FOURTH SESSION

DISCUSSION

MEHMET DOMAÇ

I am now beginning the fourth session. As of now, there are 4 questions, two of them are common questions, it is being asked to all of the speakers, one is asked to me, but in fact it is directed to the General Directorate of Occupational Pension Fund, I will ask this question here, I presume that we will receive the answer to the question later.

Are there any more questions?

I will answer the questions directed to me lastly, and I will ask the other questions to the speakers.

There is a question for Aidan O'Shea:

"Why is chain pharmacies accepted at Ireland or did the pharmacists resist at this accepting, wasn't there any boycott?"

Another question: *"Are the hospital pharmacies under the monopoly of the government in Europe?"*

There is a question to all of the speakers: *"Are there enough pharmacists in the home countries of the speakers? If there is, are there any projects that have been determined for new profession areas?*

If it is known by them, how many pharmaceutics faculties are there in their home country?

According to which criteria is the number of students determined?

What factors are required to open a new faculty?

What are the applications/practices applied during the training of an appropriate pharmacist?"

Our Mersin University Pharmaceutics Faculty Dean has asked this.

I am asking this question, if the speakers can reply shortly, they can also answer this too.

A question to all guests related to hospital pharmacies:

"Do the Hospital pharmacies only give drug to the lying patients? Is this subject to any limitation?

Is the drug service cheaper at the hospital pharmacies when compared to the drug service at the free pharmacies? Is this profit taxed in your countries?

Is this profit distributed among the personnel employed at the hospital?"

Related to the cheap equivalent drug practice, our colleague asks this: *"There is cheap equivalent drug practice at the self-employed pharmacies, however such a practice is not present at Occupational Pension Fund at the lying patients, at the hospital pharmacies. This creates a double standard. And this double standard has to be removed in some way. In this condition, the patient may prefer in-bed treatment which creates an extra load to the Social Security Organization. How can it be solved?"*

I deem that this question has been asked to the Esteemed General Directorate, since his drawee is not present here.

Our friends have concentrated too much on this hospital pharmacy business. I think an explanation will have to be made by all the speakers related to the pharmacies present in the hospital.

The question goes to Phillippe Liebermann and Eckart Bauer: *"Where does the hospital pharmacies supply its drugs? Do they buy them collectively by way of tenders of do they obtain it from the pharmaceutics warehouses with discount?*
How much discount do they get from the place where they buy these drugs or in what manner do they purchase the drugs? "

The questions increase; my friend has caught an important point, I was also going to ask to Marie Savane such a question:

"How does the equaling system work?" This is also something that draws much of my attention. As you know, there are also vast differences between the pharmacies in Turkey. "How does the equaling system work in terms of their work and endorsement? "

A question to all of the speakers: *"What is the condition of the cooperatives that work in the area of drug distribution?"*

The question of Ms. Nükhet is related to the authorities of the Ministry of Health: *"What is the total amount of health expenses in the year of 2001 in Turkey?" There is no one to answer this question among the speakers.*

"What is the ratio of drug expenditures in the health expenses in 2001?

Will the savings that is being tried to be made at the drug expenses be made in the same manner at the treatment institutions?

How did the Ministry of Health give license to 82 different-branded drugs that contain the same agent compound?"

I can answer these questions, but since they are asked to the authorized person of the Ministry of Health, I think I will hand over the question to my friends.

There is a question to all of the speakers, it can be a bit hard to perceive, since the speakers have not mentioned anything related to this topic. But let's anyhow ask the question and see if such a problem is experienced in their countries: *"If the reimbursement is not paid on time by the reimbursement institutions, what kind of security do the pharmacists receive? What kind of rights do they have?"*

There has been a question concerning the state of the cooperatives. Do they see the cooperatives as an alternative model on the topic of "chain" pharmacies? Shall the cooperatives form a chain pharmacy at their countries?" I will also answer this question.

"What kind of studies can be made to decrease the share of the government at the drug payments? What are their suggestions?"

This is asked to all of the speakers.

There is a question for Aidan O'Shea: *"You mentioned in your presentation that the chain pharmacies form the 35% of the pharmacies and they will own an amount of 50% of the market. As it seems here, this creates a risk for the free pharmacies, that is the self-employed pharmacies belonging to individuals. Are you planning any planning to take any measures?"*

Please come Sincere O'Shea.

AIDAN O'SHEA

Thank you Mr. Domaç. What I've done as you read the questions is to try to cluster them together to give a composite answer possible and to some of these very specific questions, I may not have an exact answer. I think, as my paper dealt with the significant growth of chains in Ireland; I will try to give some detail on that particular topic and that I would have adequately for the different questions which were asked. If you have a liberal ownership model as we have in Ireland that is a very fertile ground for the growth of chains because corporate ownership is committed. The second point is that the main vehicle of the main way which chains are growing is by pharmacists themselves creating chains. And I want to stress that point. Pharmacists who have a large individual pharmacy buy pharmacies in the same town which the owner may be retiring and develop small chains. And my belief is that is like the first stage in a 2-stage evolution of chains. I say this because this is what happened in the United Kingdom 20 years ago. Individual pharmacists began to form small chains of 10 or less in number in each chain. As these chains grow in size, they become more difficult to manage for a person who only has the training of a pharmacist and not the experience of big business management. And for these pharmacist chain owners, it becomes a logical and very tempting step to sell that chain to a large corporation. And from the point of view of the large owners, now who dominate the community pharmacy sector in the United Kingdom such as Boots. This is exactly how they grow very rapidly; not by buying single pharmacies, but by buying small chains. I don't agree with this trend, but I must be honest and explain that we have created this trend from within our own profession. These chains have certain advantages over the individual pharmacist and I will mention a few of these advantages. They have economy of scale with regard to purchasing and often can purchase their products at a more preferential price because of their size. They have more streamlined administration and management. They offer to the young pharmacist perhaps a more structured career than he would have with an individual pharmacist. And they would have collectively a stronger influence on government than would the Pharmacy Chamber. Because I believe that in the western countries, big business talks big to government. Mostly, we don't hear what they are saying; we are not aware of the influence they have. But it is quite strong. And that is why - as I see it - chains are growing.

As to what steps may be taken; one point which has been mentioned is the question of the independent pharmacists forming a cooperative wholesaler. And this has happened in Ireland. And this cooperative wholesaler sponsors young pharmacists - who want to buy a pharmacy - by giving them loans at low rates of interest with a long payment period of 20 years. So, we are trying to reverse the trend of multiple ownerships by creating a financial model that will help the young pharmacist to get first step to be a proprietor. From a political point of view, at national level in our union, in our chamber. We must cooperate with these chain pharmacies, be aware that they are born by pharmacist companies or non-pharmacist companies. We must ensure that they keep the same ethical standards which are expected of the individual pharmacist. And to that extent, we must cooperate with them. I don't want to take up all the time with the meeting on this matter, but I do think that the change we're seeing in Ireland is also driven by the economic growth of the country. And it would not have been attractive for multinationals to come into Ireland 10 years ago when the economy was very low and not yielding very much profit.

The hospital pharmacies are owned by the state. The employees and the pharmacists, who work there, are state employees and the medicines are dispensed only to patients in the hospital, not to outpatients. And all the profits return to the hospital itself. And the question of price was also raised, but it's not relevant since the social insurance covers 100% of the cost of drugs of patients in the hospital in Ireland. But in fact, the hospital pharmacies buy their drugs at 85% of the price which the private pharmacist can buy the same medication. But since there is no cost to the citizen, that's not a very evident fact to the individual citizen. Thank you.

PHİLLİPPE LİEBERMANN

Today, I' d like to talk about the French education system and the number of educated pharmacists. The number of pharmacists is determined by the law. Today there are 24 Faculty of Pharmacies in France. This is quite a high number. It is ridiculous that some of them even raises 20 students. So the problem is this: Will the government allow there to be more pharmacy students in the future? We hope that this will be the case for some reasons. The first is, the number of pharmacicts is limited these days. However, the demand for industrial pharmacies and pharmacists increase continuously. Other foundations will require more and more pharmacists. The second is in fact peculiar to France only. You have to pass an examination in order to attend the Faculty of Pharmacies. Girls are more successful in this exam than the boys. But the girls usually get married and have children after completing their education and no more work in the pharmacies. Therefore we have problems with girl students.

I'd like to attract your attention to this matter regarding pharmacy education. Because at the eve of entegration to Europe, Turkey's or other countries' health systems or drug prices can differ from country to country. One of the matters that the European Union is determined on the most is the level of education. The reason for this is that,

diplomas' and diploma beares' having free circulation in the future is in question. Therefore today, I know that The European Union is considering a practice of an education at least 5 years long and a training period of 6 months in a pharmacy. I think the next step that the European Union will be taking is the contiuous education after receivinig thediploma.

The French system regarding hospitals is a little similar to the Irish system. That is to say: The pharmacy of the hospital is only established to provide drugs to the patients staying at the hospital. Therefore, the pharmacists working at the hospitals can purchase drugs in the market for different prices than us. But there is this point: They can not purchase all kinds of antibiotics, they purchase one kind and give their patients whatever antibiotics they want. Besides, the hospital pharmacists can provide for emergency patients and the specific drugs for the patients residing in the city. .For example, the situation was just like this in the case of AIDS drugs. But these drugs are being sold in cities now. As I have metioned before, while the sales price of drugs and products that require special treatment is quite high, the share of the hospital pharmacists' is quite low.

In the pay back system of France, no patient or pharmacist pays money to receive treatment or drugs. Everything in pay back is arranged for the system of "payment of one third". So, we gather the information electronically and again electronically transfer them to the insurance companies. There is a special law in France which syas that: Health insurances don't belong to the government completely. That is to say, they are semi-private foundations and provide us to have special agreements with the insurances. When they receive the informations electronically and since they are in the form of codes, the health insurance safes have to pay in 4 days time. The system was constituted this way. We provide them with every information and they don't have to write them down. This avoids the over-employment in the insurance system. So, today the system totally works electronically and theoretically we have them economize and profit from this. We haven't seen these profits yet but this is another problem that we encounter in France totally.

We don't have pharmacy chains in France today. Because the pharmacist has to own his/her own pharmacy and one pharmacist is entitled to have only one. But this law can always be altered. To provide this, the majority of the parliament or new political ideas can be enough and the system can be changed in just a day and take the form of the Irish one or another system in European countries. That is what saves us in France today. Public forces would like to have a pharmacy in every village and remote place of France. If we are to provide our citizens with a pharmacy just beside their houses, regardless of the population, then we can't establish pharmacy chains. Because these chains would destroy these small establishments and gather in strategic areas of economical importance So, it can be seen that there is always a controversy between economy and health issues.

So; the French system stands still by this way. Today it is too early to say anything on this subject. Perhaps, if we are to correspond again, I may have some bad news for you.

MARIE SVANE

Thank you. In Denmark, as in more or less as in France and Ireland, pharmacies are public and have their pharmacy services as an in-house activity. Hospital pharmacies in Denmark perform production of medicines and distribution of medicines to the different areas of the hospital. And they perform clinical pharmacy. That is increasing the pharmacists' looking to the prescribing of the doctors in the hospital and may be give them advice about economic and rational use of medicines. So, as public purchasers, hospitals purchase medicines altogether. So, 14 out of the 16 possible hospitals buy medicines together via European Union procurement rooms. And this means that they are able to purchase their medicines sometimes at a completely ridiculous price compared with the purchase price in private hospitals. But these medicines are used only for the patients that are in the hospital and with the possibility of sending people home from hospitals with medicines for 2 or 3 days treatment at the most. However, there is pharmaceutical concern about the continuation of medication. If you are let go from a hospital and you have received a product which is sold at a price of 5 or less percent of the price in primary sector, the patient might pressure his doctor to prescribe the same product because they want to continue the same. So, there is suspicion that industry is dumping their prices in the hospital sector, in the hope that they will increase their sale in the primary sector. So, the hospitals when they purchase, they choose between different products and as in France, they do not have all the products. They may buy generics, buy parallel imported products. They will buy the cheapest and take on an assortment which pleases them.

Hospitalization is free in Denmark. There is no cost for the patient. And as a patient, you cannot purchase medicines at the hospital pharmacy. It is only in-house, for the use in hospital. I'll turn to the subject of chains in Denmark. As I said in my presentation, pharmacies in Denmark are privately owned by the pharmacists and that we have between 16 and 18 thousand people per pharmacy. But the concession to own a pharmacy may include a sub-branch. So, there might actually an additional shop. So, if you say in Denmark "How many places can you go and hand in your prescription, get medicines back?" It's not one for 18,000 people. It may be 8 or 10 thousand people. But these are all - they are considered to be part of the concession of one pharmacy and it is the pharmacist's long arm in rural areas and places where there is not considered to be enough people to keep up a whole pharmacy. So one question was whether the number of pharmacies was satisfactory and the answer to that is, in Denmark it is political decision how many pharmacies there are and how many long arms there are. The pharmacist cannot freely have sub-branches. It will still be the decision of the Ministery of Health, how many shops that you have as a pharmacist. And some of the smallest sub-branches are manned by pharmacy technicians, not by

pharmacists who in Denmark, as in the other countries, have a 5-year education. But then they receive prescriptions and tell the customer "Come back tomorrow" or "Come back in the afternoon". And the prescription would have been dispensed at the mother pharmacy. And the medication will be sent to the pharmacy shop which will then hand out the medicine to the customer who will then not be face-to-face with the pharmacist in these situations. We do have co-operations, but as I've said, the prices are fixed. Industry can set their prices, but the pharmacy purchase price is fixed. So the co-operations in Denmark are about the non-pharmaceutical business of the pharmacy. On the question of pharmacy schools, we have one and we have a problem with qualified personnel. The Danish Pharmaceutical Association is trying to convince a second university that they should take on educating pharmacists as well. One of the questions was kind enough to let me know during coffee break that there would be a question about the equalization system. And I see that the overhead is cut-off, so if it's OK; the equalization system between Danish pharmacies function so that if you have the average turnover which in year 2000 was 25.8 million krones which corresponds to - I think it's 3.5 million Euro. That's the average turnover of a pharmacy. And as I said before, each pharmacy may consist of more shops. If you have a turnover above the average, then you pay a fee on the turnover - not on your profit, on your turnover of 4.3%. And if your turnover is below, you receive similarly, a subsidiary of 4.3%. Now the next slide in the same series will show you the effect of this. There you can see that before equalization, you have the spread. You actually have 17 pharmacies that have a negative result and you have almost 30 pharmacies with the result of over 2 million Danish krones which is a substantial result. And the red shows after equalization that the profit - you equalize on turnover, but this shows with the result and the profit, that the profit gathers in the middle. Each pharmacist of course is depending on running his pharmacy in a sensible way. And the ones who have poor results are typically young pharmacists that have just started and are still paying off on their investments in equipment and so on. So I hope this answers the question directed to me. And that completes my comment.

ECKART BAUER:

First I'd like to address the question concerning the number of pharmacists. There is a political decision in Germany to how many pharmacists there are. There are about 2,000 seats for students of pharmacy each year in about 20 faculties. There is constant shortage of pharmacists. That means there are many vacant jobs for pharmacists in public pharmacies, in community pharmacies that can't be filled at the moment. Another question was how the universities decide on the students. Most of it is decided on their marks and the levels of achievement in school. But everyone who has the high-school degree can study pharmacy after a waiting period of I think now there are 4 years about. So this is not rather attractive. That means start after finishing school the military service or they don't do any study of pharmacy at all. Then there was a question on reimbursement - what is done to that reimbursement in time. Well, when I presented German statutory discount of 5 or 6% who could have mentioned that

this discount can only be applied when this payment is on time. Therefore, the statutory health insurance system is very interested in paying on time so that they can deduct this 6%. It's a good yield for them for paying on time. Well, most questions targeted hospital pharmacies. Not every hospital in Germany has a pharmacy. There are different reasons. One is that there is merchant of hospital pharmacies so that many hospitals share one pharmacy. Hospitals have contracts with public pharmacies who supply pharmaceuticals to hospitals. Most hospitals are not for profit hospitals. That doesn't mean that they are always state-owned. Many of them are owned by the churches and organizations. There are a few for profit organizations who hold hospitals. The drug price ordinance is only applied to drugs supplied by public community pharmacies. It isn't valid for hospital pharmacies. Hospital pharmacies can buy drugs wherever they want. Normally they buy them directly from the producers. There are special prices for them especially for those drugs that get the first application in hospital and 2 or 3 prescribed by physicians later on. By giving these special prices to hospital pharmacies, the pharmaceutical manufacturers want to get patients accustomed to these drugs in order that later on want these drugs prescribed by the physicians. Hospital pharmacies are not allowed to give drugs to out of house patients. They want to do so and say that they have special prices. The Pharmacies Association strictly opposes this. Our idea is that they can give drugs to the patients who leave the hospital for 2 or 3 days, but do not get reimbursed for these drugs so that they don't have really large interests to spend too much on these drugs. Consequently, the pricing of drugs for pharmaceuticals is a market of generics in the hospital is rather low. Those who supply generics normally haven't any interest in making the patients get accustomed to their product. That means most drugs used in hospitals are branded drugs. Those drugs that are only used in hospitals are rather high-priced. That means they do not get any special prices there. There isn't any interest for the pharmaceutical industry to give anything like discount to them.

LUBOMIR CHUDOBA:

In the Czech Republic, we have two faculties and approximately about 280 pharmacists are graduated every year. Unfortunately, a lot of them are going to market producers company or in other places. And then we have in all republic, a lack pharmacists. If the reimbursement is not on time, we can by general trade law or give our health insurance companies some penalty. But it's very hard to receive of course for all. We have a very liberal system in a hospital pharmacy. And then the hospital pharmacies mostly are owned by state because course the prices or the offer from wholesale of producer companies to the ducers. But we will see.

AIDAN O'SHEA:

Could I just add one or two additional points that. One is briefly on the reimbursement question and the question of late payments by the state or by the insurance authorities. And in Ireland there is a law by which the state degrees the time contract for the payment of a given charge. If this

time is exceeded, the state now has to pay 1% interest a month of the amount. This was introduced precisely because we had some of these problems that you would have. There are 3 dates for the pharmacist. From the wholesaler, he will receive 30 days credit from the end of a given month. And the state is due to pay him in 40 days which is 10 days more. So he must pay as wholesaler 10 days before the state will pay him. But we have negotiated with our government that the pharmacist receives a loan of the net monthly cost of drugs supplied to the state -one month's supply. And this loan is adjusted each year in accordance with the average monthly cost. So we have a grant or a loan of this amount of money. This is a great help from the liquidity of making the payments to the suppliers. Finally, when we introduced electronic transmission of claims, we argued that the state would save a great deal of time and administration in dealing with paper claims. And we wanted an additional payment for this. They weren't prepared to make additional payment so instead we negotiated early payment for these electronic claims. And these claims are paid in 15 days from the end of the month. So the pharmacist who has an electronic claiming system has a grant of 1 month net value of stuffs supplied; plus 15 days advantage in the time of payment promise date. That's the end of that point.

MEHMET DOMAÇ:

I think there is no other answers left. Now I have some answers.

I would like to clarify the last point in his words. We have suggested a more detailed suggession about interferon issue to the Social Security Institution. In other words dispensing the medicines and getting some fee for this service. They have suggested a more detailed one and I think they are going to have an agreement.

The aim is not to have problems with the institutions but find solutions for them. If the government starts to think about like this, in other words, getting rid of this thought of being robbed or paying too much money, the it is rationalized and the more it is rationalized, the more the government saves money. I think, pharmacists throughout the world assists their governments. We are trying to provide the same assistance.

One of our friends has a question: "Can active substance name be written on a prescription and can this help with the savings?"

Of course. In fact, phycians do not know the trade names of the drugs when they are graduating, afte they garduate pharmaceutical companies teach them to the physicans. A small number of companies teach them so they prescribe them mostly. If generics are prescribed then the government saves money because generics are usually cheaper than the original drug and also this generic medicine should be a substitutable one. Therefore, bioequivalance studies should already be done.

We had a question: " Since the government sets the price of the medicine and purchases medicine, how will the government monopoly be over?" Government monopoly can not be over because in no other parts of the world, with-

out government's effect, social security institutions don't have a chance of survival. There are special insurance groups, may be there is a special insurance system in the United States, but the United States model is a very different one. So no social security institutions have a chance of survival without government's support. Therefore, when we are setting the prices, we should be serious, research about them, check the prices and our econo-mic status with the world and European countries and make an evaluation. And we should find a way for working with these people from professional organizations, etc. I think we found a way for this because, Turkish Pharmacists' Association makes the agreements between the government's social security institutions. Bu this is not a very long period, about seven years, if this period was 20-25 years, then we would understand each other more.

Nobody other than government can make this organization and make the reimbursements. We have problems in our reimbursement systems, but we will find solutions for them.

We, as pharmacists, are rationalized and see that the government is rationalized too. Therefore, the government should accept sanctions for itself. So, in my opinion, whatever the system is in the country, the same thing should be applied to late payments. More than an opinion, we request that.

There are some other questions, but I don't want to get into details.

Pharmacy education should be 5 years. If Turkey wants to be a member of the EU, we have to make this change for the future of the profession, free circulation of pharmacists in the EU, for the equality of the professions. It is not only making pharmacy education 5 years but also creditted therefore, the quality of the profession and the service is high.

That is all I can say. I would like to thank to all of our speakers for their presentations and participations for this meeting. Mr. Aidan O'Shea, Mr. Philippe Liebermann, Ms. Marie Svane, Mr. Eckart Bauer and Mr. Lubomir Chudoba, I would like to thank you all again, your presence has provided a support for us, thank you for your attention.

Have a nice day.

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