rate in the community pharmacies account for a total expenditure of NLG 1,372, 22 percent of the total expenditure in 1999. These ten drugs in addition account for 28% of the total expenditure growth in 1999. So, the amounts spent on top-10 drugs increase more than average. It can further be ascertained that in general, 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 a prescription drug from NLG 32.46 in 1991 to NLG 46.04 in 1999.

### Losec

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 NLG 403 million in 1999, NLG 60 million more than in 1998. By the way, the patent on this drug will expire in the not too distant future. Through introducing the variation Losec Mups, AstraZeneca wants to curb an impending loss of turnover. Because pharmacies can no longer obtain the original Losec, roughly 97% of users were switched to this new variation in the middle of 2000.

### Lipitor

Atorvastatine (Lipitor®), a cholesterol-reducer put on the market by American company Parke-Davis in 1997, is close on omeprazol's heels with an increased turnover of NLG 49 million. The amount spent on atorvastatine increased by 74% from NLG 66 million to NLG 115 million.

### Seroxat

The increased consumption of the antidepressant paroxetine (Seroxat®) is also striking. Seroxat® has been available in our country for quite some time now. Because on the one hand the number of prescriptions for Seroxat® increased by 27% and on the other hand the amount supplied per prescription rose, the turnover increased from NLG 88 million to NLG 120 million.

### In vitro fertilisation

When looking at the top-10 of drugs that generated the highest turnover increase in 1999, the ovulation-stimulating hormones follitropine alfa (Gonal F®) and follitropine beta (Puregon®) deserve special attention. These hormones are used to boost the success rate of artificial impregnation. The total expenditure on ovulation-stimulating drugs increased from NLG 27 million in 1998 to NLG 51 million in 1999. For the year 2000, the SFK expects a further increase to an amount of well over NLG 70 million.

### Paracetamol

When looking at the number of times a certain drug was dispensed, good old paracetamol is still the most popular drug in community pharmacies. Paracetamol was supplied 3,075,000 times through the community pharmacy, a decrease of 75,000 compared to 1998. This drop can be explained by the 'First of September measure'. From the first of September, 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.

1.06 Top-10 drug expenditure 1999

Substance name	Brand name	Sort of drug	Expenditure (NLG)
1 A02BC01 Omeprazol	Losec®	Antacid	403 million
2 C10AA01 Simvastatine	Zocor®	Cholesterol-lowering	217 million
3 N06AB05 Paroxetine	Seroxat®	Antidepressant	120 million
4 C10AA05 Atorvastatine	Lipitor®	Cholesterol-lowering	115 million
5 C09AA02 Enalapril/enalaprilat	Renitec®	For high blood pressure	111 million
6 A02BA02 Ranitidine	Zantac®	Antacid	99 million
7 R03BA02 Budesonide	Pulmicort®	Respiratory complaints	85 million
8 A10AD01 Insulin human	Various	For diabetes	78 million
9 R03BA05 Fluticason	Flixotide®	Respiratory complaints	77 million
10 N02CC01 Sumatriptan	Imigran®	For migraine	67 million

Source: Foundation for Pharmaceutical Statistics

1.07 Top-10 increase drug expenditure 1999

Substance name	Brand name	Sort of drug	Increased expenditure (NLG)
1 A02BC01 Omeprazol	Losec®	Antacid	61 million
2 C10AA05 Atorvastatine	Lipitor®	Cholesterol-lowering	49 million
3 N06AB05 Paroxetine	Seroxat®	Antidepressant	31 million
4 G03GA05 Follitropine alfa	Gonal F®	For <i>in vitro</i> fertilisation	23 million
5 L03AB07 Interferon bèta-1a	Avonex®, Rebif®	For multiple sclerosis	17 million
6 J05AF30 Combination-preparations	Combivir®	For AIDS	13 million
7 G03GA06 Follitropine bèta	Puregon®	For <i>in vitro</i> fertilisation	13 million
8 A02BC02 Pantoprazol	Pantozol®	Antacid	12 million
9 N05AH03 Olanzapine	Zyprexa®	For schizophrenia	12 million
10 R03AB05 Fluticason	Flixotide®	Respiratory complaints	12 million

Source: Foundation for Pharmaceutical Statistics

1.08 Top-10 prescribed drugs 1999

Substance name	Brand name	Sort of drug	Number of prescriptions
1 N02BE01 Paracetamol	Various	Pain killer	3.075.000
2 N05BA04 Oxazepam	Seresta®	Sedative	2.655.000
3 M01AB05 Diclofenac	Voltaren®	Pain killer for rheumatism	2.274.000
4 N05CD07 Temazepam	Normison®	Sleep-inducing drug	2.240.000
5 M01AE01 Ibuprofen	Various	Pain killer	1.864.000
6 A02BC01 Omeprazol	Losec®	Antacid	1.769.000
7 B01AC06 Acetylsalicylic acid	Aspirine®	Diluent	1.714.000
8 R03AC02 Salbutamol	Ventolin®	For asthma or COL/COPD	1.575.000
9 G03AA07 Oestrogen with leonorgestrel	Various	Contraceptive	1.540.000
10 C07AB02 Metoprolol	Lopresor®, Selokeen®	For migraine	1.406.000

Source: Foundation for Pharmaceutical Statistics

1.09 Top 10 toename geneesmiddelenvoorschriften 1999

Substance name	Brand name	Sort of drug	Increased prescriptions
1 N06AB05 Paroxetine	Seroxat®	Antidepressant	284.000
2 A02BC01 Omeprazol	Losec®	Antacid	242.000
3 B01AC06 Acetylsalicylic acid	Aspirine®	Diluent	228.000
4 C10AA05 Atorvastatine	Lipitor®	Cholesterol-lowering	179.000
5 R03AB05 Fluticason	Flixotide®	Respiratory complaints	165.000
6 A10BA02 Metformine	Glucophage®	For diabetes	126.000
7 C07AB02 Metoprolol	Lopresor®, Selokeen®	For migraine	124.000
8 H02AB06 Prednisolon	Various	Inflammation inhibitor	116.000
9 G03AA07 Oestrogen with leonorgestrel	Various	Contraceptive	113.000
10 N05CD07 Temazepam	Normison®	Sleep-inducing drug	100.000

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, 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.

### 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 39.9% in 1999, while in 1995 a generic drug was dispensed in only 27.8% of all cases. In 1999, 47 million prescribed generic drug were supplied via the community pharmacy. Compared to 1998, that is an increase of 10.8%; considerably more than the growth of proprietary medicinal products (1.9%) and parallel imports (4.5%).

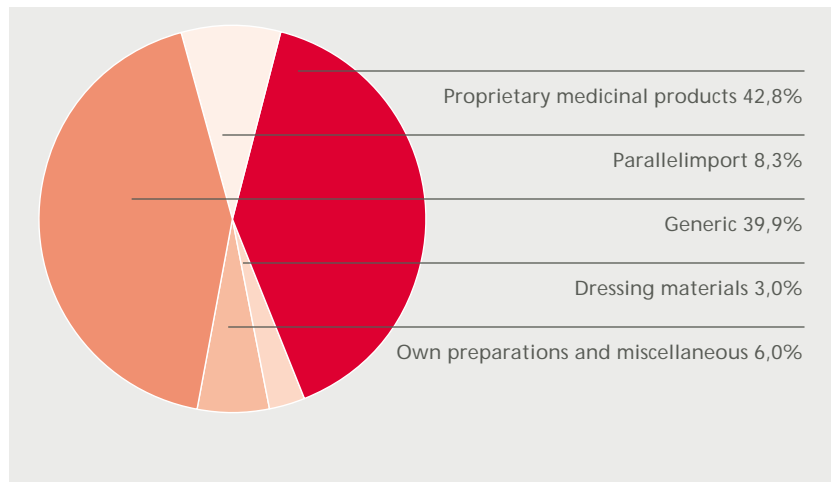
The declining market share of the original brand drugs also confirms the fact that pharmacists are increasingly replacing proprietary medicinal products with pharmaceutical imports and generic drugs. Of all drugs going over the pharmacy counter, less than half, 42.8%, is a proprietary medicinal product. However, the share in the drug expenditure is one and a half times as high. Including parallel imports, branded drugs even account for 81.6% of the costs.

Despite the fact that pharmacists supply more and more unbranded drugs, the savings attached with 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 hardly amounts to 5%.

The number of drugs manufactured by community pharmacies remains stable at 7.2 million dispensations (only the dispensations that fall under the statutorily insured drug packet). Some of the most common preparations are various cough remedies, vitamin K (since the disappearance of the trade product Konakion no longer available as such), prednisolon, which is applied for asthmatic attacks in dosages that are manufactured by the industry, and several skin products (preparations containing vaseline and hydrocortisone) that are adjusted to the needs of the individual patient.

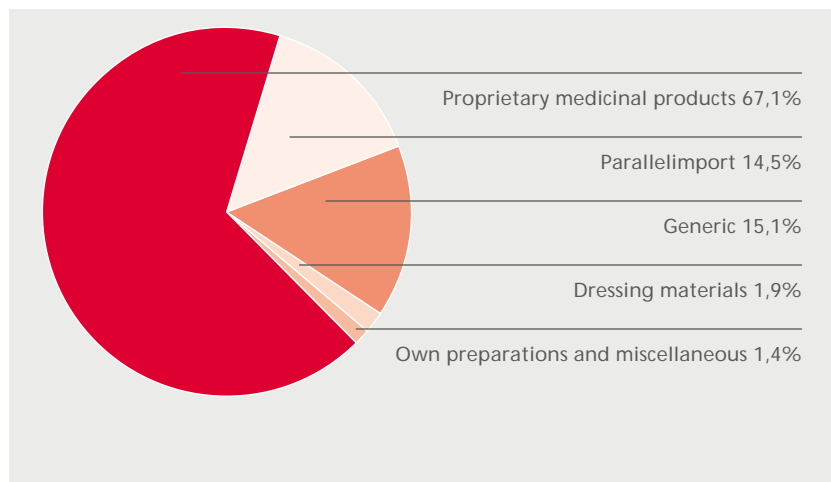
Besides drugs, the phrase pharmaceutical aid also entails dressing materials. With 3.5 million dispensations per year, it is a relatively small group. In 1999, community pharmacies supplied 9.8% more dressing materials than in the previous year.

1.10 Usage of drugs and dressing materials per product group: prescriptions 1999



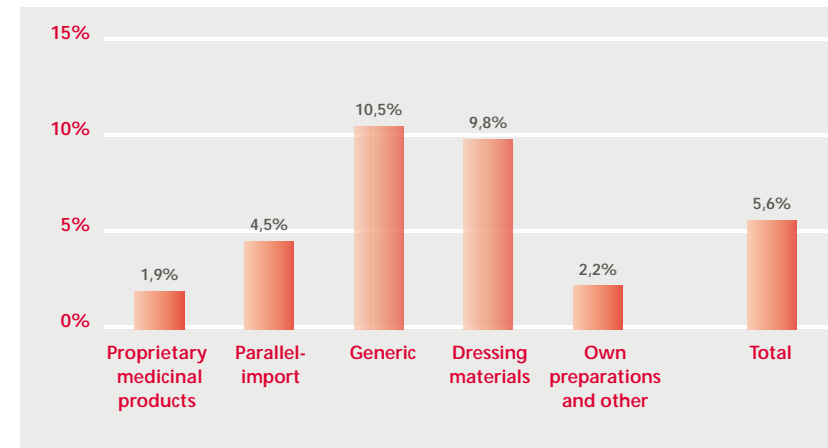
Source: Foundation for Pharmaceutical Statistics

1.11. Usage of drugs and dressing materials per product group: drug expenditure 1999



Source: Foundation for Pharmaceutical Statistics

1.12 Development in the use of drugs and dressing materials per product group: prescriptions 1998-1999



Source: Foundation for Pharmaceutical Statistics

## 1.6 Pharmacy fees

In 1999, the community pharmacies generated NLG 1,311 million worth of fees. This amount includes the fixed fee per prescription (NLG 1,130 million), revenues from incentive-related measures (NLG 46 million) and the margin on (self-care) drugs (NLG 135 million) that are not covered by the Health Care Charge Act (WTG). The increase in pharmacy fees is mainly attributable to the annually returning adjustment of the fixed pharmacy fee per prescription from NLG 10.80 to NLG 11.20 per supplied WTG-drug and 5.6% more prescriptions (partly attributable to a larger patient population and an increased market share of community pharmacies).

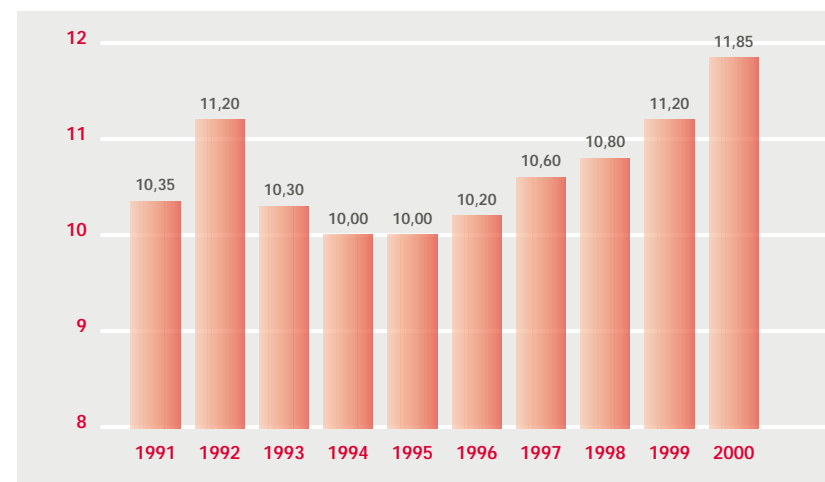
### Fee per prescription

The pharmacy's revenues 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 with 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.

For 1999, the National Health Tariffs Authority (CTG) has limited the fixed pharmacy fee per WTG-prescription to NLG 11.20. From the first of January 2000, the maximum fixed fee is NLG 11.85.

The most recent increase in the fixed fee is attributable to the three-year agreement, signed by the Minister of VWS and the KNMP on 8 October 1999.

1.13 Pharmacy fee per WTG-prescription in NLG



Source: Foundation for Pharmaceutical Statistics

Until last year, the fixed fee per prescription was based on the outcomes of a survey of the practice costs carried out by the accountancy firm Moret Ernst & Young among community pharmacies in 1987. Since then, the CTG (formerly known as the COTG) has adjusted the fixed pharmacy fee per prescription only for inflation. Because of this, the fixed fee per prescription no longer corresponds with the actual costs of the pharmacy practice. Since 1991, pharmacists are expected to earn back this difference through rebates. These very rebates spurred a long political discussion about the acceptability of rebates as pharmacy income. The three-year agreement ended this discussion. The pharmacists and the minister jointly agreed on a statutory rebate percentage of 6.82% regarding the pharmacy prices of WTG-drugs in exchange for a phased increase of the fixed fee per prescription between 2000 and 2002.

## 2 Cost control

### 1.14 Total expenditure on pharmaceutical aid via community pharmacies in 1999

	ZFW-insured	Privately-insured	Totaal
<b>Total expenditure on pharmaceutical aid</b>	<b>NLG 4.523 million</b>	<b>NLG 1.780 million</b>	<b>NLG 6.303 million</b>
• Of which GVS-co-payments	NLG 29 million	NLG 12 million	NLG 41 million
<b>Drug costs</b>	<b>NLG 3.577 million</b>	<b>NLG 1.415 million</b>	<b>NLG 4.992 million</b>
• WTG-drugs	NLG 3.334 million	NLG 1.310 million	NLG 4.644 million
• Non-WTG-drugs	NLG 243 million	NLG 105 million	NLG 348 million
<b>Pharmacy fees</b>	<b>NLG 946 million</b>	<b>NLG 365 million</b>	<b>NLG 1.311 million</b>
• Fixed prescription fees WTG	NLG 819 million	NLG 311 million	NLG 1.130 million
• Incentive revenue	NLG 33 million	NLG 13 million	NLG 46 million
• Margin on non-WTG	NLG 94 million	NLG 41 million	NLG 135 million
<b>Prescriptions</b>	<b>84 million</b>	<b>34 million</b>	<b>118 million</b>
• WTG-drugs	73 million	28 million	101 million
• Non-WTG-drugs	11 million	6 million	17 million
<b>Patients</b>	<b>8,9 million</b>	<b>5,3 million</b>	<b>14,2 million</b>

Source: Foundation for Pharmaceutical Statistics

Controlling the amount spent on pharmaceutical aid is one of the main themes in the care policy of the second social-liberal coalition that took office in the summer of 1998. This is because the extra means allocated by this Cabinet to health care at the start of this period of government will be completely absorbed by the drug expenditure file, if the structural increase in the amount spent on drugs is not curbed. Although no one will contradict the importance of striving for a more efficient system of drug provision, the question is whether the aims the Cabinet has set itself, and with that also the sector, are feasible. When drawing up the drug budget for the period 1999-2002, the Cabinet assumed an allowed annual growth of 6 to 7%, while it has been ascertained that structural causes will lead to an annual increase of 11 to 12% (also see paragraph 1.3). This implies that for the coming years, the amount spent on drugs will have to be reduced between NLG 200 million and NLG 300 million per year. This is a more than ambitious goal. The government has acknowledged this fact in the Spring Memorandum Care, issued in May 2000. Because of some fiscal windfalls, the government was able to allocate an additional one-time amount of NLG 400 million to in the short term tackle the drug expenditure deficit.

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

The feasibility of the political aims regarding the increase of the amount spent on drugs is generally substantiated by referring to the period of the first social-liberal cabinet, Paars I. Between 1994 and 1998, the drug expenditure on average roughly remained stable at 5.25%. 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 the 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 to general practitioners	0.5%
1998	Introduction of a 'claw back'-percentage to compensate for the rebates of pharmacists	2%

If the measures mentioned above would not have been introduced, the cost expenditure increase would have been twice as high in that period. The measures have in common that they are all aimed at the level of the drug expenditure. There is no restructuring of the structural increase in drug consumption. In the future, such an approach will not suffice to keep the growth within the boundaries deemed necessary by the government. The possibilities for additional price interventions and a further thinning out of the statutorily insured drug package are gradually running out. That is why the Minister of VWS now tries to realise cost reductions through long-range agreements with the various parties in the health care sector. Regarding the drug file, these long-range agreements to a great extent depend on an intensification of the cooperation between physicians and pharmacists. Through regional trial projects, so-called 'experimental gardens', the limits and possibilities of such co-operational structures are being explored. For the time being, it can be concluded that a more intensive level of cooperation between the various care disciplines offers certain possibilities for improving the level of care, but that realising such cooperations takes a certain degree of time. The main question is whether politicians will grant the sector this time.

## 2.2 Cost control in 1999-2000

### 2.2.1 Updating 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.

#### Veiled price law

The lower reimbursement limits lead to a price adjustment by the drug manufacturers. In real-life, the fact of the matter is that the GVS more influenced the behaviour of the supplier than that of patients. In fact, there is a second 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. The fact is, Dutch patients are not accustomed to (co)financing prescription drugs themselves (the patient on average pays 3% of the total costs himself) and are not easily persuaded to do so.

#### Unnecessary panic

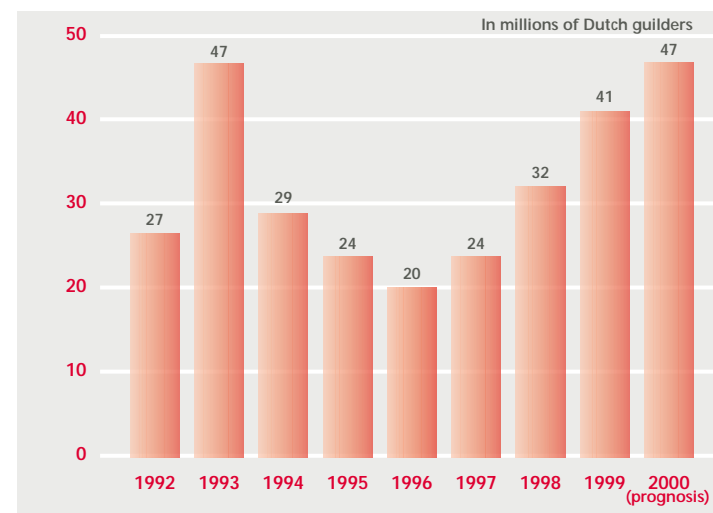
According to SFK-calculations, the adjustment of the GVS-limits annually saves NLG 158 million (including VAT) on the drug expenditure. That the drug manufacturers are mainly responsible for this cost reduction is illustrated by the limited increase in patient contributions. The GVS-contributions from patients only increased by NLG 9 million. In February 1999, the adjustment of the GVS caused some unrest among the Dutch population. The Ministry of VWS even had to set up a telephone panel in order to calm people down. As the limited increase of the GVS-contribution illustrates, there was definitely no reason for this panic.

Besides various contraceptive pills (GVS-contribution of NLG 15 million), the co-funding is mainly attributable to the antidepressant Remeron® (GVS-contribution of NLG 8 million). Manufacturer Organon by the way offers users of their drug Remeron® a reimbursement arrangement for the amount they initially had to advance in the pharmacy. Dodging GVS-measures is on the increase. The reason why manufacturers do not directly adjust their prices to the GVS-limits is because a price reduction in the Netherlands may have consequences for the price of the same product in other countries.

### Unrealistic aim

Beforehand, the Ministry had estimated that the cost-saving effect of this adjustment of the reimbursement limits would amount to NLG 255 million (including VAT). This figure however mostly had a political background. As a result of a motion by then-Member of Parliament Wallage, the GVS-savings were set at this level so that the funding of nursing homes could be beforehand rounded off on paper in 1997. Besides raising the GVS-limits to the actual price level, the Ministry of VWS for some time now has been announcing a modernisation of the GVS. Modernisation in this case entails that the way of clustering is revised. Until now, this modernisation has been continuously postponed.

2.01 Total GVS-contributions via community pharmacies



Source: Foundation for Pharmaceutical Statistics

### 2.2.2 Non-WTG

Of all prescription drugs dispensed by community pharmacies, 85.3% falls under the Health Charge Act. These drugs are only available on prescription in the pharmacy. For these drugs, a fixed fee per dispensed drug applies (NLG 11.85 in 2000). Some other (self-care) drugs can sometimes also be obtained outside of the pharmacy, at the chemist's or supermarkets. In 1999, these kinds of drugs involved an amount of NLG 483 million at community pharmacies with a total of 17 million dispensations.

#### 'First of September'-measure

Since the first of September 1999, these 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). In the past, these drugs were always reimbursed, provided a doctor prescribed them. Various players within the health care sector criticised the 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 NLG 145 million (including VAT) attached to this measure by the Ministry of VWS, was questioned. By shifts in the drug consumption, 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 and will remain reimbursable. The University of Nijmegen based on a survey among general practitioners states that 28% of GP's is willing to switch to a drug that is fully reimbursed. In addition, 26% of GP's questioned were willing to label the prescription 'for chronic use' when the drug in fact was only meant for short-term use. According to the SFK, the actual cost-saving effect of this measure will remain limited to maximally half of the savings estimated by VWS.

#### Limited effect

Prior to the introduction of the 'First of September'-measure, the expenditure on non-WTG drugs annually increased by 10.6%. If the policy had not been adjusted, this trend would have continued in 2000. However, SFK-data from the first six months of 2000 shows that the amount spent on non-WTG drugs dropped by an average 5.7% compared to the previous year. The conclusion can be drawn that the 'First of September'-measure has a cost-reducing effect of 16.3% on the expenditure on non-WTG drugs. Annually, this corresponds with NLG 79 million. Remarkable is that ZFW-insured patients are more influenced by the measure than privately insured patients. Of the cost reduction of NLG 79 million, NLG 61 million is attributable to ZFW-patients. In addition to shifts in the way doctors

prescribe, the SFK observes that health insurance companies have moved a number of drugs from the non-WTG segment to the WTG-segment, securing reimbursement. Some eye-catchers are the Calci chew® chewing tablet 500 mg and Denorex® RX shampoo. These two products generate an annual turnover of NLG 10 million. This amount in any event has to be deducted from the apparent cost reduction of NLG 79 million. The SFK has insufficient data to confirm and quantify the switching behaviour of general practitioners as reported by the University of Nijenrode.

### 2.2.3 'Claw back'

Besides the fixed fee per prescription for WTG-drugs and the pharmacy margin for non-WTG drugs, rebates comprise a statutory and in the current situation necessary source of income for pharmacies. Nevertheless, the purchasing rebates led to a long political debate regarding the acceptability of rebates as pharmacy income. To gain more insight into the scale of the bonuses and rebates, the Ministry of VWS in early 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 realised NLG 360 million worth of rebates in 1997. This corresponds with an average discount percentage of 8.9%. PWC ascertained that dispensing general practitioners realise the same level of discount as community pharmacies in relation to the size of their practices.

### Three-year agreement

Based on PWC's findings, the minister of VWS announced that she wanted to re-claim NLG 425 million worth of rebates from pharmacies and dispensing practitioners in April 1999. VWS reached this amount by extrapolating the established total of NLG 360 million for 1997 to the expenditure level of 1999. Many pharmacies would have got in trouble if this policy intention would have been realised. The fact of the matter is that the minister was oblivious to the fact that the fixed fee per prescription pharmacists are allowed to charge for their services does not cover the costs. The Dutch Lower House therefore did not approve it. More so because pharmacists had been promised a cost-effective fixed fee in exchange for pruning away excessive rebates. Following the usual scimmages in the media, VWS and the professional body KNMP during the summer months of 1999 tried to come to a mutual understanding. This consultation eventually resulted in the three-year agreement for the period 2000-2002, agreed upon by the Minister of VWS and the KNMP on the 8th of October 1999. Both parties found one another in a phased approach.

### Phased approach

For a period of three years, pharmacists and dispensing physicians will pass on a 6.82%-discount to the prices of prescription drugs, with a limit of NLG 15 per dispensed drug. The levelling-down to NLG 15 prevents pharmacists (and patients) from getting into trouble regarding very expensive drugs such as AIDS drugs and interferon beta, for which the pharmacists can obtain no rebates. Assuming that the amount spent on drugs will structurally increase by 10% per year, this so-called 'claw back'-measure will have an expected cost-saving effect of NLG 350 million in 2000, NLG 385 million in 2001 and ultimately NLG 425 million in 2002. These amounts include VAT.

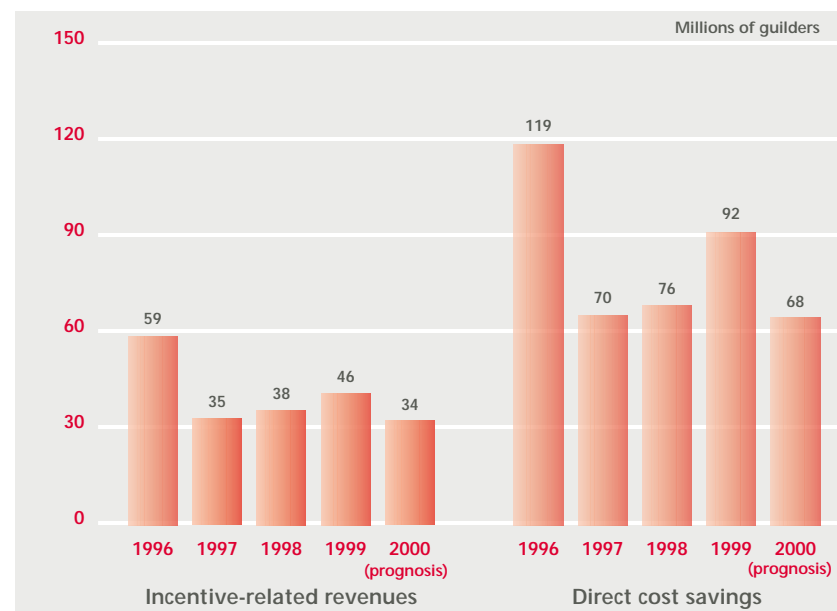
Based on the first half-year figures for 2000, the SFK estimates that the savings generated by the 'claw back'-measure will amount to NLG 370 million this year. NLG 20 million more than was assumed in the three-year agreement.

Against the phased handing-in of more rebates stands a phased increase of the fixed fee per prescription. For example, the fixed fee was increased from NLG 11.20 to NLG 11.85 on the first of January 2000. In the next two years, the fixed fee will be further increased. The final increase here depends on the increase or decrease in the number of prescription drugs dispensed. An increase in the consumption of prescription drugs will be passed on for 60% to the height of the fixed fee. This adjustment method on the one hand prevents pharmacists from earning 'too much' if more drugs are consumed, but on the other hand ensures that they are compensated for the extra work and costs involved in handling more prescriptions.

### 2.2.4. Incentives measure

The aim of the incentives measure that has been in effect since 1988 is to persuade pharmacists to dispense generic (unbranded) drugs or pharmaceutical imports instead of the generally more expensive original drug. For this, the drugs have been classified based on generic name, pharmaceutical form, method of administration and strength. Based on the CTG-guidelines, each month a reference price is determined. 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 extra premium revenues for the pharmacies. At the end of 1999, the Ministry of Health decided that the incentive-related revenues should be considered regular pharmacy revenues in relation to establishing the fixed fee per prescription. The incentive premium will remain in effect as a measure, but from the first of January 2000 the pharmacy tariff has been cut by NLG 0.32. Through this measure, the minister saves NLG 35 million on the pharmacy fee.

### 2.02 Generic substitution by community pharmacies



Source: Foundation for Pharmaceutical Statistics

After the substitution savings dropped considerably because of the introduction of legally fixed maximum prices in the middle of 1996, the first figures for 2000 point towards a further decline. Although pharmacists do dispense more generic drugs (see paragraph 1.5), the savings generated by substitution are dropping because the mutual price differences between proprietary medicinal products and generic parallel imports are becoming smaller and smaller.

Where a couple of years ago price differences of 20% between proprietary medical products and generic drugs and 14% between proprietary medicinal products and parallel imports were quite common, the average price differences have now dropped to 5 and 4% respectively.

### 2.2.5 Approach good runners

As early as in the Care Memorandum 1999 (Zorgnota), issued by the Ministry of VWS in September 1998, the Ministry announced measures aimed at consequently reducing the consumption of antacids and cholesterol-lowering products. The Ministry in the Care Memorandum stated that these drugs would only be eligible for reimbursement if treatment conforms to a protocol to be established by VWS.

Although VWS in its budget for 2000 has incorporated economic measures amounting to NLG 90 million (including VAT) for dealing with good runners, it up till now has not taken any concrete steps here. In the meantime, the amounts spent on antacids and cholesterol-lowering drugs continue to increase strongly (paragraph 1.4). For example, the SFK has established that in 1999, NLG 596 million was spent on antacids (NLG 60 million more than in 1998) and NLG 424 million on cholesterol-lowering drugs (NLG 53 million more than in 1998).

The Health Council mid 2000 however explicitly advised the Minister of Health to stimulate the preventive use of cholesterol-synthesis-reducers (or statines) by people with a hereditary disorder of the fat metabolism, people who already 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.

### 2.2.6 SFK-prognosis 2000

Having taken into consideration the above-mentioned measures and expenditure development over the first half of 2000, the SFK expects the expenditure on pharmaceutical aid to increase by 7%. Regarding drugs supplied through the community pharmacy, this means an increase from NLG 6,303 million in 1999 to NLG 6,745 million in 2000. This percentage is very much in line with the growth margins of 6 to 7% the Ministry of VWS generally strives for in its budget. For the year 2000, the Ministry had initially set its goals much higher. As indicated above, flattering estimates regarding the cost-saving effects of adjusting the GVS-limits, the 'First of September'-measure and the approach of good runners are wiped away in practice.

The minister of Health at the moment is in the fortunate situation that she has an additional NLG 400 million to spend on fixing the drug expenditure budget. This however changes nothing to the fact that the (too) conservative estimates Paars II made at the beginning of this period of government with regard to the development of the drug expenditure will in the next two years prove a heavy burden, unless the continuing economic growth allows for further reconstructions.

### 2.3 Long-term policy

In April 2000, the second social-liberal Cabinet formulated its adjusted point of view regarding the drug policy for the long term. The Cabinet at the moment has put forward three focal points

- I Improving the quality and efficiency regarding the prescription of drugs.*  
With this, the Cabinet for example refers to protocol-based prescribing in line with agreements made in FTTO-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 pharmacies and also feedback regarding prescriptions by pharmacists and health care insurance companies.
- II Stimulating the market mechanism regarding drugs and drug distribution.*  
Over the last period of time, the government has taken all possible measures to stimulate competition in the area of drug distribution: the introduction of maximum prices instead of national prices, easing the requirements that were previously made of pharmacies regarding 24-hour-accessibility and the handling of pharmaceutical preparations, allowing for non-pharmacists to run pharmacies and allowing hospitals

and other intramural institutes to supply patients with drugs for home use. The Cabinet wants to continue this course.

### *III Transferring responsibility from the government to health insurance companies.*

The most essential change in the Cabinet's standpoint involves the fact that it wants to transfer the control of the drug provision to the health insurance companies. In line with the report of the interdepartmental MDW study group drugs (Market mechanism, Distribution and Legislative Quality), the conclusion can be drawn that the health care insurance companies must be provided with the appropriate instruments and that some legal impediments will have to be tackled, if they are to fulfil this more central role in a good manner. The remaining cabinet period has been reserved for this path of instrumentation and deregulation. This path for example entails: registering specialist prescription, updating the GVS (renewed clustering of drugs, exploring whether the reimbursement limit per cluster can be adjusted to the lowest price instead of the average price), revising the fee system for pharmacists and dispensing physicians (following on the three-year agreement between the KNMP and the minister of VWS) and allowing the health insurers to run their own pharmacies. At the end of the government period in 2002, a moment of evaluation will follow. Then, it will be determined whether the chosen course will be continued or not.

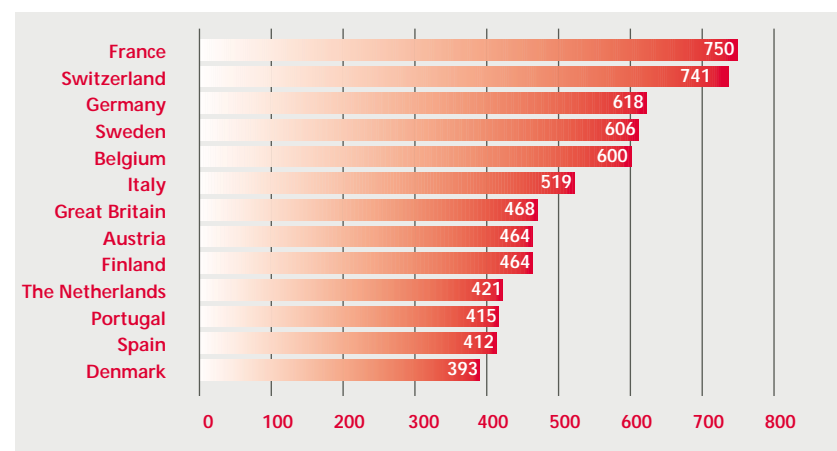
The Cabinet explicitly states that it does not have the intention to have patients pay more for drugs, with the exception of own co-payments resulting from a (possibly modernised) GVS.

To conclude, the Cabinet also emphasises the importance of a good system for data provision about drug consumption and drug expenditure. They underline that the dissemination of information in our country is on a very high level from an international point of view. Regarding certain aspects, a higher degree of specification of the available information is strived for. The SFK supports this ambition.

### 3 Drug consumption in a European perspective

Compared to most Europeans, the Dutch on average do not consume a lot of drugs. This has been a familiar trend for some years now. Following the price reductions as a result of the Drug Price Act and the reclamations of rebates from pharmacies via the 'claw back', it turns out that The Netherlands is also low on the European list with regard to the level of expenditure. This becomes apparent from an adaptation carried out by the SFK on the results of a survey conducted by the Pharmaceutical Group of the European Union (PGEU). In 1998, the Dutch on average spent NLG 421 each on drugs in community pharmacies (or dispensing physicians). The non-reimbursable (self-care) drugs are included in this amount. This amount is 30 to 45% below the expenditure pattern in countries such as Belgium (NLG 600), Germany (NLG 618) and France (NLG 750)

3.01 Drug consumption via the pharmacy per head of the population in guilders in 1998

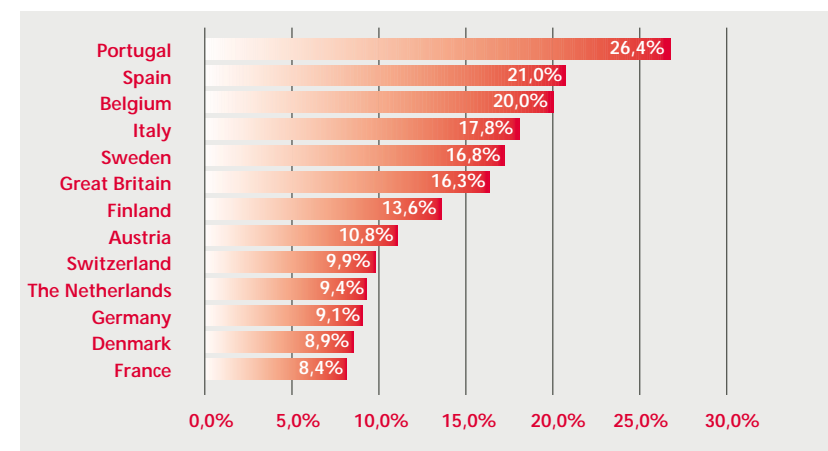


Source: Pharmaceutical Group of the European Union  
Foundation for Pharmaceutical Statistics

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. According to the Annual Care Review ('Jaaroverzicht Zorgnota), a publication of the Ministry of VWS, 9.4% of the total costs of health care in The Netherlands in 1998 was related to the expenditure on pharmaceutical aid. This percentage is comparable to the expenditure level in countries such as France, Denmark, Germany and

Switzerland. With the exception of Denmark, the amounts spent on drugs are relatively much higher in these countries than in the Netherlands. Or, in other words: in general, more money is being spent on health care in these countries. This difference to a very small extent is attributable to the degree of ageing in the different countries. In the Netherlands, 18% of the population is 60 years or older, against 20% in France and 22% in Germany.

3.02 Percentage spent on pharmaceutical aid in the total expenditure on health care in 1998



Source: Pharmaceutical Group of the European Union  
Foundation for Pharmaceutical Statistics

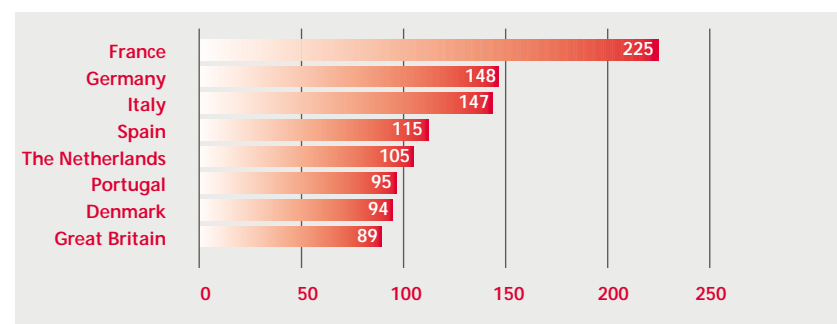
When looking at the figures of other European countries, one can wonder whether it is correct that the amounts spent on drugs in the Netherlands have led to so much political discussion over the last couple of years. After all, the Dutch expenditure figures in general compare favourably with the figures of other Western European countries. On the other hand, the conclusion can be drawn that the drug expenditure will increase considerably if the Dutch mentality surrounding drug consumption will conform to the European pattern in coming years.

Regarding the control of the drug expenditure in our country, the last link in the pharmaceutical-industrial chain is often put in the spotlights: the pharmacies. The current government has adopted the point of view that stimulating the market mechanism by creating more distribution points will contribute to controlling the drug expenditure. A point of view that is not backed by European figures. A pharmacy in the Netherlands serves an average 9,000 persons. In France (1 pharmacy per 2,500 inhabitants), Germany (1 pharmacist per 4,000 inhabitants) and Italy (1 pharmacy per

3,500 inhabitants), the number of pharmacies is two to three times as high as in our country. Not only do they spend more on drugs in these countries, but the costs of distribution and service rendering by pharmacies are also relatively higher than in the Netherlands.

Following the raise of the 'claw back'-percentage to 6.82% from the first of January 2000, the average gross profit percentage (including net purchasing advantages) of an average pharmacy amounts to 23%. In most countries, a gross profit percentage of 25% is usual. French pharmacies with an average 30% head the list.

### 3.03 Pharmacy remuneration per person in guilders in 1998



Source: Pharmaceutical Group of the European Union  
Foundation for Pharmaceutical Statistics

## 4 The community pharmacy in figures

At the end of 1999, there were 1,588 community pharmacies in The Netherlands. Although 11 pharmacies closed down, that still ultimately means 17 pharmacies more than at the end of 1998; last year's upward trend has continued. In the first six months of 2000, the SFK has already registered more than 1,600 community pharmacies. The SFK predominantly attributes the increase in the number of pharmacy outlets to the development of new housing estates at so-called VINEX locations and the liberalised government policy regarding the establishment of pharmacies. The latter is a result of the government policy pursued by the previous Cabinet (first social-liberal Cabinet: 1994-1998).

From the starting point that more distribution points lead to more competition and that more competition leads to lower prices (and with that a lower drug expenditure), the government then pursued a policy aimed at involving more parties in the exploitation of pharmacies. Requirements that were previously made of pharmacies no longer applied. These requirements among other things entailed the round-the-clock availability of the pharmacy and the facilities for pharmacy-made products. In addition, non-pharmacists have also been allowed to run pharmacies since early 1999. The condition that drug dispensation takes place under the supervision of a pharmacist however remains in force. Besides the temporary arrival of British pharmacy chain Boots, the liberalisation up till now has not led to the introduction of new market parties in our country. Boots by the way in August 2000 announced it would close down the pharmacy departments in their shops. The Boots pharmacies turned out to be far from cost-effective. The main result of the liberalisation is that existing market parties, especially pharmaceutical wholesalers, have expanded their market position by acquiring pharmacies and setting up pharmacy chains. Through vertical integration, the pharmaceutical wholesaler aims to strengthen his negotiating position in view of the changing role of health insurance companies as proposed by the current Cabinet.

Since the first of April 2000, hospitals and other intramural institutions are allowed to provide patients who are no (longer) in the hospital with drugs. It is expected that this broadening of the Drug Supply Law will lead to a further expansion of the number of distribution points.

#### 4.1. Turnover community pharmacy

The average community pharmacy serves a patient population of 9,000 persons. Compared with 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. Only in some Scandinavian countries are there less community pharmacies than in the Netherlands. In 1999, the average community pharmacy dispensed 74,900 prescription drugs. These drugs entail a turnover of NLG 3,990,000. Of the total turnover of NLG 3,990,000 20.8% or NLG 830,000 is earmarked as fee for the pharmacy. The costs of materials for drugs amount to NLG 3,160,000. The main source of income for the pharmacy is the fixed fee per prescription (average NLG 715,000). This entails the fixed pharmacy fee the pharmacist may charge for supplying a WTG-drug (drugs only available in pharmacies on prescription). For 1999, this fixed fee was established at NLG 11.20. Since the first of January 2000, the fixed fee is NLG 11.85.

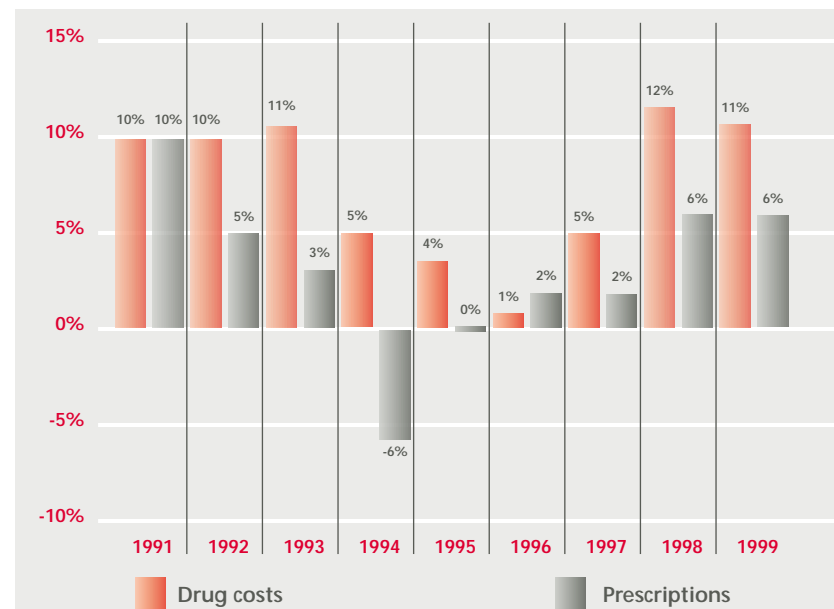
The turnover of a pharmacy on its own does not serve as a reliable indication regarding its profitability. The income of the pharmacist to a great extent is determined by the number of fixed fees per prescription. A more expensive WTG-drug does not automatically mean more income for the pharmacist. Because the drug turnover with a structural growth of 11 to 12% in general increases more than the number of prescribed drugs (structural growth roughly 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).

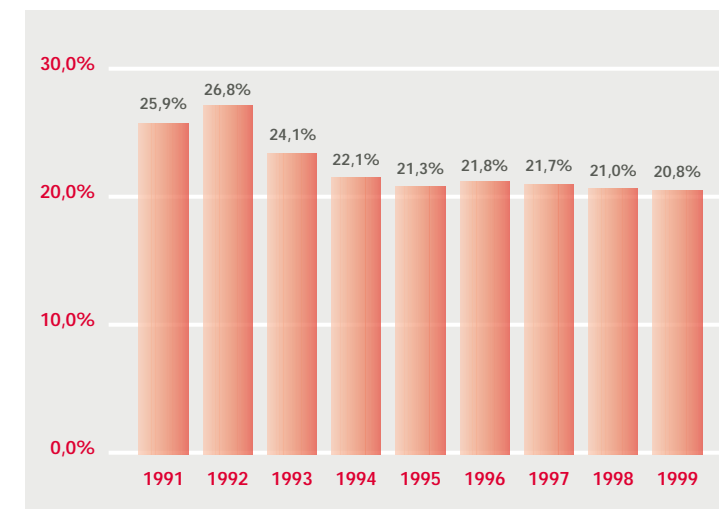
During the period 1996-1999, the share of the pharmacy fee stabilised through several price measures initiated by the government, such as the introduction of maximum drug prices and the introduction of the 'claw back'-percentage.

4.01 Development drug costs and number of prescriptions



Source: Foundation for Pharmaceutical Statistics

4.02 Stake of pharmacy fees in the expenditure on pharmaceutical aid



Source: Foundation for Pharmaceutical Statistics



## 4.2 Gross profit percentage

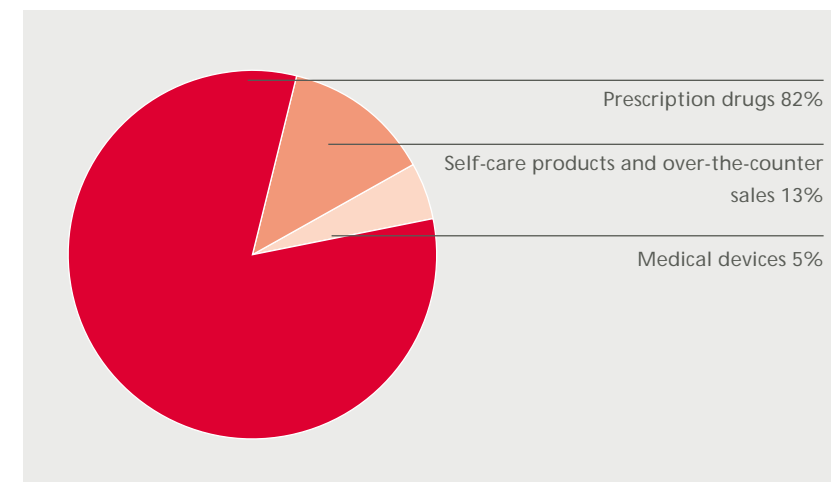
By order of the Ministry of Health, the accountancy and advice firm PriceWaterhouseCoopers (PWC) in 1999 chartered the rebate advantages realised by pharmacists in addition to the above-mentioned pharmacy fee. The results of this survey show that pharmacists and dispensing physicians on average realise an 8.9% rebate on the purchase value of drugs. This percentage consists of all forms of rebates measurable in money. Of this amount, well over 3% (NLG 90,000 per pharmacy) was passed on through a statutory discount on the pharmacy prices for WTG-drugs in 1999: the so-called 'claw back'. Although the 'claw back'-percentage is at the expense of the revenues of the community pharmacy, this is not reflected in the components of the pharmacy fee (fixed fee per prescription, incentives and non-WTG margin).

From the first of January 2000, the 'claw back'-percentage has been increased to 6.82% (with a limit of NLG 15 per supplied drug). In other words: of the average 8,9% of purchase rebates established by PriceWaterhouseCoopers, a mere 3% remains for the pharmacy. From these revenues, the pharmacist among other things pays for the costs of the pharmacy that are not (yet) reimbursed through the fixed fee per prescription rule. 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.

## 4.3 Pharmacy practice costs

In principle, pharmacists have to finance the costs of their practice by the fixed fee per prescription that applies for 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 real terms, the opposite is in fact happening, because the revenues attached with this are deducted from the fixed fee per prescription.

### 4.03 Turnover of pharmacies per product category, 1999



Source: Foundation for Pharmaceutical Statistics

As a result of the three-year agreement signed by the KNMP and the Minister of Health on the 8th of October 1999, it was decided to adjust the fee for the costs of pharmacy practice to NLG 859,000 from the first of January 2000. The norm income for the owner of the pharmacy, NLG 182,000, is included in this amount. The norm income also entails matters such as social taxes and pension contribution. The norm income for owners of pharmacies corresponds with a gross annual income of NLG 130,000. The total fee for the costs of pharmacy practice, NLG 859,000, is the starting point for establishing the fixed fee per prescription for each dispensed WTG-drug. The fee does not cover all the costs. Within the framework of the three-year agreement, the fee for the costs of pharmacy practice will in the

next two years be increased with at least NLG 42,000. At the moment, the pharmacy has to finance these costs from rebates it has to additionally obtain.

#### 4.04 Build-up fee for costs of pharmacy practice from 1 January 2000

	Fee for costs of pharmacy practice (NLG)	Fixed fee per prescription (NLG)
Staff costs	406,224	5.64
Housing costs	97,525	1.35
General costs	86,073	1.20
Computer costs	28,690	0.40
Interest	26,124	0.36
Depreciation	21,907	0.30
Motor car costs	9,988	0.14
Norm income	182,326	2.53
<b>Total fee</b>	<b>858,857</b>	<b>11.92</b>
Deduction incentive revenues		-0.32
Adjustment 1998/1999		0.25
<b>Fixed fee per prescription</b>		<b>NLG 11.85</b>

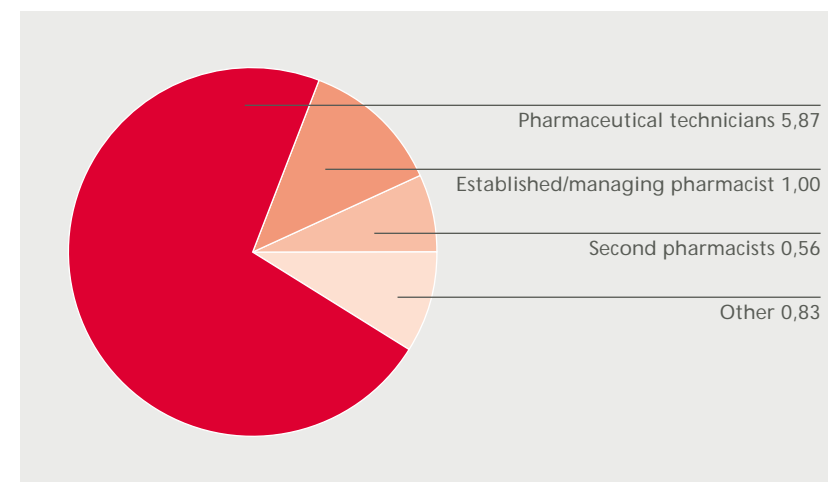
Source: Foundation for Pharmaceutical Statistics

#### 4.05 Number of persons employed in community pharmacies

	1995	1996	1997	1998	1999	Annual increase
Pharmacies	1.518	1.530	1.547	1.571	1.588	1,1%
Pharmacists	2.198	2.319	2.381	2.439	2.472	3,0%
Pharmaceutical technicians	10.789	11.239	11.589	11.931	12.189	3,1%
Other	2.000	2.042	2.123	2.280	2.549	6,2%

Source: Foundation for Pharmaceutical Statistics

#### 4.06 Number of staff in the average pharmacy Begin 2000, converted to full-time units



Source: Foundation for Pharmaceutical Statistics

The limited availability of pharmaceutical technicians and the increased drug consumption have led to a considerably higher level of working pressure in community 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 by the SFK among associated pharmacies in the middle of 2000, shows that 40% of pharmacies is looking for a pharmaceutical technician. In total, this means well over 900 unfulfilled positions (the part-time factor has been taken into account). By attracting second pharmacists and employees for deliveries and administration, some pharmacies try to cushion the problems to some extent. By now, especially second pharmacists have also become quite hard to find. 15% of all community pharmacies have an opening for a second pharmacist.

#### Processing rate

The processing rate, the number of prescriptions in relation to the number of pharmaceutical technicians (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 1999, the average processing rate increased to 13.712 prescriptions per full-time pharmaceutical assistant. This is up 5% compared to 1998. The increasing processing rate is a result of

the labour shortage. 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 are not taken into account for determining the processing rate.

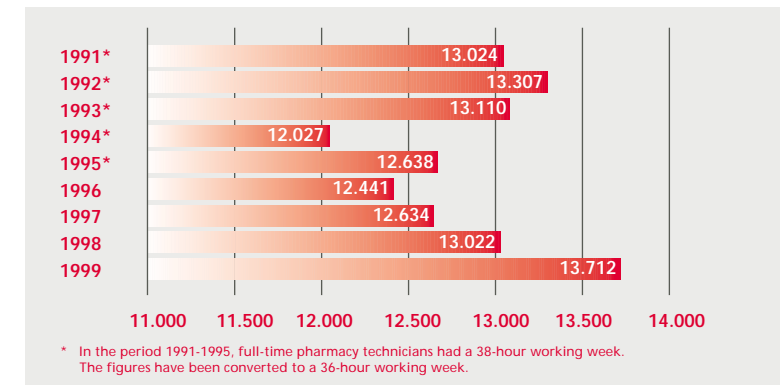
#### Not an absolute norm

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 pharmaceutical assistant may vary considerably from pharmacy to pharmacy. In pharmacies in the big cities, the average processing rate with 13,355 prescriptions is below the national average. Rural pharmacies on the other hand have a higher processing rate: 14,100 prescriptions per full-time pharmaceutical assistant. 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. Because the shortage of pharmaceutical technicians is more prevalent in the large cities, the difference regarding the processing rate is less high in rural settings than in the past.

Some other factors influencing the processing rate are the way in which weekend shifts are organised and the extent to which pharmacy preparations are provided.

In the early nineties, pharmaceutical technicians 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 4.07 have been adjusted for a 36-hour working week. The graphic 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 fluctuations in the processing rates are mainly caused by package interventions by the government: no longer reimbursing certain drugs, as a result of which the demand for those drugs drops. The market can only react to such measures with a certain degree of delay. After all, in real life adjusting the level of staffing is not immediately realisable.

#### Continuing shortage

Figures from the Pension Fund Pharmacy Staff indicate that the number of active pharmaceutical assistants only increased by 258 persons to 12,189 assistants in the last year. Of these assistants, only 42.5% works full-time. The part-timers on average work 21 hours a week. Converted to full-time units, an average community pharmacy has 5.87 pharmaceutical assistants. It does not look as if the influx of pharmaceutical assistants over the coming years will be sufficient to meet the current and future demand for pharmaceutical assistants.

#### Pharmacists

With 250 graduating pharmacists, the annual influx of young pharmacists on the labour market at the moment is twice as high as a couple of years ago. Of the 250 graduated pharmacists, roughly 170 opt for a function in a community pharmacy. On the whole, the increase in the number of active pharmacists in the community pharmacy remained limited to 33 pharmacists last year. The difference is attributable to a remarkable outflow. Community pharmacists decide to withdraw from the pharmaceutical sector at an increasingly younger age. Due to the increasing (financial) insecurity, a large

group of older pharmacists has decided to put their pharmacy up for sale. In addition, some pharmacists feel that their profession has become less attractive because of the increasing administrative burden, the high working pressure caused by the labour shortage and the varying legislation and rules. But a change of behaviour can also be observed among younger pharmacists. Where a couple of years ago they sort of definitely opted for a community pharmacy, it now increasingly happens that they turn their backs on the community pharmacy after a couple of years.

As a result of the limited net influx, vacancies for the function of second pharmacist are becoming harder and harder to fulfil. At the moment, each community pharmacy on average has 0.56 second pharmacist. Pharmaceutical wholesalers have problems finding pharmacists for the pharmacies they own. A survey carried out by the Association of Young Pharmacists shows that a mere 11% of the new generation of pharmacists is interested in a position with a pharmacy chain owned by a pharmaceutical wholesaler.

#### 4.08 Core figures expenditure on pharmaceutical aid per pharmacy in 1999

	ZFW-insured	Privately insured	Total
<b>Total expenditure on pharmaceutical aid</b>	<b>NLG 2,863,000</b>	<b>NLG 1,127,000</b>	<b>NLG 3,990,000</b>
• GVS-contribution	NLG 18,000	NLG 8,000	NLG 26,000
<b>Drug costs</b>	<b>NLG 2,265,000</b>	<b>NLG 895,000</b>	<b>NLG 3,160,000</b>
• WTG-drugs	NLG 2,111,000	NLG 829,000	NLG 2,940,000
• Non-WTG drugs	NLG 154,000	NLG 66,000	NLG 220,000
<b>Pharmacy fee</b>	<b>NLG 599,000</b>	<b>NLG 231,000</b>	<b>NLG 830,000</b>
• Fixed fee per prescription	NLG 518,000	NLG 197,000	NLG 715,000
• Incentive revenue	NLG 21,000	NLG 8,000	NLG 29,000
• Margin non-WTG	NLG 60,000	NLG 26,000	NLG 86,000
<b>Prescriptions</b>	<b>NLG 53,300</b>	<b>NLG 21,600</b>	<b>NLG 74,900</b>
• WTG-drugs	NLG 46,200	NLG 17,700	NLG 63,900
• Non-WTG drugs	NLG 7,100	NLG 3,900	NLG 11,000
<b>Patients</b>	<b>5,600</b>	<b>3,400</b>	<b>9,000</b>

Source: Foundation for Pharmaceutical Statistics

## 5 Drug expenditure per person in 1999

### ZFW-insured

	Prescriptions	Costs per prescription (NLG)	Expenditure per person (NLG)
WTG	8.19	Material costs Fixed fee per prescription Incentive Total	469
		45.62 11.20 0.46 57.28	
Non-WTG	1.28	Material costs Pharmacy fee Total	38
		21.33 8.26 29.59	
<b>Total</b>	<b>9.47</b>		<b>507</b>

### Privately insured

	Prescriptions	Costs per prescription (NLG)	Expenditure per person (NLG)
WTG	5.24	Material costs Fixed fee per prescription Incentive Total	308
		47.15 11.20 0.45 58.80	
Non-WTG	1.14	Material costs Pharmacy fee Total	28
		17.40 6.81 24.21	
<b>Total</b>	<b>6.38</b>		<b>336</b>

### Average

	Prescriptions	Costs per prescription (NLG)	Expenditure per person (NLG)
WTG	7.09	Material costs Fixed fee per prescription Incentive Total	409
		46.04 11.20 0.45 57.69	
Non-WTG	1.23	Material costs Pharmacy fee Total	34
		19.97 7.76 27.73	
<b>Total</b>	<b>8.32</b>		<b>443</b>

Source: Foundation for Pharmaceutical Statistics

