NIHDI

Monitoring Of Reimbursement Significant Expenses

MORSE report 2021 (2020 data)

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CONTENTS

INTRODUCTION

The MORSE report aims at the financial follow-up of the expenditure for reimbursable medicinal products in relation to the adopted policy measures (including new introductions of medicines in the reimbursement scheme, saving measures, etc.) and the reporting on trends in spending on proprietary pharmaceuticals (pharmaceuticals) delivered both in public pharmacies and in hospitals.

This report deals with pharmaceuticals as well as with other pharmaceutical dispensing. As far as the pharmaceuticals are concerned, this report doesn't include an in-depth analysis of the evolution of the expenditure for different classes of medicine but the analysis is limited to a graphical representation of the evolution of the expenditure, the consumption (DDD) and the number of patients treated. In contrast, a number of categories of pharmaceutical dispensing are analysed in more detail.

This report examines data up to and including December 2020.

The corona pandemic (COVID-19) became apparent in 2020. It affected the consumption and the expenditure of the health insurance.

In order to evaluate NIHDI net expenditure, NIHDI data are used (Pharmanet for public pharmacies, docPH consolidated invoicing data for hospitals).

The data on the pharmaceuticals supplied during 2020 by public pharmacies are complete (Pharmanet data). Hospital data were extrapolated (DocPH 2020 data available for ten months, these are 85 % complete).

The expenditure referred to in this report is NIHDI net expenditure as invoiced to the health insurance funds (pharmaceuticals budget).
For those pharmaceuticals for which an 'Article 81/111 convention' has been concluded between the company and NIHDI, the amounts repaid to the health insurance (general health insurance budget) are not taken into account: details of the refund mechanism, set out in the annex to these conventions, are confidential.

'NIHDI net expenditure' should always be taken to mean NIHDI gross expenditure minus the individual patient co-payments. 'NIHDI net expenditure' does not therefore include money received under the Article 81/111 conventions. A distinct section is dedicated to the Article 81/111 conventions.

Financial monitoring is not an exact science: observations are also tested against probability factors, in the view of the internal staff (internal evaluator, case managers, Pharmanet cell, etc.).
In addition, earlier forecasts are regularly checked against real expenditure, once the data are available, to ascertain the extent of any deviations.

Several reports on pharmaceutical expenditure exist: the permanent audit, Infospot, reports from the data management department, etc. In the MORSE report, we try to process the relevant information gleaned from other sources: where deemed necessary, data from NIHDI's actuarial department were added to this report.

The main aim of these MORSE reports is to stimulate reflection and discussion. All comments are welcome!

OVERVIEW OF GLOBAL EXPENDITURE ON PHARMACEUTICALS, BROKEN DOWN INTO PUBLIC PHARMACIES AND HOSPITALS

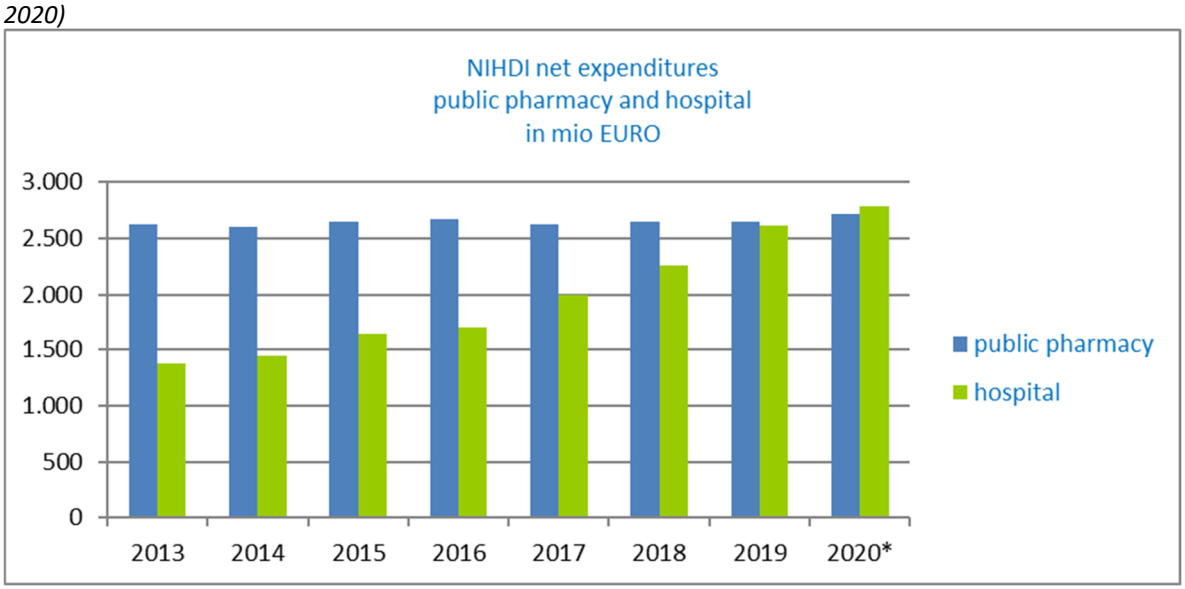
GENERAL

Table 1: NIHDI net annual expenditure on medicines 2013-2020[1]

NIHDI net expenditure x 1,000,000 €								
	2013	2014	2015	2016	2017	2018	2019	2020*
Public pharmacies	2,619.3	2,604.8	2,651.8	2,665.0	2,626.3	2,647.6	2,649.8	2,718.0
Hospitals	1,371.4	1,444.8	1,642.0	1,702.4	1,991.4	2,262.5	2,617.8	2,787.0
Total	3,990.7	4,049.6	4,293.7	4,367.4	4,617.7	4,910.1	5,267.6	5,504.9
% Growth								
		'13- '14	'14- '15	'15- '16	'16- '17	'17- '18	'18- '19	'19- '20
Public pharmacies		-0.6	1.8	0.5	-1.5	0.8	0.1	2.6
Hospitals		5.4	13.6	3.7	17.0	13.6	15.7	6.5
Total		1.5	6.0	1.7	5.7	6.3	7.3	4.5

*Source: Pharmanet (public pharmacies) and docPH (hospitals), * 2020 based on extrapolated docPH data*

Figure 1: Net annual expenditure on reimbursable pharmaceuticals in public pharmacies and hospitals (2013-2020)



[1] The figures on NIHDI net expenditure for public pharmacies are Pharmanet data. The figures on NIHDI net expenditure in hospitals come from: docPH data (NIHDI data), where total expenditure = outpatient expenditure + total expenditure on hospital admission lump sums + expenditure on hospitalised patients booked at 100% (not included in lump sum) + expenditure on hospitalised patients booked at 25% (included in lump sum).

The global expenditure for medicinal products continues to show an upward trend. With a growth rate of 4.5% in 2020 compared to 2019, the increase is less steep than the growth rate of 6 to 7% in 2017, 2018 and 2019. The same trend can be observed in hospitals: a less steep growth of 6.5% in 2020 compared to the more significant growth of 14 to 17% during the 3 previous years (2017, 2018 and 2019).
However, in public pharmacies, after a near status quo of expenditure in 2018 and 2019, we see a 2.6% increase in expenditure in 2020 compared to 2019.
The 2.6% growth in expenditure in public pharmacies in 2020 and the 6.5% growth in expenditure in hospitals, result in a 4.5% growth in overall expenditure for pharmaceuticals. As a result, expenditure will increase to EUR 5.5 billion in 2020.

Figure 1 shows that expenditure on pharmaceuticals in hospitals makes up a growing share of overall expenditure on these products. Broadly speaking, the share of the expenditure in public pharmacies/hospitals has been equally split since 2019. In 2020, we see, for the first time, that expenditure in hospitals (narrowly) exceeds the expenditure in public pharmacies (share of hospital expenditure 50.6%).

Her we note the expenditure figures given in this report are figures for NIHDI net expenditure (NIHDI gross expenditure minus patient co-payments). This 'NIHDI net expenditure' does not take into account sums received under Article 81/111 conventions.

Every year, there is an increase in the share of expenditure on pharmaceuticals temporarily included in the list of reimbursable pharmaceuticals, i.e. pharmaceuticals on which an Article 81/111 convention has been concluded between the NIHDI and the company. This is due to the increasing number of conventions, larger volumes and higher prices of medicines covered by such conventions.
In 2020, the medicinal products for which an Article 81/111 convention has been reached, account for 35% of the expenditure. In public pharmacies, a minority (11%) of the expenditure can be attributed to these medicines under contract, whereas in hospitals, this expenditure amounts to more than 50% (58% to be precise).
By way of comparison, in 2019, the share of expenditure for medicines under contract within the expenditure in public pharmacies and hospitals, was 10% and 55% respectively.

Table 2: Breakdown NIHDI net expenditure 2020 depending on whether or not the medicinal product falls under an Article 81/111 convention

NIHDI expenditure 2020 (in million EUR)							
	Code T**	Public pharmacies		Hospital*		TOTAL	
Medicines without contract	0	2,411.1	*88.7%*	1,181.0	*42.1%*	3,592.1	*65.0%*
Medicines under contract	**1**	**306.9**	***11.3%***	**1,623.6**	***57.9%***	**1,930.5**	***35.0%***
TOTAL		2,718.0	*100.0%*	2,804.6	*100.0%*	5,522.6	*100.0%*

*1) extrapolation based on data recorded in 2021 and 2) for lump sum medicines, the expenditure is calculated based on the real expenditure (25%) x 4 (this is a theoretical calculation of part of the expenditure for that which is covered by the lump sum)
** situation code T on 1 December 2020

In order to gain an overview of the budgetary compensation measures (a detailed analysis is not possible, due to the confidential nature of the refund mechanisms), we use the data from NIHDI's actuarial department. For completeness' sake, we report on the sums received through the annual levies on the pharmaceutical industry. The table below shows how the 81/111 receipts and levies have evolved over time.

Table 3: Evolution of expenditure, taking account of receipts under Art. 81/111 conventions and levies (in million EUR)

	2015	2016	2017	2018	2019	2020
Recorded expenditure (*docN*) (1)	4,277.7	4,378.2	4,594.8	4,891.8	5,263.3	5,586.2
Art 81/111 receipts (2)	54.5	123.6	273.4	359.3	605.0	754.2
(3) = (1) minus (2)	4,223.2	4,254.6	4,321.4	4,532.5	4,658.2	4,832.0
Levies (4)	281.1	321.5	344.4	365.9	431.5	343.1
(5) = (3) min (4)	3,942.1	3,933.1	3,977.1	4,166.6	4,226.7	4,488.9

Source: NIHDI's actuarial department

EXPENDITURE ON PHARMACEUTICALS IN PUBLIC PHARMACIES

Table 4: NIHDI net annual expenditure on medicines 2013-2020

	2013	2014	2015	2016	2017	2018	2019	2020
NIHDI net expenditure x 1,000,000 €	2,619.3	2,604.8	2,651.8	2,665.0	2,626.3	2,647.6	2,649.8	2,718.0

		2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
% growth		-0.6	1.8	0.5	-1.5	0.8	0.1	2.6

Table 5: Top 80% of NIHDI net annual expenditure on medicines in public pharmacies

	Denomination	Growth 2019-2018	Growth 2020-2019	2020 NIHDI expenditure (in MEUR)
	Total	**0.1%**	**2.6%**	**2,718.0**
L04A	IMMUNOSUPPRESSANTS	-4.9%	6.2%	433.5
B01A	ANTITHROMBOTIC AGENTS **(T)**	9.3%	3.9%	275.2
A10B	BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS **(T)**	12.0%	15.5%	145,7
J05A	DIRECT ACTING ANTIVIRALS	-3.1%	-1.3%	142.7
R03A	ADRENERGICS, INHALANTS	4.6%	2.1%	122.5
A02B	DRUGS FOR PEPTIC ULCER AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)	-1.5%	0.3%	102.6
C10A	LIPID MODIFYING AGENTS, PLAIN **(T)**	-10.6%	1.9%	95.2
A10A	INSULINS AND ANALOGUES	5.8%	1.5%	92.4
N06A	ANTIDEPRESSANTS	-0.2%	-1.0%	85.3
N05A	ANTIPSYCHOTICS	-8.0%	0.2%	84.8
B02B	VITAMIN K AND OTHER HEMOSTATICS **(T)**	-1.7%	23.2%	73.7
N03A	ANTIEPILEPTICS	4.3%	3.2%	71.2
N02A	OPIOIDS **(T)**	-1.1%	-3.0%	56.7
R03D	OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	18.0%	20.0%	54.9
C07A	BETA BLOCKING AGENTS **(T)**	-3.5%	-2.5%	44.3
C09B	ACE INHIBITORS, COMBINATIONS	7.6%	6.2%	42.3
C09D	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs), COMBINATIONS	14.7%	5.1%	40.8
J07B	VIRAL VACCINES	1.5%	52.4%	40.4
M05B	DRUGS AFFECTING BONE STRUCTURE AND MINERALISATION	0.2%	-2.2%	37.9
M01A	ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STEROIDS	-6.0%	-16.4%	34.4
C09A	ACE INHIBITORS, PLAIN	-1.3%	-4.6%	30.5
H01C	HYPOTHALAMIC HORMONES	1.0%	2.3%	28.1
L03A	IMMUNOSTIMULANTS	-14.6%	-9.9%	25.7
R03B	OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS	-7.3%	-20.7%	25.4

(T): This ATC3 class includes 1 or more pharmaceuticals which are on the list temporarily via an Art. 81/111 convention

The overview of expenditure and growth per ATC3 class (Table 5) shows that **24 of the 150 classes** account for **80% of the expenditure** in public pharmacies**.**

ATC3 classes which include 1 or several pharmaceuticals which are temporarily on the list via an Article 81/111 convention are indicated in Table 5 by the letter (T). The real cost to the NIHDI of these ATC3 classes may be lower than the net expenditure reported, due to the financial compensation set out in Article 81/111 conventions.

In the public pharmacies, 11% of the expenditure is due to expenditure for medicines under contract (see Table 2).

Globally speaking, the expenditure for the reimbursement of medicinal products in public pharmacies showed a limited increase compared to the previous year (2.6%), but underneath that, (for each class of medicines) important and very divergent evolutions were observed (either a strong growth, or a strong decrease, or a reverse trend).

This report, which focuses on the pharmaceutical dispensing other than the dispensing of pharmaceuticals, doesn't include an in-depth analysis of the evolution of the expenditure and the consumption of certain ATC3 classes, but is limited to a graphical representation of these evolutions. For this, we refer to the graphs annexed to the report.
For the following ATC3 classes, the evolution of the NIHDI net expenditure, the number of DDDs and the number of patients treated are plotted in graphs:

- The 6 highest ranked ATC3 classes when ranked by annual net expenditure or also the classes for which, in 2020, the NIHDI net expenditure is more than 100 million euros:

	Denomination	Growth 2019-2018	Growth 2020-2019	2020 NIHDI expenditure (in MEUR)
	Total	**0.1%**	**2.6%**	**2,718.0**
L04A	IMMUNOSUPPRESSANTS	-4.9%	6.2%	433.5
B01A	ANTITHROMBOTIC AGENTS **(T)**	9.3%	3.9%	275.2
A10B	BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS **(T)**	12.0%	15.5%	145.7
J05A	DIRECT ACTING ANTIVIRALS	-3.1%	-1.3%	142.7
R03A	ADRENERGICS, INHALANTS	4.6%	2.1%	122.5
A02B	DRUGS FOR PEPTIC ULCER AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)	-1.5%	0.3%	102.6

- and 4 ATC3 classes with a significant evolution in net expenditure:

	Denomination	Growth 2019-2018	Growth 2020-2019	2020 NIHDI expenditure (in MEUR)
B02B	VITAMIN K AND OTHER HEMOSTATICS **(T)**	-1.7%	23.2%	73.7
R03D	OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	18.0%	20.0%	54.9
J07B	VIRAL VACCINES	1.5%	52.4%	40.4
R03B	OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS	-7.3%	-20.7%	25.4

The ATC3 class with the highest growth rate is J07B, the antiviral vaccines, with a 52.4% growth rate. This strong growth is due to the extension of the reimbursement modalities for the anti-influenza vaccines (flu vaccines). As a result of the COVID-19 pandemic, the target group eligible for reimbursable vaccines was expanded and the insurance coverage was increased (transfer from reimbursement category Cs to category B). In addition, an increase in the price of influenza vaccines was granted in mid-2020. In 2020, 2.1 million patients had their vaccine

reimbursed, compared to 1.6 million in previous years (+26%). The health insurance costs for these vaccines increased from €10.3 to €26.8 million in 2020.

Figure 2 illustrates total expenditure in relation to the number of patients being treated. In 2020, we see a decrease in the number of patients treated (minus 4.8% compared to 2019), while the expenditure increases (2.6% growth). Both evolutions result in 2020 in an increase of the average NIHDI expenditure per patient reaching 333 euros (7.8% growth). Table 6 shows developments in the number of patients treated per ATC3 class.

Figure 2: Evolution of NIHDI net expenditure in public pharmacies against number of (unique) patients treated

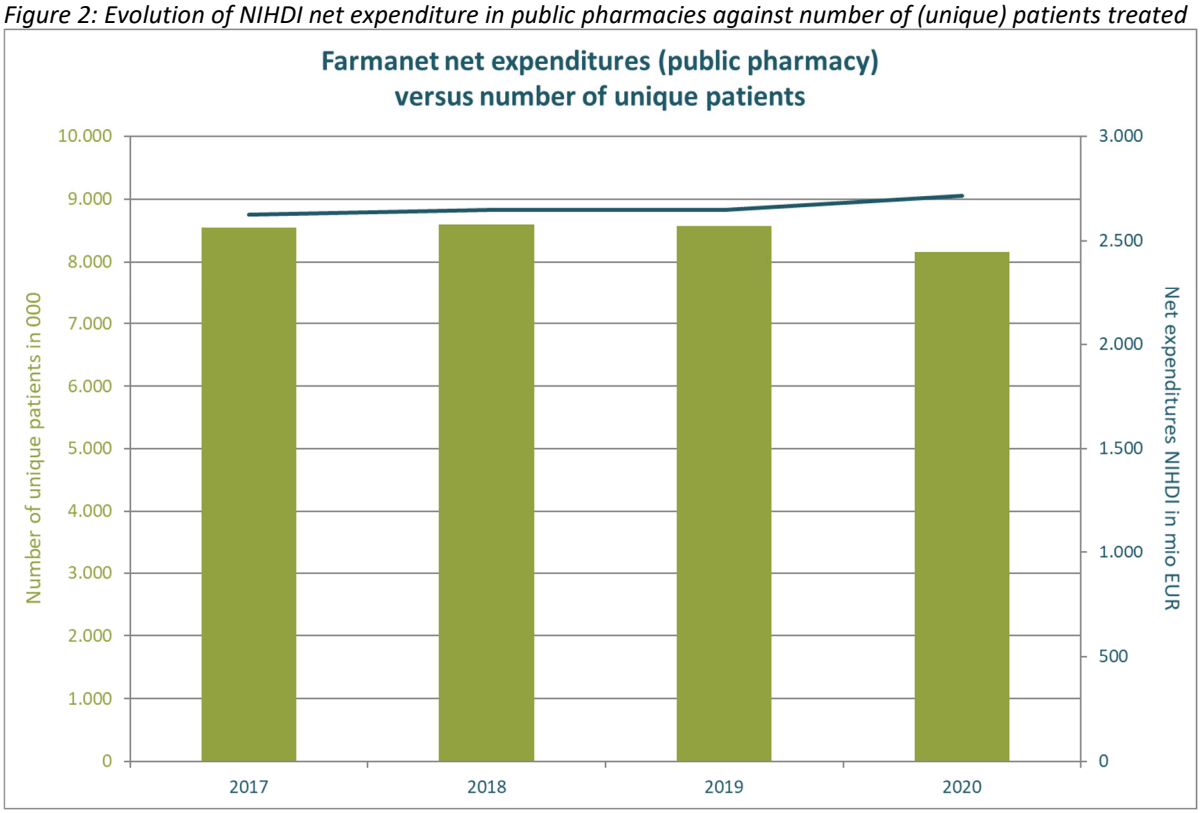


Table 6: Evolution of number of (unique) patients treated in public pharmacies (in 000) per ATC3 class

	Denomination	Growth 2019-2018	Growth 2020-2019	Patients in 2020 (x 1000)
	Total	**-0.4%**	**-4.8%**	**8,152.0**
L04A	IMMUNOSUPPRESSANTS	4.6%	2.4%	125.4
B01A	ANTITHROMBOTIC AGENTS	0.6%	-2.6%	1,510.3
A10B	BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS	4.2%	2.2%	655.4
J05A	DIRECT ACTING ANTIVIRALS	7.5%	0.5%	38.9
R03A	ADRENERGICS, INHALANTS	-1.1%	-14.1%	1,052.7
A02B	DRUGS FOR PEPTIC ULCER AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)	2.6%	-3.5%	2,177.9
C10A	LIPID MODIFYING AGENTS, PLAIN	1.0%	-0.5%	1,555.7
A10A	INSULINS AND ANALOGUES	1.9%	1.7%	163.4
N06A	ANTIDEPRESSANTS	2.0%	-0.5%	1,218.8
N05A	ANTIPSYCHOTICS	0.5%	-0.8%	367.0
B02B	VITAMIN K AND OTHER HEMOSTATICS	3.7%	5.8%	0.4
N03A	ANTIEPILEPTICS	4.3%	-0.2%	335.2
N02A	OPIOIDS	1.0%	-7.1%	1,046.6
R03D	OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	-1.4%	-8.0%	158.2
C07A	BETA BLOCKING AGENTS	0.8%	-0.8%	1,292.8
C09B	ACE INHIBITORS, COMBINATIONS	7.7%	4.2%	465.6
C09D	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs), COMBINATIONS	6.2%	4.2%	321.7
J07B	VIRAL VACCINES	1.0%	22.8%	2,243.8
M05B	DRUGS AFFECTING BONE STRUCTURE AND MINERALISATION	-1.5%	-4.7%	136.3
M01A	ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STEROIDS	-1.4%	-15.9%	2,532.3
C09A	ACE INHIBITORS, PLAIN	1.5%	-5.9%	536.9
H01C	HYPOTHALAMIC HORMONES	2.5%	-1.3%	3.6
L03A	IMMUNOSTIMULANTS	-12.2%	-11.3%	3.7
R03B	OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS	-3.4%	-28.7%	442.3

These percentages, and the relationships between them, differ from those in the table on expenditure over time (see Table 4). This suggests significant changes in NIHDI expenditure per patient, as illustrated in Table 7.

Table 7: Evolution of average NIHDI expenditure per patient in public pharmacies, per ATC3 class

	Denomination	Growth 2019-2018	Growth 2020-2019	NIHDI expenditure per patient 2020
	Total	**0.4%**	**7.8%**	**333.4**
L04A	IMMUNOSUPPRESSANTS	-9.0%	3.7%	3,456.7
B01A	ANTITHROMBOTIC AGENTS	8.7%	6.6%	182.2
A10B	BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS	7.4%	13.0%	222.3
J05A	DIRECT ACTING ANTIVIRALS	-9.9%	-1.7%	3,671.6
R03A	ADRENERGICS, INHALANTS	5.8%	18.8%	116.4
A02B	DRUGS FOR PEPTIC ULCER AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)	-4.0%	4.0%	47.1
C10A	LIPID MODIFYING AGENTS, PLAIN	-11.5%	2.4%	61.2
A10A	INSULINS AND ANALOGUES	3.9%	-0.1%	565.3
N06A	ANTIDEPRESSANTS	-2.1%	-0.6%	70.0
N05A	ANTIPSYCHOTICS	-8.4%	1.0%	231.1
B02B	VITAMIN K AND OTHER HEMOSTATICS	-5.3%	16.5%	192,359.6
N03A	ANTIEPILEPTICS	0.1%	3.4%	212.4
N02A	OPIOIDS	-2.1%	4.3%	54.2
R03D	OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	19.6%	30.5%	347.1
C07A	BETA BLOCKING AGENTS	-4.2%	-1.7%	34.3
C09B	ACE INHIBITORS, COMBINATIONS	-0.1%	1.9%	90.9
C09D	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs), COMBINATIONS	8.0%	0.8%	126.9
J07B	VIRAL VACCINES	0.5%	24.2%	18.0
M05B	DRUGS AFFECTING BONE STRUCTURE AND MINERALISATION	1.7%	2.6%	278.3
M01A	ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STEROIDS	-4.6%	-0.6%	13.6
C09A	ACE INHIBITORS, PLAIN	-2.8%	1.4%	56.8
H01C	HYPOTHALAMIC HORMONES	-1.5%	3.6%	7,732.1
L03A	IMMUNOSTIMULANTS	-2.7%	1.6%	6,947.2
R03B	OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS	-4.0%	11.3%	57.4

Table 8: NIHDI net annual expenditure on medicines 2013-2020 (docPH)

	2013	2014	2015	2016	2017	2018	2019	2020*
NIHDI net expenditure x 1,000,000 EUR	1,371.4	1,444.8	1,642.0	1,702.4	1,991.4	2,262.5	2,617.8	2,787.0

		2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
growth %		5.4	13.6	3.7	17.0	13.6	15.7	6.5*

(*) extrapolation

Table 9: Evolution of NIHDI net annual expenditure on medicines - top 80% (hospitals)

Ranking			Lump sum	ATC 3		growth (%)	growth (%)	total in million EUR[2]
2018	**2019**	**2020***				**2019-2018**	**2020*-2019**	**2020***
1	1	1	No	L01X (**)	OTHER ANTINEOPLASTIC AGENTS **(T)**	21.3%	20.9%	865.8
2	2	2	No	L04A	IMMUNOSUPPRESSANTS **(T)**	15.8%	8.6%	403.2
3	3	3	No	L01E (**)	PROTEIN KINASE INHIBITORS **(T)**	27.5%	16.5%	373.0
4	4	4	No	S01L	OCULAR VASCULAR DISORDER AGENTS **(T)**	13.2%	3.9%	114.4
6	7	5	No	L02B	HORMONE ANTAGONISTS AND RELATED AGENTS **(T)**	32.2%	13.5%	102.7
5	6	6	No	J06B	IMMUNOGLOBULINS	6.1%	3.2%	93.5
9	9	7	No	B02B	VITAMIN K AND OTHER HEMOSTATICS **(T)**	-1.5%	18.7%	63.5
8	8	8	Yes	B05B	I.V. SOLUTIONS	-0.6%	-5.7%	55.7
11	10	9	No	L01B	ANTIMETABOLITES **(T)**	14.3%	4.6%	55.6
7	5	10	No	J05A	DIRECT ACTING ANTIVIRALS **(T)**	41.8%	-40.4%	54.4
10	11	11	Mix	A16A	OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS **(T)**	-0.5%	-4.7%	48.3
12	12	12	No	L03A	IMMUNOSTIMULANTS	16.2%	-15.4%	41.5

(T): this ATC3 class includes 1 or several pharmaceuticals which are temporarily included in the list via an Article 81/111 convention
(*) extrapolation
(**) WHO changes ATC classification 2021: the protein kinase inhibitors were removed from class L01X and moved to a new ATC 3 class: L01E

This overview of the (virtual) expenditure and the growth observed per ATC3 class shows that **12 of the 166 classes** account for **80% of expenditure** on pharmaceuticals in hospitals.

ATC3 classes which include 1 or several pharmaceuticals which are temporarily on the list via an Article 81/111 convention are shown in Table 9 by a letter (T). The real cost to the NIHDI of these ATC3 classes may be lower than the net expenditure figure given, due to the financial compensation set out in the Article 81/111 conventions.

[2] The NIHDI net expenditure per ATC 3 class is based on: docPH data (NIHDI data), where the total expenditure = expenditure outpatients (A) + expenditure booked at 100% (lump sum not included) (B) + expenditure booked at 25% (lump sum included) (C) + a theoretically calculated sum based on C (D). By adding the amount D, the expenditure is not absolute but virtual, thus allowing a ranking.

In hospitals, more than half of the expenditure (58%) is attributed to expenditure for medicines under contract (see Table 2).

Table 9 shows that the highest ranked class, year after year, is L01X (other antineoplastic agents). In 2021, the WHO made a change in the ATC classification system: the protein kinase inhibitors were removed from class L01X and moved to a new ATC3 class: L01E. Despite this division, class L01X remains ranked 1st, while the protein kinase inhibitor class moves to third place. The ocular vascular disorder agents, class S01L, therefore moved to 4th place.

Expenditure for immunosuppressants (L04A) also continues to rise and, as was the case in previous years, is ranked 2nd.

In 2020, the expenditure for the 3 highest ranked classes, L01X, L04A and L01XE, amounted to more than 1.6 billion euros or almost 60% of the expenditure for pharmaceuticals in hospitals. All molecules belonging to these classes are excluded from the hospital lump sum.

Whereas class L04A is ranked 2nd in the top 80% of pharmaceutical expenditure in hospitals, it is ranked 1st in the top 80% in public pharmacies (433.5 million euros in 2020). In 2019, we saw, for the first time in years, a decrease in expenditure on immunosuppressants of almost 5% in public pharmacies. This decrease was due to the commercialisation of biosimilar medicines and the associated price drop within the scope of the measure taken with regard to 'biological medicines'. In 2020 however, we saw again an increase in expenditure of 6.2%.

In 2020, the expenditure for class L04A amounted to 433.5 million euros in public pharmacies and 403.2 million euros in hospitals. That is equal to a total expenditure of 836.7 million euros or 15.2% of the global budget for medicinal products. In comparison, in 2016, the total expenditure for class L04A was 598.01 million euros or 13.7% of the 2016 global budget for medicinal products.

This report, which focuses on the pharmaceutical dispensing other than the dispensing of pharmaceuticals, doesn't include an in-depth analysis of the evolution of the expenditure and the consumption of certain ATC3 classes, but is limited to a graphical representation of these evolutions. For this, we refer to the graphs annexed to the report.
For the following ATC3 classes, the evolution of the NIHDI net expenditure, the number of DDDs and the number of patients treated are plotted in graphs:

- The 5 highest ranked ATC3 classes when ranking by annual net expenditure or also the classes for which, in 2020, the NIHDI net expenditure exceeds 100 million euros:

		growth (%) 2019-2018	**growth (%) 2020*-2019**	2020* NIHDI expenditure (in MEUR)
L01X	OTHER ANTINEOPLASTIC AGENTS **(T)**	21.3%	20.9%	865.8
L04A	IMMUNOSUPPRESSANTS **(T)**	15.8%	8.6%	403.2
L01E	PROTEIN KINASE INHIBITORS **(T)**	27.5%	16.5%	373.0
S01L	OCULAR VASCULAR DISORDER AGENTS **(T)**	13.2%	3.9%	114.4
L02B	HORMONE ANTAGONISTS AND RELATED AGENTS **(T)**	32.2%	13.5%	102.7

- and 2 ATC3 classes with a significant evolution in net expenditure:

		growth (%) 2019-2018	**growth (%) 2020*-2019**	2020* NIHDI expenditure (in MEUR)
B02B	VITAMIN K AND OTHER HEMOSTATICS **(T)**	-1.5%	18.7%	63.5
J05A	DIRECT ACTING ANTIVIRALS **(T)**	41.8%	-40.4%	54.4

EXPENDITURE ON MEDICINES IN HOSPITALS: BREAKDOWN BY TYPE OF PATIENT

BASIS

We use docPH data: consolidated invoicing data (NIHDI net expenditure), broken down by pharmaceutical packaging and type of patient (hospitalised – outpatient).
In the case of docPH data, the invoicing data for a given period refer to the period during which the medicines were delivered. DocPH data are always available at a later time, since the data for a year of delivery are selected from the data recorded for an 18-month period (the specific year and the semester following that year). In the case of the 2020 DocPH figures, the data recorded for the first half of 2021 are not yet available. The data reported are extrapolated from the recorded 2020 data (extrapolation based on about 85% of the data of the full year).

GENERAL: MEDICINES LUMP SUM

On 1 July 2006, the **medicines lump sum** was introduced for hospitalised patients in acute hospitals. In principle, all the medicines provided to these patients are covered by a fixed reimbursement scheme (lump sum).

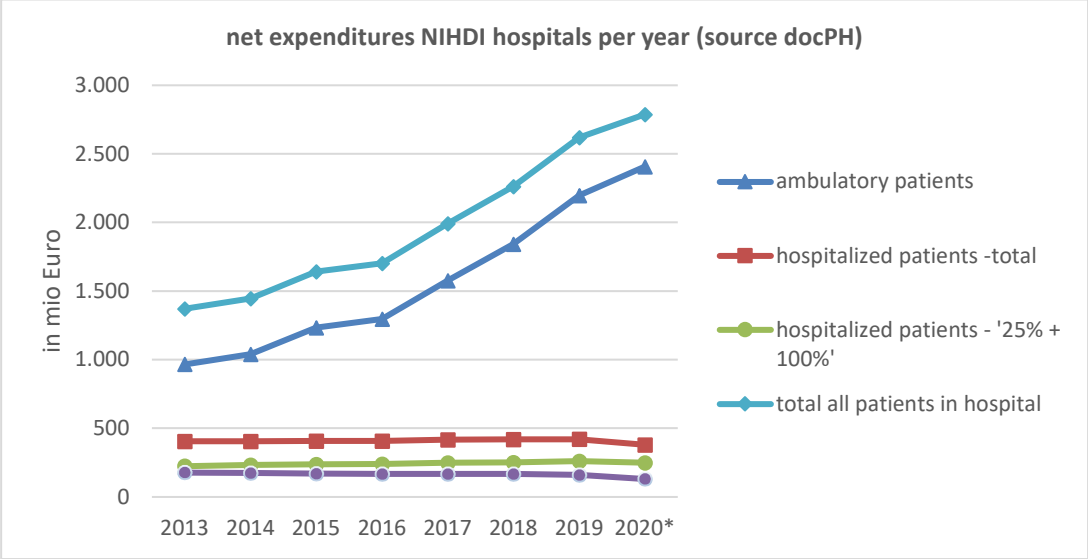
There is, however, a list of exceptions to this principle (based on the ATC5 code).
Medicines are excluded either by law (e.g. orphan drugs, antineoplastic agents, cf Article 127(3) of the Royal Decree of 1 February 2018) or on the basis of a proposal from the 'permanent working group lump sum medicines' (if either the active ingredient is extremely important in medical practice and/or if the cost of the product could substantially limit its use if it were included in the lump sum).

According to the legislation, for pharmaceuticals included in the lump sum, 25% of the reimbursement basis is still invoiced. The remaining part is covered by the hospitalisation lump sum (fixed amount per admission).

This partial invoicing (25% of the reimbursement basis is invoiced in the standard way, i.e. per unit used) means the actual use of medicines can be monitored without these data disappearing into a general medicines lump sum based on APRDRG (All Patients Refined Diagnosis Related Groups).

Plotting the annual figures per patient type gives the graph shown below (Figure 3).

*Figure 3: NIHDI net expenditure, 2013-2020**



*Source: docPH, *2020 based on extrapolated data*

In 2020, we experienced the COVID-19 pandemic resulting in periods of deferred care. This crisis has a considerable impact on the evolution of the expenditure.
When looking at the expenditure for hospitalised patients, which was stable from 2014 to 2019, we see a decrease in the expenditure of 9.6% in 2020: 17.1% less was spent on the lump sum per admission and a decrease of 5.1% can be observed in the expenditure for medicines.
The distinct growth in expenditure for outpatients, which can be observed in 2017, 2018 and 2019, with a respective growth rate of 21.6%, 16.6% and 17.4% compared to the previous year, slows down to a growth rate of 9.6% in 2020.
Although total hospital expenditure continues to grow by 6.5% in 2020 compared to 2019, the sharply rising expenditure curve observed in 2017, 2018 and 2019 is flattening out.

The table below (Table 10) shows that the share of expenditure on outpatients out of the total hospital expenditure on pharmaceuticals is growing year on year.
In 2020, this share has risen to 86.4%. In 2020, expenditure on hospitalised patients accounted for less than 15% (14.6%) of the total hospital expenditure on medicines.

Table 10: Outpatient expenditure as a percentage of total hospital expenditure on pharmaceuticals 2013-2020 (in %)

	2013	2014	2015	2016	2017	2018	2019	2020*
Percentage of expenditure on outpatients / total expenditure hospitals	70.5%	71.9%	75.2%	76.1%	79.1%	81.4%	83.9%	86.4%

*Source: docPH, *2020 based on extrapolated data*

The national budget for lump sums (invoicing by fixed amount per admission) is set each year by the General Council. These are open-ended budget envelopes. The individual hospital receives a lump sum amount per admission, which depends on the reported case mix (based on minimum hospital data).

Table 11 shows the amounts set aside in the national budget for the medicines lump sum. The hospital lump sum has been in force since 1 July 2006. The amount earmarked in the national budget for the first year of application of the medicines lump sum (1.7.2006-30.6.2007) was 258.86 million euros. This amount has been reduced gradually over the years, and now, in the fifteenth year of the system (1.7.2020-30.6.2021) stands at 148.825 million euros.

From 1.1.2014, the price per admission is reduced to 82% of the original value if the same patient is re-admitted to the same hospital within 10 days of a previous admission. This saving measure aims to save 1.9 million euros annually.

Table 11: Amounts set aside in the national budget for hospital admission lump sums, July 2013-June 2021 inclusive

Period	Sum in national budget (in million EUR)
1.7.2013 - 30.6.2014	172.865
1.7.2014 - 30.6.2015	174.964
1.7.2015 - 30.6.2016	168.161
1.7.2016 - 30.6.2017	167.159
1.7.2017 - 30.6.2018	169.612
1.7.2018 - 30.6.2019	168.100
1.7.2019 - 30.6.2020	154.010
1.7.2020 - 30.6.2021	148.825

Source: data NIHDI's actuarial department

From 2015 to 2019, the number of admissions remains stable (about 1.8 million per year). In 2020, the year in which the COVID-19 pandemic manifested itself, the number of admissions drops below 1.6 million per year (decrease of 12.1% in 2020 compared to 2019) and the average amount per admission is 83.06 euros. The evolution of the average amount per admission from 2015 to 2020 is shown in the table below (Table 12).

Table 12: Evolution of average amount per admission (2015-2020)

	2015	2016	2017	2018	2019	2020
Expenditure on admission lump sum	173,386,000	167,277,000	168,141,000	166,587,000	160,298,000	129,974,000
Number of admissions	1,763,104	1,789,423	1,798,581	1,775,695	1,781,763	1,564,852
Amount per admission	*98.34*	*93.48*	*93.49*	*93.82*	*89.97*	*83.06*

Source: data NIHDI's actuarial department (recorded data, docN)

The yearly figures for the various types of expenditure are shown in the table below (*Table 13*).

Table 13: NIHDI net expenditure 2013-2020 (in million EUR) - breakdown of hospital expenditure*

	2013	2014	2015	2016	2017	2018	2019	2020*
Outpatients[1]	**966.9**	**1,039.1**	**1,234.3**	**1,295.4**	**1,575.1**	**1,842.2**	**2,197.1**	**2,406.8**
Hospitalised patients, total	**404.5**	**405.8**	**407.7**	**407.1**	**416.3**	**420.3**	**420.7**	**380.1**
-Hospitalised patients, total – 25 % + 100 %[2+3]	225.6	231.8	236.9	240.0	249.3	252.3	261.2	247.9
- Admission lump sum[4]	178.9	174.0	170.7	167.1	167.0	168.0	159.5	132.2
Total hospitals	**1,371.4**	**1,444.8**	**1,642.0**	**1,702.4**	**1,991.4**	**2,262.5**	**2,617.8**	**2,787.0**

*Source: docPH, *2020 based on extrapolated data*

[1]*Outpatients*	*Medicines supplied to outpatients in the hospital, never included in the lump sum (100% reimbursement basis, actual reimbursement depends on reimbursement category)*
[2]*Hospitalised patients – 100% (NOT included in the lump sum)*	*Medicines supplied to hospitalised patients, not reimbursable as part of the lump sum because* *- the medicine is not included in the lump sum (on the list of exceptions)* *- the medicine was supplied to a patient:* *- admitted before 1.7.2006 (entry into force of the medicines lump sum)* *- admitted to a non-acute hospital* *(reimbursement basis 100%, actual reimbursement depends on reimbursement category)*
[3]*Hospitalised patients – lump sum 25 %*	*Medicines supplied to hospitalised patients in an acute hospital (date of admission since 1.7.2006), and medicine included in the lump sum* *(reimbursement = 25% of the reimbursement base rate; abolition of reimbursement depending on reimbursement category)*
[4]*Admission lump sum*	*Lump sum received by the hospital for each admission.* *This amount is revised each year and depends on the case mix reported by the hospital* (minimum hospital data).

Table 14: Growth percentages NIHDI net expenditure period 2013-2020 - breakdown expenditure hospitals*

	2013	2014	2015	2016	2017	2018	2019	2020*
Outpatients[1]	4.4	7.5	18.8	4.9	21.6	17.0	19.3	9.5
Hospitalised patients, total	**-8.1**	**0.3**	**0.5**	**-0.1**	**2.3**	**0.9**	**0.1**	**-9.6**
-Hospitalised *patients, total – 25 % + 100 %*[2+3]	-8.6	2.7	2.2	1.3	3.9	1.2	3.5	-5.1
- Admission lump sum[4]	-7.6	-2.7	-1.9	-2.2	0.0	0.5	-5.0	-17.1
Total hospitals	**0.3**	**5.4**	**13.6**	**3.7**	**17.0**	**13.6**	**15.7**	**6.5**

*Source: docPH, *2020 based on extrapolated data*

OVERVIEW OF THE EXPENDITURE FOR OTHER PHARMACEUTICAL DISPENSING IN PUBLIC PHARMACIES

IN GENERAL

In addition to the dispensing of reimbursable pharmaceuticals, there is other pharmaceutical dispensing that is reimbursed by the health insurance.

The database Pharmanet contains the data on reimbursable pharmaceutical dispensing that is reimbursed in public pharmacies.

Most of the expenditure for reimbursable pharmaceutical dispensing goes to pharmaceuticals. In 2020, the expenditure for reimbursable pharmaceuticals in public pharmacies amounted to 2,718.0 million euros (94%) compared to 167.3 million euros (6%) for other reimbursable pharmaceutical dispensing.

Table 15: Evolution of the annual NIHDI net expenditure for reimbursable pharmaceuticals and other pharmaceutical dispensing in public pharmacies (2017-2020; in million EUR)

NIHDI net expenditure x 1,000,000 EUR				
	2017	**2018**	**2019**	**2020**
Pharmaceuticals	2,626.3	2,647.6	2,649.8	2,718.0
Other pharmaceutical dispensing	107.2	125.6	149.3	167.3
Share other pharmaceutical dispensing (%)	4.1	4.7	5.6	6.2
Growth %				
		2017-2018	**2018-2019**	**2019-2020**
Pharmaceuticals		0.8	0.1	2.6
Other pharmaceutical dispensing		17.3	18.8	12.0

Source: Pharmanet

The other pharmaceutical dispensing includes, among other things, magistral preparations, various fees (waiting fees, fees for supplying methadone, oxygen, ...), medical nutrition, dispensing within the scope of care trajectories for diabetes and chronic renal failure (strips and lancets, blood glucose meter, blood pressure monitor).

When we sort the NIHDI 2020 net expenditure by size, we see that the following 6 categories are ranked highest. These 6 categories represent 88% of the expenditure for other pharmaceutical dispensing.

Table 16: Evolution of the annual NIHDI net expenditure for other pharmaceutical dispensing in public pharmacies, top 6 of the expenditure (2017-2020; in million EUR)

Ranking	**Category**	**2017**	**2018**	**2019**	**2020**	***Cumulative share***
	Total	*107.2*	*125.6*	*149.3*	*167.3*	1
1	Magistral preparations	*64.4*	*63.3*	*66.5*	*65.0*	0.39
2	Fee reference pharmacist function	*0.0*	*2.0*	*19.5*	*25.5*	0.54
3	Self-catheterisation	*2.7*	*19.0*	*19.9*	*21.7*	0.67
4	Fees and lump sums 'oxygen'	*8.0*	*9.1*	*9.6*	*13.6*	0.75
5	Specific reimbursement for contraceptives	*6.5*	*6.6*	*6.7*	*11.4*	0.82
6	Dietary nutrition	*7.9*	*8.0*	*8.8*	*9.6*	0.88
	Growth %					
			2017-2018	**2018-2019**	**2019-2020**	
	Magistral preparations		-1.7	5.0	-2.1	
	Fee reference pharmacist function			890.2	30.7	
	Self-catheterisation		614.3	4.6	8.9	
	Fees and lump sums 'oxygen'		13.6	5.5	42.1	
	Specific reimbursement for contraceptives		1.3	2.7	69.8	
	Dietary nutrition		0.5	10.8	8.5	

In line with the section on expenditure for magistral preparations, a lump-sum intervention is provided for the fractional dispensing of methadone-based substitution treatments by the pharmacist. The evolution of this expenditure is shown in the following table.

Table 17: Evolution of the annual NIHDI expenditure for fractional dispensing of methadone-based substitution treatments (2017-2020)

	2017	2018	2019	2020
Expenditure in million euros	3.27	3.29	3.32	3.36
Growth %		0.6	1.1	1.2

For a detailed analysis of the expenditure and consumption of some of this 'other pharmaceutical dispensing', in paricular magistral preparations and specific reimbursement for contraceptives and dietary nutrition, we refer to the respective thematic dossiers included in this report.

DOSSIERS

DOSSIER – MAGISTRAL PREPARATIONS

INTRODUCTION

A magistral preparation is a medicinal product prepared by the pharmacist on the basis of a physician's prescription for a patient and dispensed by the pharmacist to that patient. The prescription contains either a specific formula, or a standard formula from a reference work such as the Therapeutic Magistral Form (TMF) or the Belgian or European Pharmacopoeia, or from processing an existing pharmaceutical.

The compulsory insurance bears part of the costs of such a preparation provided that the products prescribed and used for preparation, are mentioned on the list of reimbursable products. The list is attached to the Royal Decree of 12 October 2004[3] establishing the conditions under which the compulsory healthcare and benefits insurance bears part of the costs of magistral preparations and assimilated products and has 6 chapters:

- CHAPTER I: Raw materials
- CHAPTER II: Phytotherapeutic products
- CHAPTER III: Registered prefabricated or prebilled preparations, compositions and pharmaceutical forms
- CHAPTER IV: Reimbursement conditions for magistral preparations reimbursable only by authorisation of the advisory physician
- CHAPTER V: Excipients and adjuvants
- CHAPTER VI: Medical devices

Magistral preparations complement available treatment options.

The added value lies in the fact that the treatment is 'customised to the patient's needs:

- The physician can decide to increase or decrease the dose of an existing pharmaceutical according to the patient's clinical condition. This offers possibilities for paediatric patients.
- The manner of administration can also be changed. That way, there's a wider range of possibilities to treat patients who have trouble swallowing. The way to administer solid, oral preparations can be modified so as to be administered by tube.

Magistral preparations are a valuable alternative if a pharmaceutical is (temporarily) unavailable or has been removed from commercialisation by the company itself.

If the patient has an allergy to one of the excipients in a pharmaceutical, a magistral preparation containing the same active ingredient, in combination with other excipients, can provide a solution.

[3] Note: On 1 February 2022, the Royal Decree of 12 October 2004 establishing the conditions under which the compulsory healthcare and benefits insurance bears part of the costs of magistral preparations and assimilated products was repealed. As of 1 February 2022, the list of reimbursable products for magistral preparations has been attached to the Royal Decree of 23 November 2021 establishing the procedures, terms and conditions for reimbursement by the compulsory healthcare and benefits insurance towards costs of pharmaceutical dispensing in kind referred to in Article 34, paragraph 1, 5° a), 19°, 20° and 20bis of the Law on compulsory healthcare and benefits, coordinated on 14 July 1994.

In this analysis, the data from Pharmanet is processed with regard to magistral preparations, delivered to non-hospitalised beneficiaries, in the public pharmacies by means of three nomenclature code numbers, from 2017 to 2020.

Table 18: Pseudo nomenclature code number with its description

Code number pseudo nomenclature	Description
750234	Magistral preparations, delivered to non-hospitalised beneficiaries, in the public pharmacies - category 1
750256	Magistral preparations, delivered to non-hospitalised beneficiaries, in the public pharmacies - category 2
750293	Magistral preparations, delivered to non-hospitalised beneficiaries, in the public pharmacies - category 4

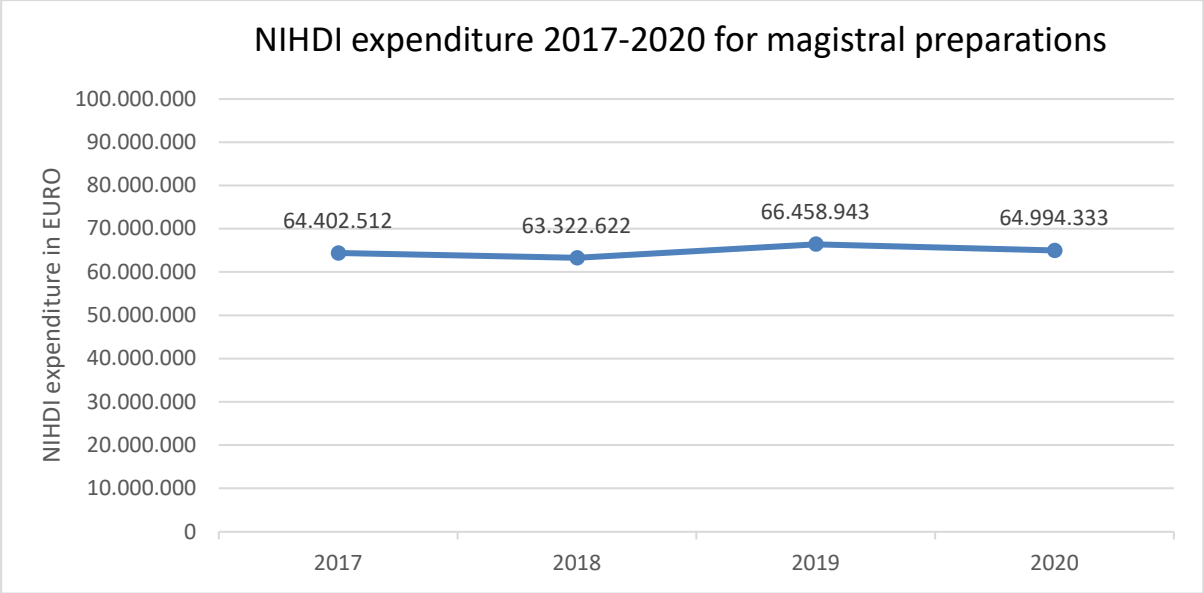
The composition of the preparation determines to which category (pseudocode) the preparation belongs:

Category 2 (750256): These are magistral preparations containing one or more active ingredients to which the letter 'A' in the column 'sign' of the list has been given, or magistral preparations containing one or more pharmaceuticals that are reimbursed in category 'A', alone or in combination with one or more active ingredients to which the letter 'A' in the column 'sign' of the list has been given.
For these preparations, the patient does not pay a personal share. The letter A refers to the category of reimbursement.

Category 4 (750293): products that are dispensed as such as the bandages included in the list of reimbursable products for magistral preparations, as well as topical preparations for ophthalmic use, including sterilization.
For magistral preparations with pseudocode 750293, the personal share is double that for code 750234.

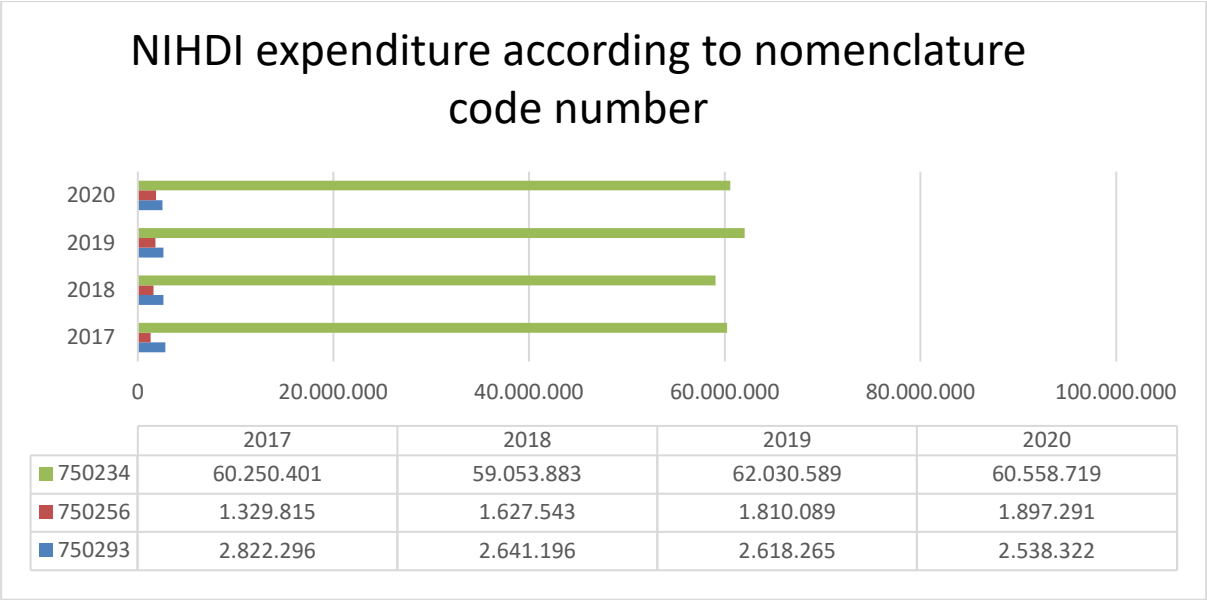
Category 1 (750234): preparations containing neither raw materials or pharmaceuticals reimbursed in category A, nor a topical preparation for ophthalmic use or a product dispensed as such.

Figure 4: Evolution of the NIHDI expenditure for magistral preparations from 2017 to 2020.



The NIHDI expenditure for magistral preparations for 2020 amounts to about 65 million euros. This amount is in line with the expenditure for the years 2017, 2018 and 2019.

Figure 5: Evolution of the NIHDI expenditure for magistral preparations per nomenclature code from 2017 to 2020.



	2017	2018	2019	2020
750234	60.250.401	59.053.883	62.030.589	60.558.719
750256	1.329.815	1.627.543	1.810.089	1.897.291
750293	2.822.296	2.641.196	2.618.265	2.538.322

Broken down by nomenclature code, the majority of the expenditure is determined by magistral preparations of category 1 with code number 750234. For magistral preparations of categories 1 and 4, a partial reimbursement is applied and the patient pays his or her personal share.

Chapter II of the Royal Decree of 7 May 1991 establishing the personal contribution of the beneficiaries in the costs of pharmaceutical dispensing reimbursable under the healthcare and benefits insurance, determines the amounts that the patient has to pay in the costs of magistral preparations.
For magistral preparations with pseudocode 750234, Article 3, § 1, point 2, of the aforementioned Royal Decree stipulates that the personal share is 0.32 euro per module as from 1 January 2021 for beneficiaries entitled to increased reimbursement and 1.23 euro per module as from 1 January 2021 for the other beneficiaries.
For magistral preparations with pseudocode 750293, the personal share is twice the amounts mentioned for code number 750234.

For magistral preparations of category 2 (characterized by code number 750256), there is a 100% reimbursement and the patient pays nothing. The NIHDI expenditure for this group of preparations is lower than that for the other two categories.

The patient's share in the cost of magistral preparations amounts to 17.2 million euros for 2020. The expenditure is in line with that of 2019.

Figure 6: Evolution of patient expenditure for magistral preparations from 2017 to 2020.

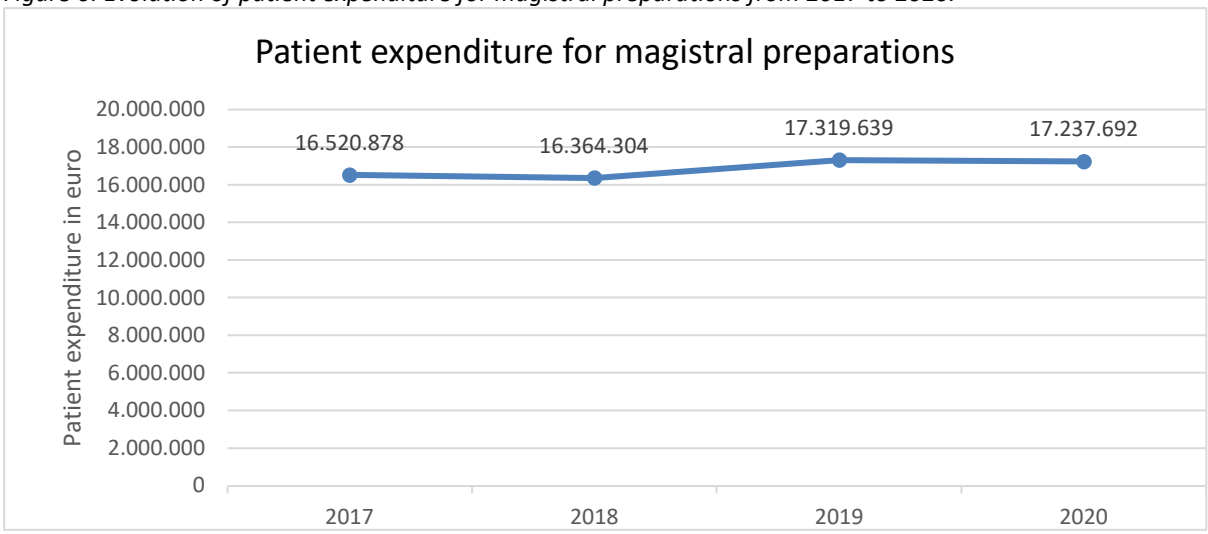


Table 19: Top 20 most prescribed active ingredients in 2017: number of magistral preparations and most common galenic form

Active ingredient	Number of magistral preparations	Most common galenic form
Calcium carbonate	828,557	Capsules
Bandages	484,559	Dispensed as such
Methadon hydrochloride	251,738	Capsules
Dexamethasone	223,260	Capsules
Urea	209,625	Ointment
Prednisolone	208,999	Capsules
Folic acid	202,350	Capsules
Betamethasone	197,978	Ointment
Hydrocortisone	194,879	Capsules
Salicylic acid	194,548	Ointment
Sulpiride	161,561	Capsules
Quinine sulphate	159,547	Capsules
Paracetamol	147,492	Capsules
Sodium bicarbonate	132,872	Capsules
Levocetirizine	126,306	Capsules
Erythromycin	119,772	Ointment
Triamcinolone	113,039	Capsules
Nystatin	107,861	Ointment
Passion flower herb tincture	97,336	Capsules
Hawthorn heterosides	96,170	Ointment

Table 20: Top 20 most prescribed active ingredients in 2018: number of magistral preparations and most common galenic form

Active ingredient	Number of magistral preparations	Most common galenic form
Calcium carbonate	814,773	Capsules
Bandages	472,888	Dispensed as such
Methadon hydrochloride	239,254	Capsules
Urea	201,801	Ointment
Prednisolone	200,967	Capsules
Folic acid	197,408	Capsules
Dexamethasone	193,437	Capsules
Hydrocortisone	190,147	Capsules
Betamethasone	188,104	Ointment
Salicylic acid	173,374	Ointment
Quinine sulphate	160,927	Capsules
Sulpiride	154,895	Capsules
Levocetirizine	152,852	Capsules
Sodium bicarbonate	134,572	Capsules
Triamcinolone	110,895	Capsules
Erythromycin	110,031	Ointment
Nystatin	109,980	Ointment
Passion flower herb tincture	101,713	Capsules
Hawthorn heterosides	96,752	Capsules
Clobetasol	91,400	Ointment

Table 21: Top 20 most prescribed active ingredients in 2019: number of magistral preparations and most common galenic form

Active ingredient	Number of magistral preparations	Most common galenic form
Calcium carbonate	859,902	Capsules
Bandages	484,013	Dispensed as such
Methadon hydrochloride	240,848	Capsules
Prednisolone	219,136	Capsules
Dexamethasone	213,799	Capsules
Hydrocortisone	208,491	Capsules
Folic acid	207,616	Capsules
Urea	207,361	Ointment
Betamethasone	198,674	Ointment
Quinine sulphate	180,531	Capsules
Salicylic acid	174,875	Ointment
Levocetirizine	168,164	Capsules
Sulpiride	165,260	Capsules
Sodium bicarbonate	154,454	Capsules
Nystatin	122,843	Ointment
Triamcinolone	120,335	Capsules
Passion flower herb tincture	119,038	Capsules
Erythromycin	115,307	Ointment
Hawthorn heterosides	111,712	Capsules
Clobetasol	96,134	Ointment

Table 22: Top 20 most prescribed active ingredients in 2020: number of magistral preparations and most common galenic form

Active ingredient	Number of magistral preparations	Most common galenic form
Calcium carbonate	856,758	Capsules
Bandages	410,514	Dispensed as such
Methadon hydrochloride	235,251	Capsules
Folic acid	213,677	Capsules
Prednisolone	209,647	Capsules
Hydrocortisone	207,095	Capsules
Urea	202,120	Ointment
Betamethasone	197,315	Ointment
Sulpiride	194,846	Capsules
Quinine sulphate	181,972	Capsules
Dexamethasone	164,300	Capsules
Salicylic acid	162,078	Ointment
Sodium bicarbonate	162,060	Capsules
Passion flower herb tincture	126,348	Capsules
Hawthorn heterosides	116,619	Capsules
Nystatin	115,310	Ointment
Levocetirizine	113,171	Capsules
Erythromycin	107,844	Ointment
Valerian dry extract	100,797	Capsules
Triamcinolone	93,037	Capsules

Table 23: Top 20 most prescribed active ingredients for 2017, 2018, 2019 and 2020

2017		2018		2019		2020	
Active ingredient	**Number of magistral preparations**	**Active ingredient**	**Number of magistral preparations**	**Active ingredient**	**Number of magistral preparations**	**Active ingredient**	**Number of magistral preparations**
Calcium carbonate	828,557	Calcium carbonate	814,773	Calcium carbonate	859,902	Calcium carbonate	856,758
Bandages	484,559	Bandages	472,888	Bandages	484,013	Bandages	410,514
Methadon hydrochloride	251,738	Methadon hydrochloride	239,254	Methadon hydrochloride	240,848	Methadon hydrochloride	235,251
Dexamethasone	223,260	Urea	201,801	Prednisolone	219,136	Folic acid	213,677
Urea	209,625	Prednisolone	200,967	Dexamethasone	213,799	Prednisolone	209,647
Prednisolone	208,999	Folic acid	197,408	Hydrocortisone	208,491	Hydrocortisone	207,095
Folic acid	202,350	Dexamethasone	193,437	Folic acid	207,616	Urea	202,120
Betamethasone	197,978	Hydrocortisone	190,147	Urea	207,361	Betamethasone	197,315
Hydrocortisone	194,879	Betamethasone	188,104	Betamethasone	198,674	Sulpiride	194,846
Salicylic acid	194,548	Salicylic acid	173,374	Quinine sulphate	180,531	Quinine sulphate	181,972
Sulpiride	161,561	Quinine sulphate	160,927	Salicylic acid	174,875	Dexamethasone	164,300
Quinine sulphate	159,547	Sulpiride	154,895	Levocetirizine	168,164	Salicylic acid	162,078
Paracetamol	147,492	Levocetirizine	152,852	Sulpiride	165,260	Sodium bicarbonate	162,060
Sodium bicarbonate	132,872	Sodium bicarbonate	134,572	Sodium bicarbonate	154,454	Passion flower herb tincture	126,348
Levocetirizine	126,306	Triamcinolone	110,895	Nystatin	122,843	Hawthorn heterosides	116,619
Erythromycin	119,772	Erythromycin	110,031	Triamcinolone	120,335	Nystatin	115,310
Triamcinolone	113,039	Nystatin	109,980	Passion flower herb tincture	119,038	Levocetirizine	113,171
Nystatin	107,861	Passion flower herb tincture	101,713	Erythromycin	115,307	Erythromycin	107,844
Passion flower herb tincture	97,336	Hawthorn heterosides	96,752	Hawthorn heterosides	111,712	Valerian dry extract	100,797
Hawthorn heterosides	96,170	Clobetasol	91,400	Clobetasol	96,134	Triamcinolone	93,037

The data from 2017 to 2020 show that there was little change in the top 20 most prescribed active ingredients over that period of time. The top three remained the same the entire time.

In 2017, 2018, 2019 and 2020, calcium carbonate was most commonly prescribed in the form of capsules. Capsules containing calcium carbonate are administered to prevent osteoporosis and are an alternative to commercialised calcium-based nutritional supplements, which are entirely to be paid by the patient.

Second was the dispensing of bandages as such. These are in fact 'pseudo' magistral preparations, dispensed by pharmacists as such (without being removed from the packaging or any other intervention). For historical reasons, this type of dispensing is currently registered as a magistral preparation but plans have been made to transfer it to the category of medical devices.
Table 24 shows that, from 2017 to 2020, 2 to 2.5% of the NIHDI expenditure for magistral preparations is spent on the dispensing of these bandages.

As a magistral preparation, methadone is prescribed as capsules or a syrup as a substitution treatment for opioid addiction or to gradually reduce the opioid dosage. In the TMF, a standard formula is provided for both syrup and capsules. Data show that the dispensing of methadone as capsules is preferred.
Substitution treatment consists of replacing illicit opioid use with the controlled (oral) use of methadone in order to reduce the 'craving' for opioids (e.g. heroin) and to stimulate the reintegration of the addict into society.

With regard to the local use, urea, salicylic acid and betamethasone are frequently prescribed by prescribing physicians. The TMF includes various formulas that contain the above-mentioned active ingredients and are reimbursed by the compulsory insurance. This is to the benefit of the patient who can rely on effective and accessible treatment.

Table 24: Evolution of the NIHDI expenditure for bandages in 2017, 2018, 2019 and 2020

Year	NIHDI expenditure for bandages	NIHDI expenditure for magistral preparations	Share of NIHDI expenditure for bandages	NIHDI expenditure, bandages not included
2017	1,667,871	64,402,512	2.59%	62,734,641
2018	1,541,809	63,322,622	2.43%	61,780,813
2019	1,428,633	66,458,943	2.15%	65,030,310
2020	1,337,889	64,994,333	2.06%	63,656,444

PRESCRIBING PHYSICIANS

Table 25: NIHDI expenditure and number of magistral preparations per group of physicians for 2017, 2018, 2019 and 2020

2017		
Group of prescribers	**NIHDI expenditure**	**Number of magistral preparations**
General practitioners	43,891,612	3,554,297
Specialists in dermato-venerology	9,922,558	484,539
Specialists in rheumatology	1,482,054	153,059
Specialists in paediatrics	1,708,863	121,695
Specialists in internal medicine	1,076,250	99,546
Surgery specialists	248,953	46,012
Specialists in medical oncology	471,499	42,579
Specialists in radiation and radium therapy	112,825	9,967
Other prescribers	5,479,332	482,924

2018		
Group of prescribers	**NIHDI expenditure**	**Number of magistral preparations**
General practitioners	43,486,521	3,410,331
Specialists in dermato-venerology	9,113,096	432,609
Specialists in rheumatology	1,529,256	153,775
Specialists in paediatrics	1,649,856	112,590
Specialists in internal medicine	1,170,899	103,243
Surgery specialists	496,451	43,851
Specialists in medical oncology	239,613	43,068
Specialists in radiation and radium therapy	106,864	9,257
Other prescribers	5,527,594	464,508

2019		
Group of prescribers	**NIHDI expenditure**	**Number of magistral preparations**
General practitioners	46,045,108	3,763,626
Specialists in dermato-venerology	9,006,105	438,945
Specialists in rheumatology	1,653,385	172,604
Specialists in paediatrics	1,306,760	121,079
Specialists in internal medicine	1,651,614	116,647
Surgery specialists	549,065	49,790
Specialists in medical oncology	247,826	44,735
Specialists in radiation and radium therapy	106,467	9,361
Other prescribers	5,892,418	509,316

2020		
Group of prescribers	**NIHDI expenditure**	**Number of magistral preparations**
General practitioners	46,020,358	3,683,411
Specialists in dermato-venerology	8,390,183	404,148
Specialists in rheumatology	1,622,694	168,290
Specialists in paediatrics	1,481,334	101,763
Specialists in internal medicine	1,361,722	126,931
Surgery specialists	543,993	49,835
Specialists in medical oncology	205,185	34,898
Specialists in radiation and radium therapy	92,880	8,208
Other prescribers	5,331,082	454,203

Table 26: Details per group of prescribers for 2020

Group of prescribers	NIHDI expenditure	Number of magistral preparations	Number of pharmaceuticals	Share of magistral preparations in the prescriptions	Share of magistral preparations compared to the total number of prescribed magistral preparations
Specialists in dermato-venerology	8,390,183	404,148	1,125,713	26.4%	8.03%
Specialists in rheumatology	1,622,694	168,290	833,535	16.8%	3.34%
Specialists in radiation and radium therapy	92,880	8,208	66,560	11.0%	0.16%
Specialists in paediatrics	1,481,334	101,763	1,158,109	8.1%	2.02%
Specialists in medical oncology	543,993	49,835	570,461	8.0%	0.99%
Specialists in internal medicine	1,361,722	126,931	1,856,270	6.4%	2.52%
Surgery specialists	205,185	34,898	524,059	6.2%	0.69%
General practitioners	46,020,358	3,683,411	78,232,377	4.5%	73.20%
Other prescribers	5,331,082	454,203	15,813,335	2.8%	9.03%
TOTAL	65,049,430	5,031,687	100,180,420	4.8%	100%

The general practitioners represent the largest group of prescribing physicians. They prescribe the most magistral preparations in absolute figures. In 2020, 73% of all magistral preparations were prescribed by general practitioners, followed by physicians-dermatologists with 8% of their prescriptions and specialists in rheumatology with 3% of their prescriptions.

In order to gain insight into the active ingredients that are prescribed per pharmaceutical, we refer to the NIHDI newsletter Infospot on the 2019 magistral preparations (published in May 2021 on the NIHDI website).

By opting for a magistral preparation, the physician can adjust the dose of an existing preparation to suit the patient's needs. This is particularly interesting for paediatric patients.
Nine standardised formulas in liquid form, specifically for paediatric patients, are included in the TMF; seven of these are reimbursed. This provides the paediatrician with a range of reimbursable and validated magistral preparations.

DOSSIER – SPECIFIC REIMBURSEMENT CONTRACEPTIVES

ANALYSIS OF THE USE OF CONTRACEPTIVES FOR WHICH A SPECIFIC REIMBURSEMENT IS AVAILABLE

Women younger than 25 and women who are entitled to increased reimbursement, as well as women(*) staying in a psychiatric nursing home, a day-care facility, a residential facility for children, adolescents or disabled people recognised by the Communities, an initiative for sheltered living or a rehabilitation centre, are entitled to **additional reimbursement** when buying certain **contraceptives**, as determined in the Royal Decree of 16 September 2013.

(*) (also applicable when dispensed through the hospital pharmacist)

This measure aims to improve access to contraceptives and prevent unwanted pregnancies among young people.

This 'additional reimbursement' for women younger than 25 and women who are entitled to increased reimbursement comes on top of the 'classic reimbursement' by the compulsory healthcare insurance. The 'classic reimbursement' is the reimbursement to which women older than 24 and without increased reimbursement, are entitled. The additional reimbursement varies depending on the product, but is equal to an amount of €3 per month.

The following information on the use of contraceptives for which a specific reimbursement is available, is based on Pharmanet data.

It should be noted that this data relates only to contraceptives for which the compulsory healthcare insurance bears part of the cost. Other contraceptives, such as condoms for instance, were not taken into account.

1. Overview of all contraceptives for which a reimbursement is available

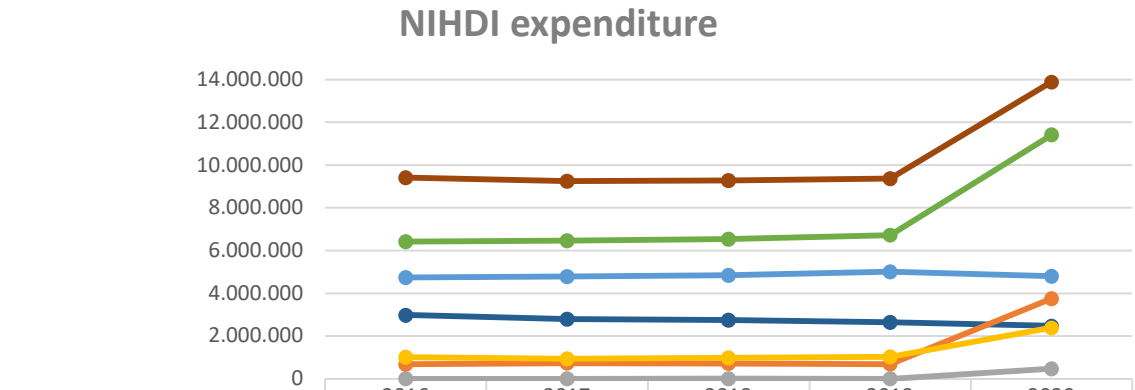
The data on contraceptives for which a reimbursement is provided for by the compulsory healthcare insurance, were divided into 2 categories:

- Data with regard to the **specific reimbursement** for contraceptives (**CJ**)
  - Until March 2020, this concerns women under the age of 21.
  - From April 2020 onwards, the reimbursement conditions were extended to women under the age of 25.
  - From September 2020 onwards, they were also extended to women entiteld to increased reimbursement and women residing in an institution (see above).

- Data on contraceptives reimbursed through the **classic procedure** (mainly through reimbursement category **Cx**).

The specific reimbursement for women younger than 25 and women entitled to increased reimbursement, is an additional reimbursement, on top of the classic reimbursement. This means that the cost of some contraceptives is covered twice by the healthcare insurance provided that they are dispensed to these patients: through the benefits from the classic healthcare insurance and through the additional reimbursement. In most cases however, these contraceptives are not reimbursed through the classic procedure.

Figure 7: Evolution of the NIHDI net expenditure for contraceptives (2016-2020)



	2016	2017	2018	2019	2020
Total Cj	6.421.712	6.456.623	6.539.938	6.720.031	11.411.622
Total Cx	2.981.534	2.790.367	2.737.847	2.636.699	2.473.885
TOTAL	9.403.246	9.246.990	9.277.784	9.356.730	13.885.507
Cj 20 year old and younger	4.737.369	4.788.755	4.844.980	5.004.199	4.799.429
CJ 21 to 24 included	676.254	735.460	712.782	695.525	3.756.920
CJ 25 year old and older	0	0	51	0	471.005
CJ with IR	1.008.088	932.408	982.124	1.020.306	2.384.268

Note:

1) The groups CJ 20 years and younger, CJ 21 to 24 included and CJ 25 years and older are beneficiaries without increased reimbursement (IR).
2) Assigning a beneficiary to a specific age group is done on the basis of the year of birth. A number of beneficiaries whose age was calculated to be 21 or 25 (year of dispensing - year of birth) were still 20 or 24 years old respectively during part of that year and were still entitled to the specific reimbursement. Consequently, 'expenditure in group CJ' can be found in the age groups for which the age limit for the specific reimbursement is exceeded.

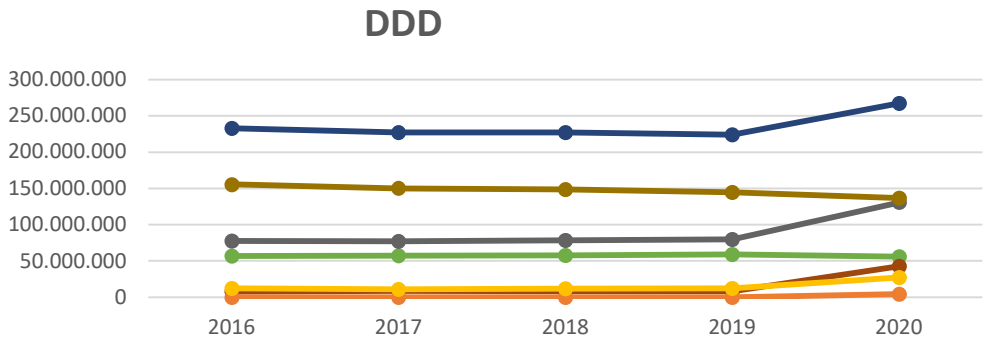
A **clear increase** can be observed in the **total NIHDI expenditure** for contraceptives in 2020, which is due to the extension of the specific reimbursement in April and September 2020.

The fact that expenditure can be found in group CJ, for the years 2016 to 2019, for the groups CJ 20 years and younger and CJ 21 to 24 (beneficiaries without increased reimbursement), is due to the method used to rank a beneficiary in a certain age group (see note 2).

The fact that expenditure can also be found in group CJ for those '25 years and older' - that's the group of 25 and older not entitled to increased reimbursement - is partly due to the method used to rank a beneficiary in a certain age group (see note 2) and partly to the extension of the reimbursement for the morning-after pill, regardless of the age of the beneficiary (see below, point 2).

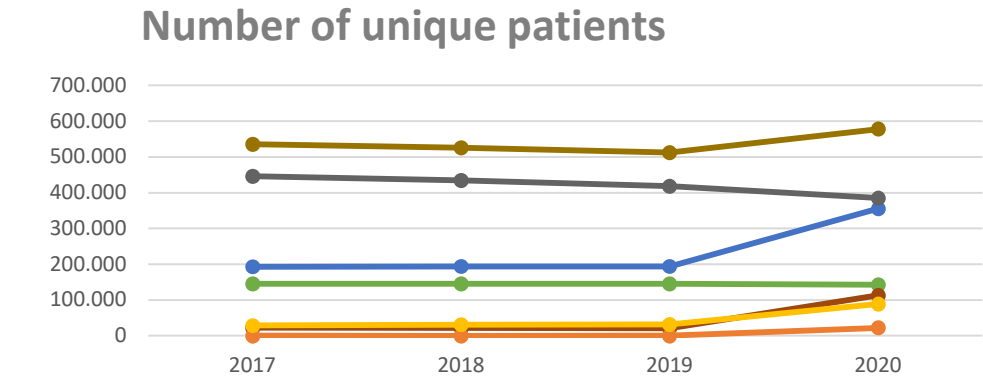
The expenditure for contraceptives reimbursed through the classic reimbursement system (**Cx**) is significantly lower than the expenditure for the specific reimbursement (**CJ**). Only a limited number of pharmaceuticals can be reimbursed through the classic reimbursement system.

Figure 8: Evolution of DDD consumption for contraceptives (2016-2020)



	2016	2017	2018	2019	2020
Cj 20 year old and younger	56.974.618	57.201.771	57.939.610	59.239.279	56.181.565
CJ 21 to 24 included	8.203.261	8.814.436	8.491.958	8.190.192	42.946.148
CJ 25 year old and older	0	0	1.095	0	4.187.181
CJ with IR	12.241.074	11.116.726	11.858.998	12.388.200	27.298.390
Total Cj	77.418.953	77.132.933	78.291.661	79.817.671	130.613.283
Total Cx	155.444.547	150.015.540	148.510.488	144.317.818	136.609.071
TOTAL	232.863.500	227.148.473	226.802.149	224.135.489	267.222.355

Figure 9: Evolution of the number of patients with regard to contraceptives (2016-2020)



	2017	2018	2019	2020
Cj 20 year old and younger	145.071	145.039	145.652	142.244
CJ 21 to 24 included	22.535	21.631	20.868	113.199
CJ 25 year old and older	0	1	0	22.102
CJ with IR	28.952	31.009	31.757	89.072
Total Cj	193.118	194.130	194.452	355.514
Total Cx	445.924	434.554	418.269	384.824
TOTAL	535.458	525.973	512.318	577.908

The data on the number of unique patients who seek reimbursement for part of the cost of a contraceptive, reflect the data on consumption, expressed in DDD: that is to say a **clear increase** in 2020 in the **specific reimbursement** (CJ) due to the extension of this specific reimbursement in April and September 2020.

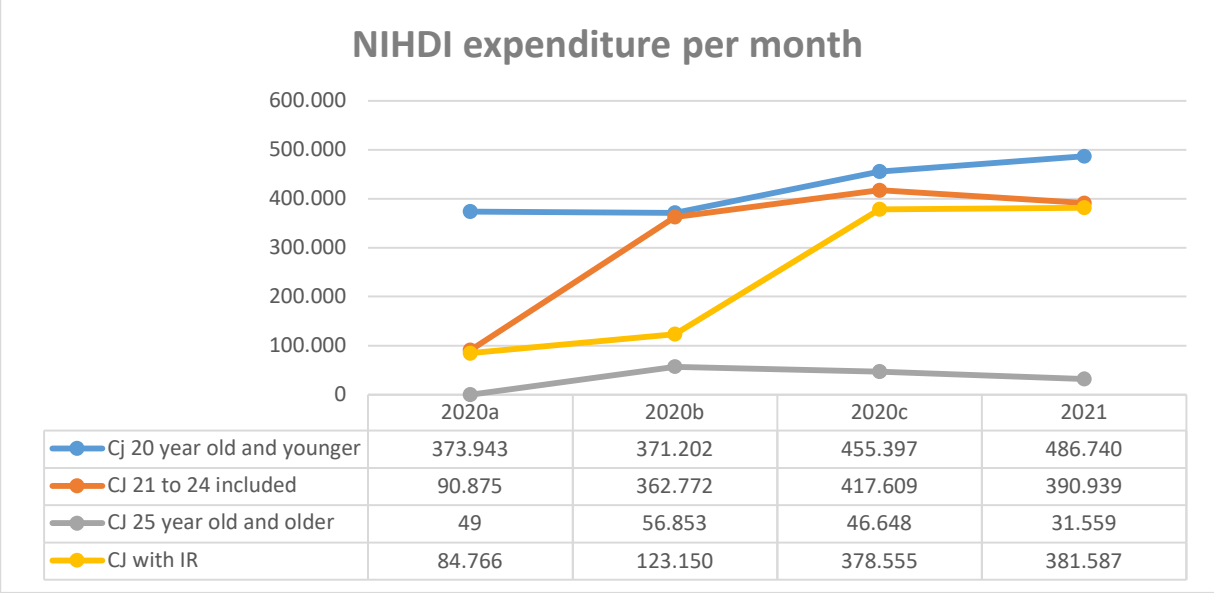
In contrast **a slight decrease can be observed in the classic reimbursement (Cx)**. Consequently, **the total number of unique patients** using reimbursable contraceptives shows a **much less pronounced increase** than the number of patients seeking the specific reimbursement.

It should be stressed that these figures only reflect the number of patients using reimbursable contraceptives. For example, IUDs are not reimbursed for patients over the age of 25 without increased reimbursement (see also point 3) and other non-reimbursable contraceptives, such as condoms, are not included.

Given that 2020 was a special year, in which the specific reimbursement was extended twice, it is also interesting to look at how this has influenced the NIHDI expenditure per category. This expenditure is shown per month because the periods into which 2020 is divided, are not equally long:

- **2020a** = period until March 2020; specific reimbursement for women under the age of 21. (3 months)
- **2020b** = period starting April 2020; extension to women under the age of 25. (5 months)
- **2020c** = period starting September 2020; extension to women entitled to increased reimbursement and residents of an institution (4 months)
- **2021** = data only available from January 2021 to May 2021 (5 months)

Figure 10: Evolution of the NIHDI net expenditure 2020-2021 for contraceptives, average NIHDI expenditure per month per specific period



	2020a	2020b	2020c	2021
Cj 20 year old and younger	373.943	371.202	455.397	486.740
CJ 21 to 24 included	90.875	362.772	417.609	390.939
CJ 25 year old and older	49	56.853	46.648	31.559
CJ with IR	84.766	123.150	378.555	381.587

A clear increase can be observed, both in April at the first extension for the category between ages 21 and 24, and in September at the second extension for patients entitled to increased reimbursement. In addition, there is also a slight increase for the category of those under the age of 21, who have always been entitled to the specific reimbursement.

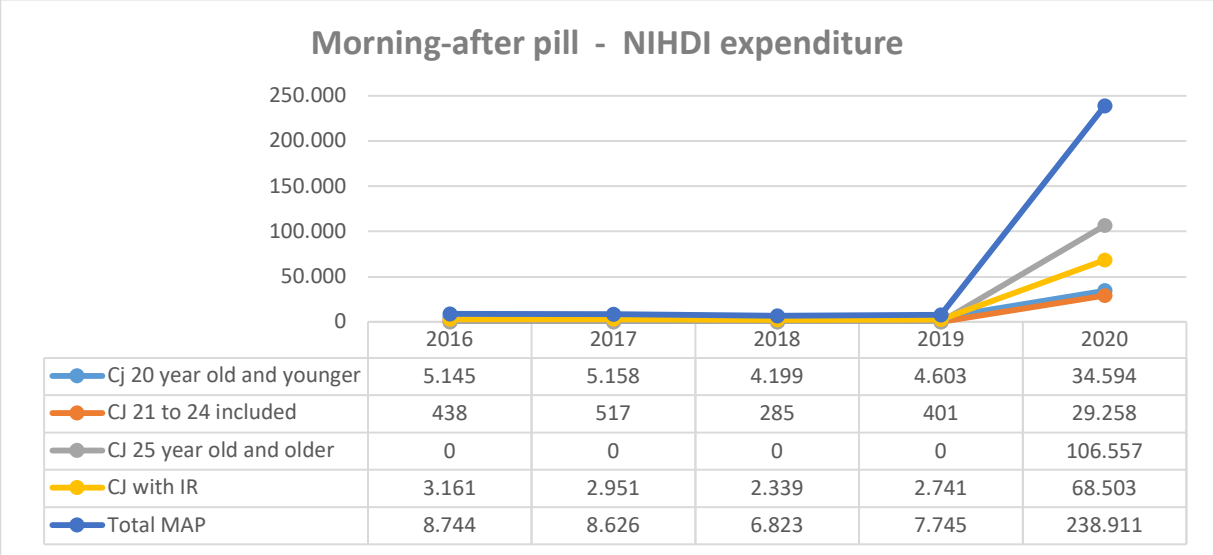
Finally, from the 3rd quarter of 2020 onwards, the expenditure per month is fairly similar to that of the first 5 months of 2021.

2. Emergency contraception (morning-after pill)

For the morning-after pill (MAP), the healthcare insurance only intervenes within the scope of the specific reimbursement. No reimbursement is provided for the morning-after pill through the classic procedure.

In the past, the morning-after pill was only reimbursed for women younger than 21. However, since 10 September 2020, the specific reimbursement has been extended so as to apply the third-party payment scheme when women, **regardless of their age**, purchase a morning-after pill and a prescription is not required to obtain reimbursement. This means that the additional reimbursement is automatically taken into account when that pill is purchased in the pharmacy.

Figure 11: Evolution of the NIHDI net expenditure for emergency contraceptives (morning-after pill) (2016-2020)

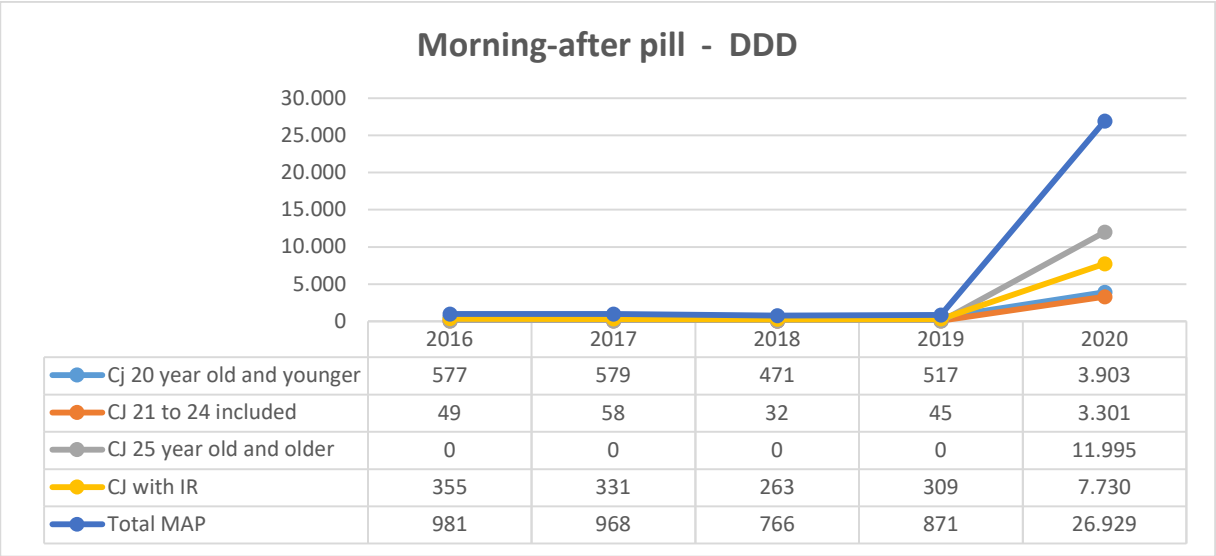


	2016	2017	2018	2019	2020
Cj 20 year old and younger	5.145	5.158	4.199	4.603	34.594
CJ 21 to 24 included	438	517	285	401	29.258
CJ 25 year old and older	0	0	0	0	106.557
CJ with IR	3.161	2.951	2.339	2.741	68.503
Total MAP	8.744	8.626	6.823	7.745	238.911

Note:

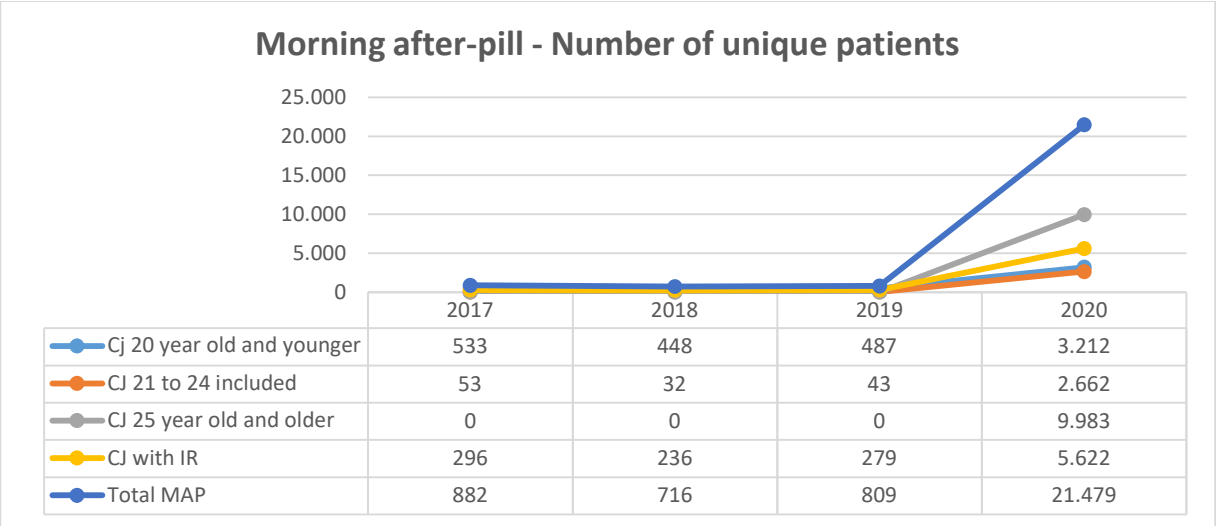
1) The groups CJ 20 years and younger, CJ 21 to 24 included and CJ 25 years and older are beneficiaries without increased reimbursement (IR).
2) Assigning a beneficiary to a certain age group is done **on the basis of the year of birth**. A number of beneficiaries whose age was calculated to be 21 or 25 (year of dispensing - year of birth) were still 20 or 24 years old respectively during part of that year and were still entitled to the specific reimbursement. Consequently, 'expenditure in group CJ' can be found in the age groups for which the age limit for the specific reimbursement is exceeded.

Figure 12: Evolution of the consumption in DDD for emergency contraception (morning-after pill) (2016-2020)



	2016	2017	2018	2019	2020
Cj 20 year old and younger	577	579	471	517	3.903
CJ 21 to 24 included	49	58	32	45	3.301
CJ 25 year old and older	0	0	0	0	11.995
CJ with IR	355	331	263	309	7.730
Total MAP	981	968	766	871	26.929

Figure 13: Evolution of the number of patients for emergency contraception (morning- after pill) (2017-2020)

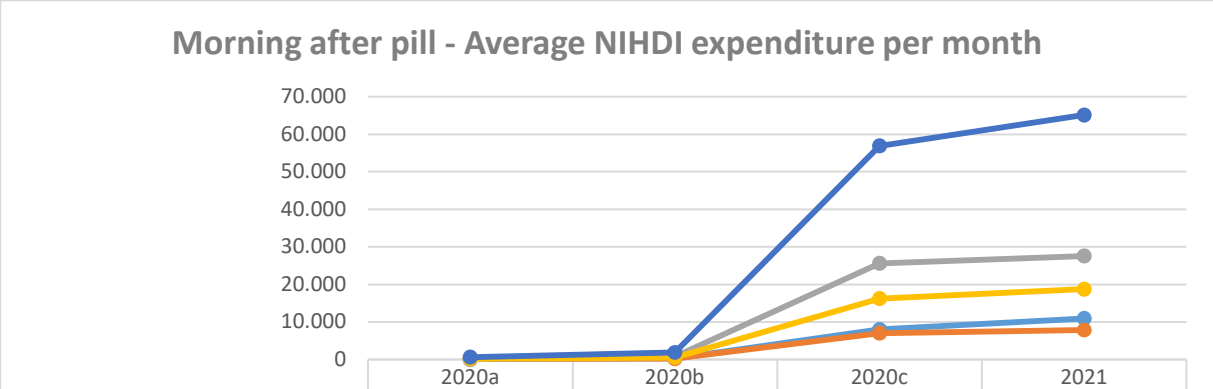


	2017	2018	2019	2020
Cj 20 year old and younger	533	448	487	3.212
CJ 21 to 24 included	53	32	43	2.662
CJ 25 year old and older	0	0	0	9.983
CJ with IR	296	236	279	5.622
Total MAP	882	716	809	21.479

Both for the NIHDI expenditure, the consumption (in DDD) and the number of unique patients, after a stagnation from 2017 to 2019, in the context of the extension of the specific reimbursement, a **strong increase** was observed in 2020. This is due to the extension as described above, with the morning-after pill being reimbursed regardless of age since September 2020. Hence, an increase can also be observed in the category '25 years and older'.

Here also, we provide an overview of the monthly NIHDI expenditure in 2020, which illustrates even better the impact of the extension of the specific reimbursement:

Figure 14: Evolution of NIHDI net expenditure 2020-2021 for emergency contraception (morning-after pill), average NIHDI expenditure per month per specific period



	2020a	2020b	2020c	2021
Cj 20 year old and younger	355	296	8.012	10.942
CJ 21 to 24 included	50	187	7.044	7.824
CJ 25 year old and older	0	827	25.605	27.572
CJ with IR	205	580	16.247	18.759
Total MAP	610	1.890	56.907	65.096

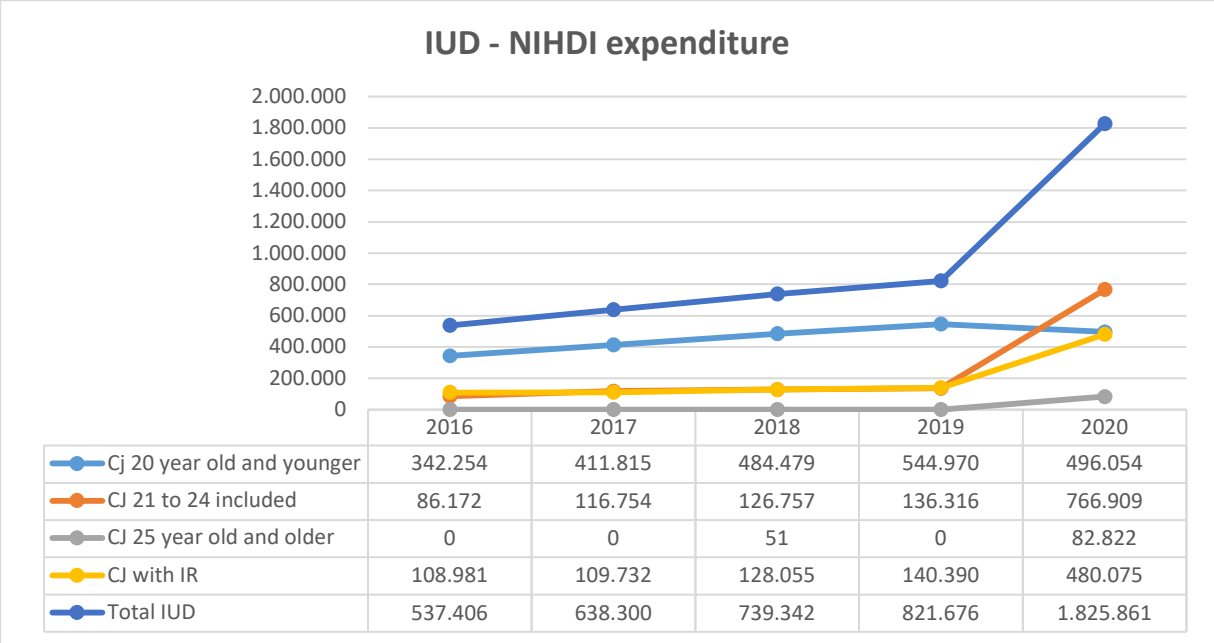
- **2020a** = period until March 2020; specific reimbursement for women under the age of 21. (3 months)
- **2020b** = period starting April 2020; extension to women under the age of 25. (5 months)
- **2020c** = period starting September 2020; extension to women entitled to increased reimbursement and residents of an institution. (4 months)
- **2021** = data only available from January 2021 to May 2021 (5 months)

In the case of the morning-after pill, a clear increase in the expenditure can thus logically be observed from the 3rd quarter of 2020 onwards, when the specific reimbursement was extended.

3. Intra-uterine devices

Also for IUDs (intra-uterine devices, such as coils, etc.) a reimbursement can only be obtained within the scope of the specific reimbursement. There is no reimbursement through the classic procedure. It should be noted that the specific reimbursement (see point 1. Overview of all contraceptives for which a reimbursement is available) covers IUDs that are registered as medicinal products as well as IUDs that are registered as medical devices.

Figure 15: Evolution of NIHDI net expenditure for intra-uterine devices (IUD) (2016-2020)

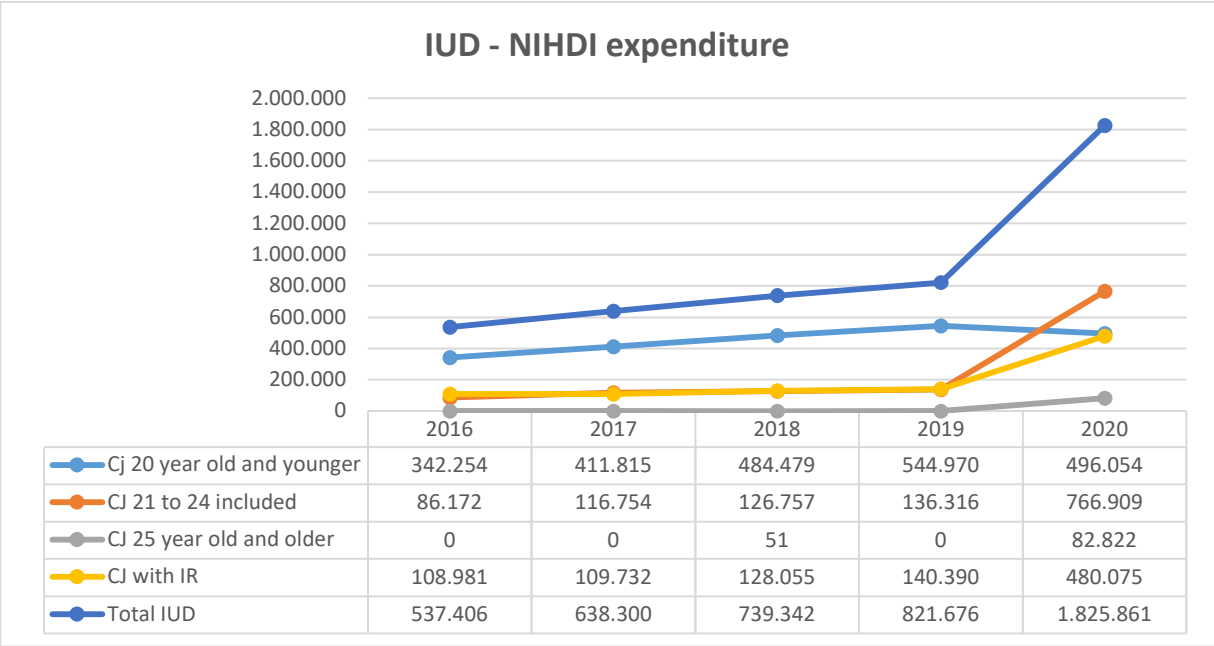


	2016	2017	2018	2019	2020
Cj 20 year old and younger	342.254	411.815	484.479	544.970	496.054
CJ 21 to 24 included	86.172	116.754	126.757	136.316	766.909
CJ 25 year old and older	0	0	51	0	82.822
CJ with IR	108.981	109.732	128.055	140.390	480.075
Total IUD	537.406	638.300	739.342	821.676	1.825.861

Note:

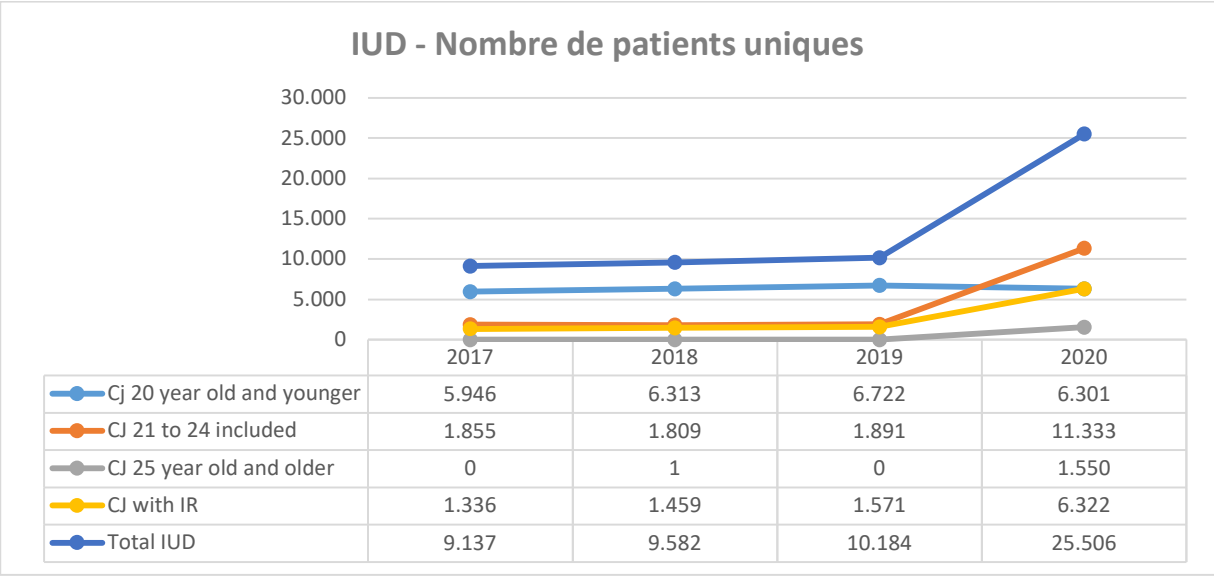
1) The groups CJ 20 years and younger, CJ 21 to 24 included and CJ 25 years and older are beneficiaries without increased reimbursement (IR).
2) Assigning a beneficiary to a certain age group is done **on the basis of the year of birth**. A number of beneficiaries whose age was calculated to be 21 or 25 (year of dispensing - year of birth) were still 20 or 24 years old respectively during part of that year and were still entitled to the specific reimbursement. Consequently, 'expenditure in group CJ' can be found in the age groups for which the age limit for the specific reimbursement is exceeded.

Figure 16: Evolution of the consumption in DDD for intra-uterine devices (IUD) (2016-2020)



	2016	2017	2018	2019	2020
Cj 20 year old and younger	342.254	411.815	484.479	544.970	496.054
CJ 21 to 24 included	86.172	116.754	126.757	136.316	766.909
CJ 25 year old and older	0	0	51	0	82.822
CJ with IR	108.981	109.732	128.055	140.390	480.075
Total IUD	537.406	638.300	739.342	821.676	1.825.861

Figure 17: Evolution of the number of patients for intra-uterine devices (IUD) (2016-2020)

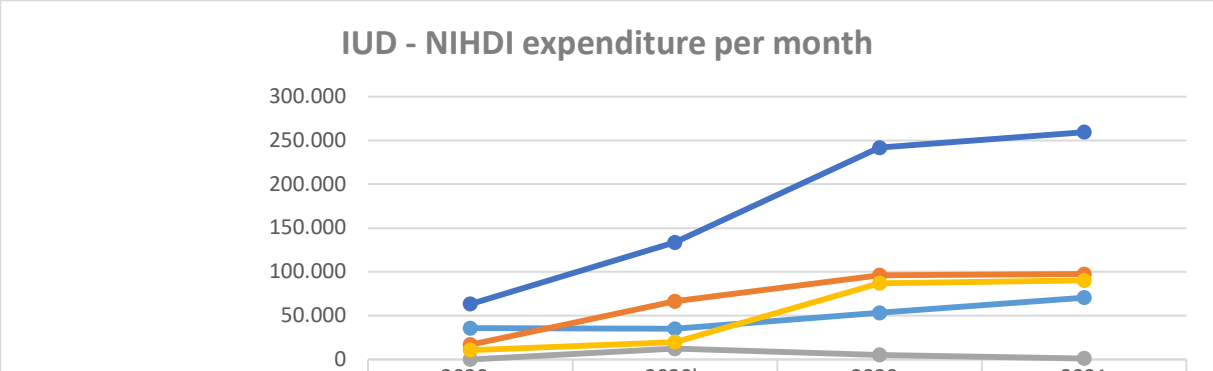


	2017	2018	2019	2020
Cj 20 year old and younger	5.946	6.313	6.722	6.301
CJ 21 to 24 included	1.855	1.809	1.891	11.333
CJ 25 year old and older	0	1	0	1.550
CJ with IR	1.336	1.459	1.571	6.322
Total IUD	9.137	9.582	10.184	25.506

For the NIHDI expenditure as well as the consumption (in DDD) and the number of unique patients, after a stagnation from 2017 to 2019, in the context of the extension of the specific reimbursement, a strong increase was observed in 2020. This is due to the two extensions described above, expanding the target group of the specific reimbursement twice in 2020.

Here as well, we provide an overview of the monthly NIHDI expenditure in 2020, which illustrates even better the impact of the extension of the specific reimbursement:

Figure 18: Evolution of the NIHDI net expenditure 2020-2021 for intra-uterine devices (IUD), average NIHDI expenditure per month per specific period



	2020a	2020b	2020c	2021
Cj 20 year old and younger	35.721	35.121	53.321	70.598
CJ 21 to 24 included	16.854	66.393	96.095	97.476
CJ 25 year old and older	49	12.317	5.272	1.216
CJ with IR	10.746	19.866	87.126	90.096
Total IUD	63.369	133.699	241.815	259.386

- **2020a** = period until March 2020; specific reimbursement for women under the age of 21. (3 months)
- **2020b** = period starting April 2020; extension to women under the age of 25. (5 months)
- **2020c** = period starting September 2020; extension to women entitled to increased reimbursement and residents of an institution. (4 months)
- **2021** = data only available from January 2021 to May 2021 (5 months)

DOSSIER – MEDICAL NUTRITION: DIETARY NUTRITION FOR MEDICAL USE

EVOLUTION OF THE NIHDI EXPENDITURE BETWEEN 2016 AND 2020 FOR THE PRODUCTS DISPENSED IN PUBLIC PHARMACIES AND REGISTERED ON THE LIST OF REIMBURSABLE MEDICAL NUTRITION OF THE ROYAL DECREE OF 24 OCTOBER 2002

The table below shows the NIHDI expenditure for the products registered on the list of the reimbursable medical nutrition of the Royal Decree of 24 October 2002[4].

Table 27: Evolution of the NIHDI expenditure for the products dispensed in public pharmacies and registered on the list of reimbursable medical nutrition of the Royal Decree of 24 October 2002 (2016-2020)

YEAR	TOTAL EXPENDITURE	Yearly growth (%)
2016	7,267,682	NA
2017	7,838,153	7.8
2018	7,899,316	0.8
2019	8,744,520	10.7
2020	9,475,553	8.4

In 2020, the NIHDI spent 9,475,553 euros for the reimbursement of medical nutrition. It has been established that the expenditure has increased by 30% between 2016 and 2020, that's an annual 6.9% growth of the NIHDI expenditure for medical nutrition.

EVOLUTION OF THE TOTAL NUMBER OF PATIENTS BETWEEN 2017 AND 2020

The following table shows, for 2017 to 2020, the evolution of the number of patients who received a reimbursement from the NIHDI for at least 1 product that is registered on the list of reimbursable medical nutrition of the Royal Decree of 24 October 2002.

Table 28: Evolution of the number of patients (2017-2020)

NUMBER OF PATIENTS				
2016	2017	2018	2019	2020
NA	3,554	3,551	4,606	5,391

In 2020, 5,391 patients were treated with medical nutrition. An increase of 51.7% in the number of patients was observed between 2017 and 2020.

[4] Royal Decree of 24 October 2002 establishing the procedures, terms and conditions under which the compulsory healthcare and benefits insurance covers the costs of dietary food for medical use.

TOP 20 OF THE NIHDI EXPENDITURE IN 2020 FOR REIMBURSABLE MEDICAL NUTRITION MENTIONED ON THE LIST OF THE ROYAL DECREE OF 24 OCTOBER 2002

Table 29: Top 20 of the NIHDI expenditure in 2020

CNK	NAME	EXPENDITURE 2020 (EUR)	IN % COMPARED TO TOTAL EXPENDITURE	Patients 2020 (n)	COSTS/ patient in 2020 (EUR)
1437615	NEOCATE	1,889,561	19.8	1,383	1,366
3183316	NUTRAMIGEN PURAMINO	1,367,627	14.3	1,092	1,252
2078798	PHLEXY-10	772,272	8.1	60	12,871
3955622	ALFAMINO	482,157	5.1	333	1,448
3674876	NEOCATE JUNIOR NON AROMATISÉ	426,164	4.5	235	1,813
1723162	PKU 2 SECUNDA	263,253	2.8	38	6,928
3050309	PKU LOPHLEX LQ 20 JUICY FRUITS DES BOIS / BESSEN (NUTRICIA)	209,817	2.2	21	9,991
3050234	PKU ANAMIX INFANT (NUTRICIA)	151,512	1.6	48	3,157
3006780	PKU GEL N/AROMAT SACH 30 X 24 G	143,524	1.5	38	3,777
3960150	NUTRAMIGEN PURAMINO JUNIOR	140,117	1.5	84	1,668
1429885	PHLEXY-10	138,835	1.5	25	5,553
2875326	MSUD 2 PRIMA (NUTRICIA)	136,935	1.4	8	17,117
3140795	KETOCAL 4:1 NEUTRAL TASTE	113,893	1.2	36	3,164
2915379	RENASTART	112,225	1.2	39	2,878
3767431	DEKAs Softer capsules	95,081	1.0	451	211
3533254	PKU AIR 20 RED 30 X 174ML	94,000	1.0	15	6,267
2840064	PKU COOLER 20 RED	91,500	1.0	9	10,167
1723147	PKU 2-MIX M	87.120	0.9	23	3,788
3097920	PKU 3 ADVANTA	80,007	0.8	9	8,889
1511963	BASIC-P	79,608	0.8	57	1,396
		TOTAL	**TOTAL**	**TOTAL**	
		6,875,209	**72.1**	**4,027**	

- In terms of NIHDI expenditure in 2020 for medical nutrition, the first 5 products in this table represent 51.8% of the total expenditure, or 4,937,781 euros for 3,103 patients (on a total of 5,391 patients).
  The 20 products generating the highest expenditure represent 72.1% of the expenditure needed to treat 4,027 patients.

- Of the five products generating the highest expenditure, NEOCATE and NUTRAMIGEN PURAMINO together contribute to 34.4% of the total expenditure in 2020 for reimbursable medical nutrition registered on the list of the Royal Decree of 24 October 2002.

- We notice that the products PHLEXY-10, ALFAMINO and NEOCATE JUNIOR NEUTRAL, all eligible to be reimbursed in 2019, represent 17.7% of total expenditure for medical nutrition in 2020, or 1,680,593 euros (compared to 868,167 and 81,611 euros in 2019 if PHLEXY-10, whose expenditure has been stable since 2016, is not taken into account).
  In contrast to the first 3 products (in terms of annual expenditure) whose annual expenditure between 2016 and 2020 is fairly stable, the growth rate of products such as ALFAMINO and NEOCATE JUNIOR NEUTRAL is very significant (1,537%). The evolution of expenditure for those products will need to be closely monitored in 2021, 2022 and 2023.

NIHDI EXPENDITURE FROM 2016 TO 2020 PER § FOR MEDICAL NUTRITION MENTIONED ON THE LIST OF THE ROYAL DECREE OF 24 OCTOBER 2002

Table 30: Evolution of NIHDI expenditure per § (2016-2020)

§	NIHDI expenditure 2016	NIHDI expenditure 2017	NIHDI expenditure 2018	NIHDI expenditure 2019	NIHDI expenditure 2020	EVOLUTION BETWEEN 2016 AND 2020 (%)	% OF TOTAL EXPENDITURE
30000	2,908,235	3,306,509	3,324,269	4,012,716	4,448,658	53.0	46.95
10000	3,316,553	3,395,184	3,357,779	3,482,344	3,636,459	9.6	37.90
160200	190,560	205,049	227,608	256,676	328,864	72.6	3.47
110000	228,887	235,851	262,477	243,117	291,973	27.6	3.08
250000	0	0	0	48,325	145,865	201.8 (vs 2019)	1.54
120000	104,414	102,980	121,745	109,192	114,050	9.2	1.20
190000	71,416	104,264	112,499	117,944	112,225	57.1	1.18
70000	97,151	90,918	82,148	95,747	86,729	-10.7	0.92
20000	62,913	64,316	63,354	73,804	73,510	16.8	0.78
90000	75,307	72,433	77,219	67,929	65,807	-12.6	0.69
130000	28,701	52,233	55,388	57,407	60,823	111.9	0.64
170000	43,873	46,804	52,293	43,877	56,148	28.0	0.59
220-100-200-300-400	16,565	30,968	36,671	38,005	31,250	88.6	0.33
200000	18,101	23,152	26,099	22,563	28,625	58.1	0.30
80000	35,331	33,209	39,653	28,273	24,902	-29.5	0.26
210000	20,219	15,735	13,866	27,419	23,762	17.52	0.25
230000	0	0	0	13,561	15,825	16.7 (vs 2019)	0.17
180000	34,138	38,642	25,422	31,669	14,091	-58.7	0.15
140000	27,039	22,550	23,422	25,496	12,194	-54.9	0.13
240000	0	0	0	4,546	11,787	159.3 (vs 2019)	0.12
60000	5,970	6,633	6,379	8,933	5,125	-14.2	0.05
260000	0	0	0	1,238	4,793	287.1 (vs 2019)	0.05
50000	934	623	1,730	21	588	-37.0	0.01
40000	4,859	1,352	1,183	1,700	579	-88.1	0.01
150000	54,516	73,874	75,614	38,766	0	-28.9 (vs 2019)	0.41
TOTAL	**7,345,682**	**7,923,278**	**7,986,816**	**8,851,270**	**9,594,510**	**30.6**	

- With regard to the NIHDI expenditure in 2020 for the medical nutritional products mentioned on the list, the 5 following §§ had the highest expenditure:
  - **§ 30000 relates to the** amino acid nutrition (reimbursement in category B).
    NEOCATE and NUTRAMIGEN PURAMINO are the first two products that contribute to the total expenditure for medical nutritional products that are reimbursed by the NIHDI.
    In that § 30000, ALFAMINO and NEOCATE JUNIOR NEUTRAL, both eligible to be reimbursed in 2019, are respectively the fourth and fifth product in terms of their contribution to the total expenditure for medical nutritional products reimbursed by the NIHDI.
    That § 30000 thus contains 4 of the first 5 medical nutritional products for which the NIHDI expenditure is the highest in 2020.
    The NIHDI expenditure for that § 30000 represents 46.95% (4,448,658 euros) of the total NIHDI expenditure for medical nutrition in 2020. Between 2016 and 2020, the NIHDI expenditure for those § 30000 products increased by 53%.
    The average number of patients treated between 2016 and 2020 was 2,663. For 2020, 3,297 of the 5,391 patients who received the reimbursement of at least one medical nutritional product, received it within the scope of § 30000 and the NIHDI cost per patient amounted to 1,349 euros.

  - **§ 10000 relates to the** amino acid-based preparations for the treatment of phenylketonuria (reimbursement in category B).
    This § comprises 83 of the 176 products for which at least one reimbursement was booked in PHARMANET between 2016 and 2020.
    The NIHDI expenditure for that § 10000 represents 37.9% (3,636,459 euros) of the total NIHDI expenditure for medical nutrition in 2020. Between 2016 and 2020, the NIHDI expenditure for the products of that § 10000 increased by 9.6%.
    The average number of patients treated between 2017 and 2020 was 655 and the NIHDI cost per patient in 2020 was 5,551 euros.

  - **§ 160200 relates to the** preparations for a ketogenic diet in case of epilepsy (reimbursement in category A).

    The NIHDI expenditure for that § 160200 represents 3.47% (328,864 euros) of the total NIHDI expenditure for medical nutrition in 2020. Between 2016 and 2020, the expenditure growth for the products of that § 160200 is a priori important (72%) but it must be put into perspective by a low contribution (3.47%) of the expenditure for the products of that § to the total NIHDI expenditure for medical nutrition in 2020.

  - **§ 110000.** Preparations for the treatment of MSUD and hyperleucinaemia.

    The NIHDI expenditure for that § 110000 represents 3,08% (291,973 euros) of the total NIHDI expenditure for medical nutrition in 2020. Between 2016 and 2020, the expenditure growth for the products of that § 110000 is 27% but it must be put into perspective by a low contribution (3.08%) of the expenditure for the products of that § to the total NIHDI expenditure for medical nutrition in 2020.

  - **§ 250000 relates to the** preparations on the basis of vitamins, minerals and trace elements for the treatment of cystic fibrosis (or mucoviscidosis) (reimbursement in category A), [Products DEKAS].

    The NIHDI expenditure for that § 250000 represents 1.54% (115,865 euros) of the total NIHDI expenditure for medical nutrition in 2020. Between 2019 and 2020, the expenditure growth for the products of that § 250000 is a priori important (201,28%) but it must be put into perspective by a very low contribution (1,54%) of the products of that § to the total NIHDI expenditure for medical nutrition in 2020.

Conclusion: the §§ 10000 and 30000 together therefore represent 84.85% of the total NIHDI expenditure for medical nutrition in 2020.

If one takes into account §§ 160200, 110000 and 250000, the 5 §§ together represent 92% of the total NIHDI expenditure for medical nutrition in 2020.

- We also mention that some products such as MCT PROCAL - LIPISTART and BASECAL 200 are mentioned in different §§ (220100, 220200, 220300 and 220400 for the first products and 70000 and 110000 for the second product).

EVOLUTION BETWEEN 2017 AND 2020 OF THE NUMBER OF PATIENTS FOR THE 5 PARAGRAPHS WITH THE HIGHEST EXPENDITURE AND OF THE EXPENDITURE PER PATIENT FOR THOSE 5 §§ IN 2020

Table 31: Evolution of the number of patients for the 5 §§ with the highest expenditure (2017-2020)

	NUMBER OF PATIENTS				
§	2017	2018	2019	2020	EXPENDITURE/PATIENT in 2020 (EUR)
30000	2,257	2,307	2,790	3,297	1,349
10000	637	612	631	653	5,387
160200	88	83	83	94	3,499
110000	44	35	40	37	7,891
250000	0	0	416	695	210

§ 30000. Amino acid nutrition
§ 10000. Amino acid-based preparations for the treatment of phenylketonuria
§ 160200. Preparations for a ketogenic diet in case of epilepsy
§ 110000. Preparations for the treatment of MSUD and hyperleucinaemia.
§ 250000. Preparations based on vitamins, minerals and trace elements for the treatment of cystic fibrosis (or mucoviscidosis).

DOSSIER – ARTICLE 81/111 CONVENTIONS

PRINCIPLE

For some new treatment options, reimbursement can involve scientific and/or budgetary uncertainties. These uncertainties may be related to the (relative) therapeutic value of the product, the cost per treatment or the overall budgetary impact of the medicine if available to the whole population. Generally, it is a combination, so there is uncertainty as to the cost benefit ratio of the new therapy.

To prevent patients being denied access to these new, sometimes very promising treatments, and to give the pharmaceutical company an opportunity to (further) prove the value of the medicine in a real-life setting, these treatments can be made temporarily eligible for reimbursement, subject to clearly specified conditions. The precise conditions to be met by the pharmaceutical company to enable this temporary reimbursement are set out in a convention. These conventions are one of the policy tools used to keep better control of the budget.

The conditions are mostly two-fold: firstly, the company is asked, during the period of temporary reimbursement, to collect additional information and evidence on specific points of uncertainty. Secondly, during this period the company shares the responsibility for the uncertainties and risks linked to reimbursement (e.g. an excessively high listing price even for someone who's responding to a treatment). In practice this means that the convention includes a budgetary compensation scheme. The risks are thus shared by the health insurance and the company.

In order to reach an agreement, negotiations take place in a working group during a number of face-to-face meetings organised by the NIHDI. This working group is made up of representatives from the pharmaceutical company, the insurance bodies (for the insurance committee), the CRM, the professional organisation representing the pharmaceutical industry, the Minister of Social Affairs, the State Secretary for the Budget and the Minister of Economic Affairs. The negotiating procedure may not take longer than 120 days. If consensus is reached within this period, a convention is signed by the NIHDI and the pharmaceutical company.

It has been possible to conclude such conventions since 2010. The relevant legislation has been amended on several occasions since then, but the key principles have remained the same. The current procedure to be followed to reach agreement on a convention is set out in Article 111 and following of the Royal Decree of 1 February 2018 concerning the procedures, terms and conditions for reimbursement by the compulsory healthcare and benefits insurance towards costs of pharmaceuticals. Before this Royal Decree came into force, the procedure to be followed was set out in Article 81 and following of the Royal Decree of 21 December 2001 concerning the procedures, terms and conditions for reimbursement by the compulsory healthcare and benefits insurance towards costs of pharmaceuticals. The terms 'Article 81/111 conventions' and 'Article 81/111 procedure' refer back to the legal basis of these conventions.

The negotiation procedure is launched on the basis of a proposal from the CRM (Article 81bis/112), or when the CRM is unable to formulate a definitive proposal with a two thirds majority (Article 81/111).

Until 1 July 2014, it was possible for a company, following a negative opinion from the CRM, to submit a request for negotiations to take place (Article 81). Since 1 February 2018, it is again possible, subject to certain conditions, for a negotiation procedure to be launched following a negative CRM opinion (Article 113).
Since 1 July 2014, companies, in certain circumstances, may submit a request for an Article 81/111 procedure for class 2 dossiers (no therapeutic added value) in cases where the reference pharmaceutical is marked on the positive list with the letter 'T'.

Since 2018, the CRM may make a proposal to begin negotiations, where reimbursement is requested, for any reference pharmaceutical on the positive list and highlighted with the letter 'T'; including, then, for generics, biosimilars, pharmaceuticals imported or distributed in parallel (Article 112).

LEGAL BASIS

Law on compulsory healthcare and benefits insurance, coordinated on 14 July 1994 - Art. 35 bis (7).

Royal Decree of 01.02.2018 concerning the procedures, terms and conditions for reimbursement by the compulsory healthcare and benefits insurance towards costs of pharmaceuticals – Articles 111 to 117 inclusive.

Law containing provisions with regard to the reimbursement of pharmaceuticals as well as the administrative costs, efficiency and transparency of insurance organisations, coordinated on 1 April 2019 - Chapter V.

BUDGETARY COMPENSATION

As described above, Article 81/111 conventions make it possible to manage the risks and uncertainties linked to the reimbursement of a new treatment. Often, this is done by means of a budgetary compensation mechanism. Most conventions are structured in such a way that the health insurance initially bears the costs of the medicine concerned. After a clearly defined period, the pharmaceutical company pays back a certain sum to the NIHDI (=budgetary compensation). The value of this budgetary compensation depends on what is stated in the convention.

Various compensation/refund mechanisms are used, either alone or in combination:

- Repayment of a percentage of the turnover resulting from the pharmaceutical in question, possibly with an individual or group ceiling applied (e.g. per therapeutic class, per indication) - any earnings in excess of this ceiling must be partially or fully repaid;
- Repayment of a set amount per unit sold, corresponding to the difference between the proposed reimbursement basis and the value, in line with the evaluation of the criteria referred to in Article 4 of the Royal Decree of 1 February 2018;
- Repayment of an amount corresponding to all or part of the difference between the expenditure foreseen and the actual expenditure on the pharmaceutical in question;
- A reduction in the reimbursement basis of (an)other pharmaceutical(s) marketed by the applicant, resulting in reduced expenditure for the health insurance on a medicine other than the pharmaceutical in question;
- Any other arrangement at the cost of the applicant which reduces expenditure.

These various forms of compensation might give the impression that these conventions are purely financial in nature. However, there is a reason for all of these mechanisms, and this reason is often science-based. The 'repayment of a percentage of the turnover' mechanism, for example, may be based on a system where the health insurance only bears the costs of patients who are deemed to have benefitted from the pharmaceutical ('outcomes-based agreement'), or maybe the costs are only reimbursed when the pharmaceutical is administered for a treatment which has been shown, with sufficient scientific proof, to be effective and safe.

The information related to the amount of a company's financial contribution and the schedule which determines how precisely the budgetary compensation is to be calculated is contained in the annex to an Article 81/111

convention. The contents of such an annex are confidential. This means that the budgetary compensation provided for each medicine or, in the case of some conventions, for each group of medicines, cannot be reflected in this MORSE report. In other words, the expenditure figures for pharmaceuticals reported in this MORSE report do not take account of the compensation received by the NIHDI by virtue of Article 81/111 conventions.

RESOLVING SCIENTIFIC AND BUDGETARY INCERTAINTIES

Conventions are used to collect additional information and evidence on particular questions on which there is uncertainty. The uncertainties which the pharmaceutical company is supposed to have clarified by the time when the convention expires may be scientific and/or budgetary in nature.

These uncertainties probably partially account for the overall increase in the number of conventions seen in recent years. The CRM often reports serious uncertainty as to the therapeutic value (the dossiers often contain immature data submitted too early to the EMA, such as phase II study results); there may also be major budgetary uncertainties (high treatment cost per patient, considerable budgetary impact due to wide target group). Although the CRM does its best to make proposals for definitive inclusion on the list of reimbursable pharmaceuticals, starting a negotiation process is often the only way to make medicines accessible to the patient in a way that the expenditure can at least be monitored.

More and more emphasis is being placed on generating evidence. Pharmaceutical companies are asked to collect data, during the term of the convention, in order to give an answer to the existing uncertainties.

It is up to the pharmaceutical companies to determine how best to clarify these uncertainties. A company may report new study-results (e.g. of a post-marketing study), or interim analyses (e.g. of an ongoing phase III study), presenting new data concerning the initial open questions.

A company may also use 'real-life data' from registers, or access information from the Common Sickness Funds Agency (IMA-AIM). The IMA can provide information from the invoiced data submitted to the insurance bodies, on, for example, the number of patients or packages per indication for one particular molecule, the duration of treatment, any concomitant medication, etc.

For a limited number of pharmaceuticals, data is collected by Sciensano, often in collaboration with the NIHDI. These are first and foremost clinical data which cannot be accessed via invoicing databases and which require specific registers to be set up or adjusted. More information can be found on the website https://www.sciensano.be/en/health-topics.

A company collects all the relevant data and produces an evaluation report, which, on expiry of the convention, is submitted to the working group responsible for the negotiations. The report is then thoroughly assessed. The working group, taking account of the data supplied and the probative force of these data, decides whether it is best to extend the convention or organise a new CRM evaluation.

In the latter case, the working group advises the company to launch a new CRM procedure using the data which became available during the time covered by the convention, so that the CRM can make a new judgment.

In conclusion, an Article 81/111 convention can offer a temporary solution to make promising therapies available to patients. However, there is always a trade-off between risks and benefits. When possibly granting a temporary reimbursement, account will be taken of the fact that the investment of public funds is sufficient so that there is no loss of social welfare if the medicine ultimately proves to be cost-effective; but also that public funds are used

responsibly if it later turns out that the product has little or no benefit for patients. There must therefore also be a clear EXIT strategy where difficult choices have to be made. Without additional evidence, the medicine will no longer be reimbursed or will be reimbursed at a publicly known price that reflects the value of the medicine. After all, we must ensure that one therapy for which there is less evidence does not supplant another therapy with a better cost-benefit profile.

SOME FIGURES

The option of Article 81/111 conventions was introduced in 2010 (see also 'Principle').

The information given refers to reimbursement dossiers for which a request was submitted by the company to the Minister for Social Affairs for the launch of a negotiation procedure, in the period 2010-2019. One request for reimbursement may cover various package sizes, or different indications for one and the same molecule. It is up to the pharmaceutical company to decide whether to submit such a joint request for reimbursement.

NUMBER OF REQUESTS TO LAUNCH NEGOTIATIONS, AND THEIR OUTCOMES

In the period 2010-2020, a total of 382 requests for the launch of Article 81/111 negotiations were received by the Minister for Social Affairs.

The decrease in the number of submitted applications in 2020 is undoubtedly due to the COVID-19 situation. Because of the COVID-19 pandemic, the terms of the CRM procedure were suspended as of 13 March 2020 (Royal Decree no. 20 of 13 May 2020 containing measures to combat the COVID-19 pandemic and to ensure the continuity of care in the compulsory healthcare insurance). This suspension was lifted on 1 April 2021.
In contrast to an earlier MORSE report, the tables below also include applications in the context of a CRM procedure for parallel distribution. So far, however, these CRM proceedings have not ended in an agreement.

Table 32 shows the status of the requests received. The status 'convention expired/reimbursed under convention' *refers to the status of the convention on 25 November 2021.*

Table 32: Evolution of number of requests to conclude an Article 81/111 convention per year in which the application was submitted.

year of submission request to conclude a convention	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
request denied	0	3	2	1	2	0	1	1	18	3	0	31
request accepted	14	14	16	16	25	37	47	34	42	64	42	351
procedure ongoing	0	0	0	0	0	0	0	0	0	0	0	0
no convention concluded	8	6	4	3	6	4	5	6	7	11	10	70
convention expired	6	8	12	13	19	33	35	14	15	8	1	164
reimbursed under convention	0	0	0	0	0	0	7	14	20	45	31	117
total	**14**	**17**	**18**	**17**	**27**	**37**	**48**	**35**	**60**	**67**	**42**	**382**

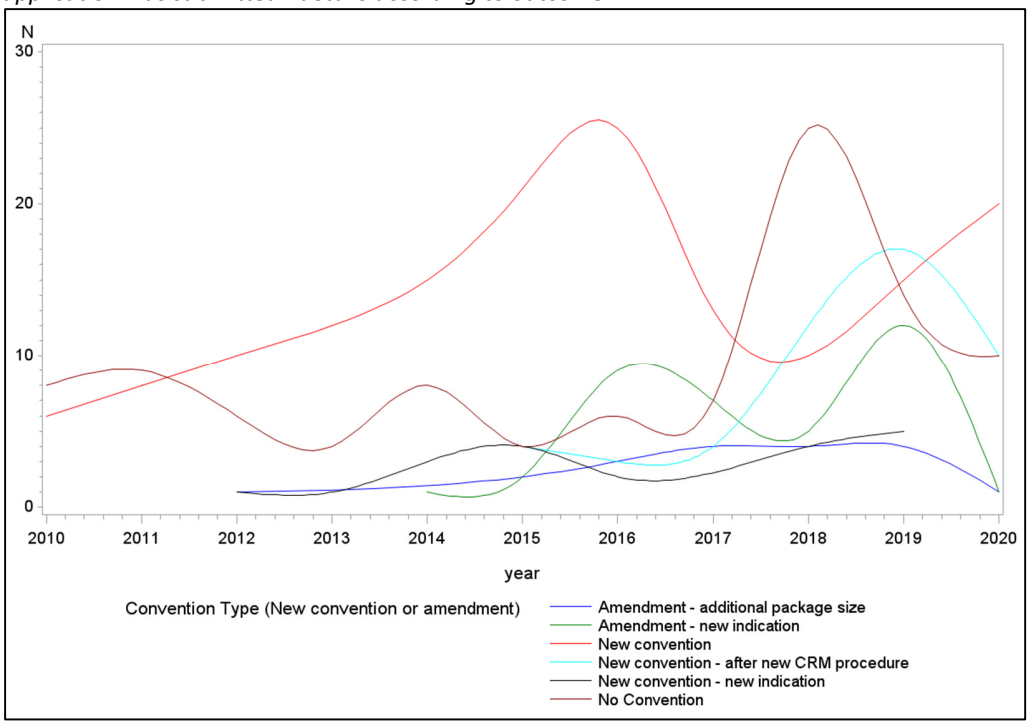
It appears in more detail from Table 33 and Figure 19

Figure 19 that the increasing trend does not only relate to applications to conclude conventions for new molecules. In recent years, there has been a logical increase in, firstly, the number of new conventions concluded for a molecule/indication which has already been reimbursed for a temporary period and was reassessed by the CRM; and, secondly, in the number of additional conventions concluded, or amendments to an existing convention, in the event of a new indication or a change of indication.

Table 33: Evolution of number of requests to conclude an Article 81/111 convention per year in which the application was submitted - details on outcomes

year of submission request to conclude a convention	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total
procedure ongoing	0	0	0	0	0	0	0	0	0	0	0	**0**
no convention concluded	8	9	6	4	8	4	6	7	25	14	10	**101**
new convention (first convention for a molecule)	6	8	10	12	15	21	25	13	10	15	20	**155**
convention after previous convention and re-evaluation by the CRM	0	0	0	0	0	4	3	4	12	17	10	**50**
additional convention (additional indication)	0	0	1	1	3	4	2	0	4	5	0	**20**
amendment to an existing convention (new indication or change of indication)	0	0	0	0	1	2	9	7	5	12	1	**37**
amendment to an existing convention (new package/ new dosage)	0	0	1	0	0	2	3	4	4	4	1	**19**
total	**14**	**17**	**18**	**17**	**27**	**37**	**48**	**35**	**60**	**67**	**42**	**382**

Figure 19: Evolution of the number of applications to conclude an Article 81/111 convention per year in which the application was submitted - details according to outcome



TIME UNTIL REIMBURSEMENT (VIA A CONVENTION)

The duration of a reimbursement procedure is specified in the Royal Decree of 1 February 2018. It amounts to a maximum of 180 days. However, the reimbursement procedure (and therefore the 180-day period) may be suspended in the event of missing elements when submitting an application or in the absence of the price attribution. Furthermore, during the reimbursement procedure, the applicant may request twice a suspension of up to 90 days, and up to 120 days may be spent in the negotiation procedure to reach an agreement.

Possible suspensions are included in the number of days given in the following analysis.

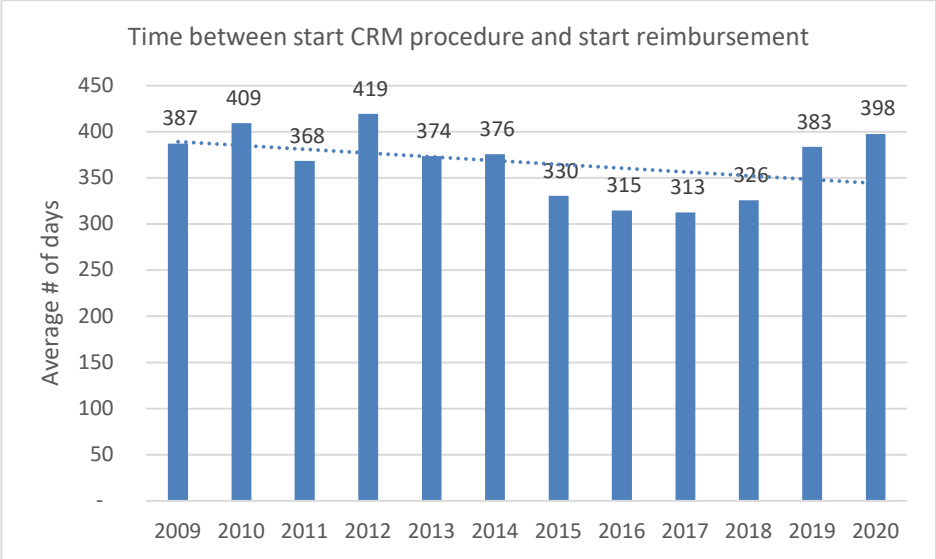
It should be noted that during the COVID-19 crisis in 2020-2021, the calendar of the CRM procedures was temporarily suspended (suspension of deadlines from 13 March 2020 to 1 April 2021). This resulted in the total duration of the suspension(s) in practice often being longer than the maximum suspension periods mentioned in the Royal Decree of 1 February 2018. This is also evident from the figures for 2019 and 2020 (year in which the application was submitted to the CRM).

Since the possibility of concluding a convention was introduced, the average number of days between submission of a request for reimbursement and the entry into force of that reimbursement is 367 days. This is the average of all cases with the exception of one outlier where the procedure took 1,443 days; however, this procedure was related to an application submitted in 2006.

In the case of 64.4% of the conventions concluded, it took less than a year to achieve reimbursement via a convention. The shortest time between submission of the request for reimbursement and the entry into force of the reimbursement was 135 days. The longest-but-one period between submission and entry into force of the reimbursement was 688 days (i.e. ± 22.5 months); a consequence of suspensions during the procedure and the calendar halt during the COVID-19 crisis.

From 2015 to 2018, the time between submission of the reimbursement request and the entry into force of the reimbursement has remained relatively stable (around 10 months). Given that conventions are largely concluded for medicines deemed by the pharmaceutical company to have therapeutic added value or for orphan drugs, the two-to-three-month acceleration compared to ten years ago means that patients have quicker access to innovative medicines. For 2019 and 2020, we notice a new increase (plus 2 months approximately) of the time between submitting the request for reimbursement and the reimbursement taking effect, that is, in all likelihood, due to the temporary suspension of the calendar for CRM procedures because of the COVID-19 crisis.

Figure 20: Evolution of time between submission of the reimbursement dossier and entry into force of reimbursement per year in which the CRM procedure was initiated



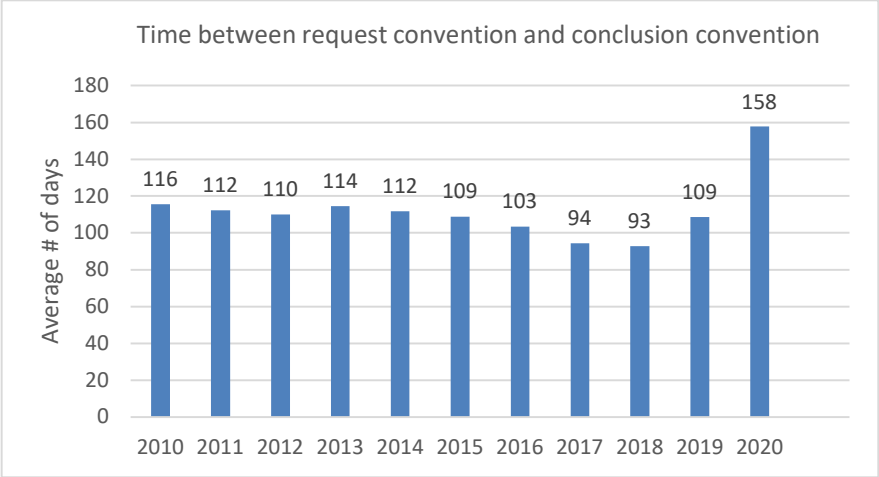
TIMEFRAME TO SUSPEND A DISCUSSION ACCORDING TO ARTICLE 111, 112 OR 113 OF THE ROYAL DECREE OF 1 FEBRUARY 2018

As described above, according to regulations, a maximum of 120 days may be spent on discussions to reach a possible 81/111 convention.

Due to the fact that during the COVID-19 crisis in 2020-2021, the calendar of procedures was temporarily halted, it was temporarily possible to have a suspension in the context of an Article 81/111 discussion that lasted longer than 120 days. This is also reflected in the 2019-2020 figures.

From 2010 to 2020, discussions took on average 112 days (taking into account the COVID-19 situation). According to regulations, 10 days of this period are spent on the assessment by the Minister/State Secretary for the Budget.

Figure 21: Evolution of the time between submitting an application for an Article 81/111 convention and signing the convention (i.e. time spent on negotiations and approval of the content of the agreement by the ministers involved) per year in which the application was submitted



EXPIRED CONVENTIONS

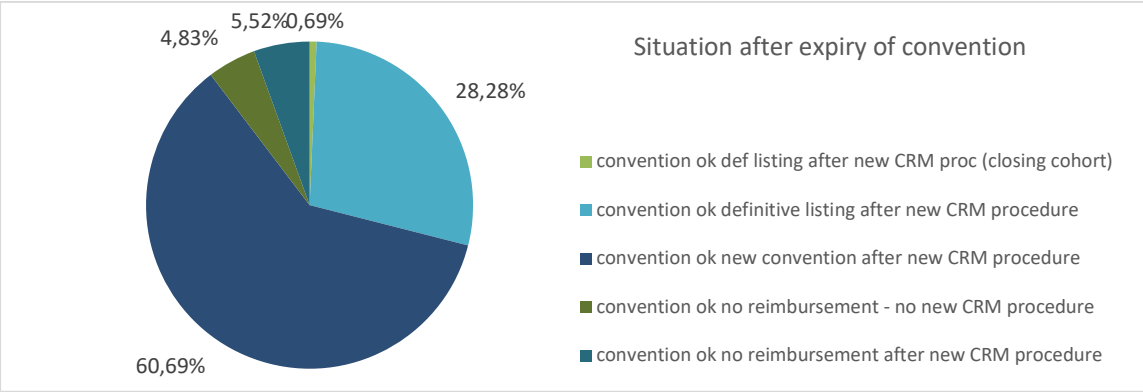
Of the 108 conventions which have expired, no new CRM procedure seems to have been launched for 5 of them (4.63%).

For 34.26% (37/108) of the expired conventions, a new CRM procedure was launched and the pharmaceutical/indication was definitively included in the list of reimbursable pharmaceuticals. It should be noted that one product was registered permanently but the reimbursement was no longer provided for new patients (0.69%).

For 60.69% (88/145) of the expired conventions, a new CRM procedure was launched and the pharmaceutical/indication was temporarily included in the list of reimbursable pharmaceuticals, via a new convention.

In the case of 5.52% (8/145) of the expired conventions, a new CRM procedure was launched, but the (temporary or definitive) reimbursability was not retained. As a result, the pharmaceutical/indication is no longer reimbursed.

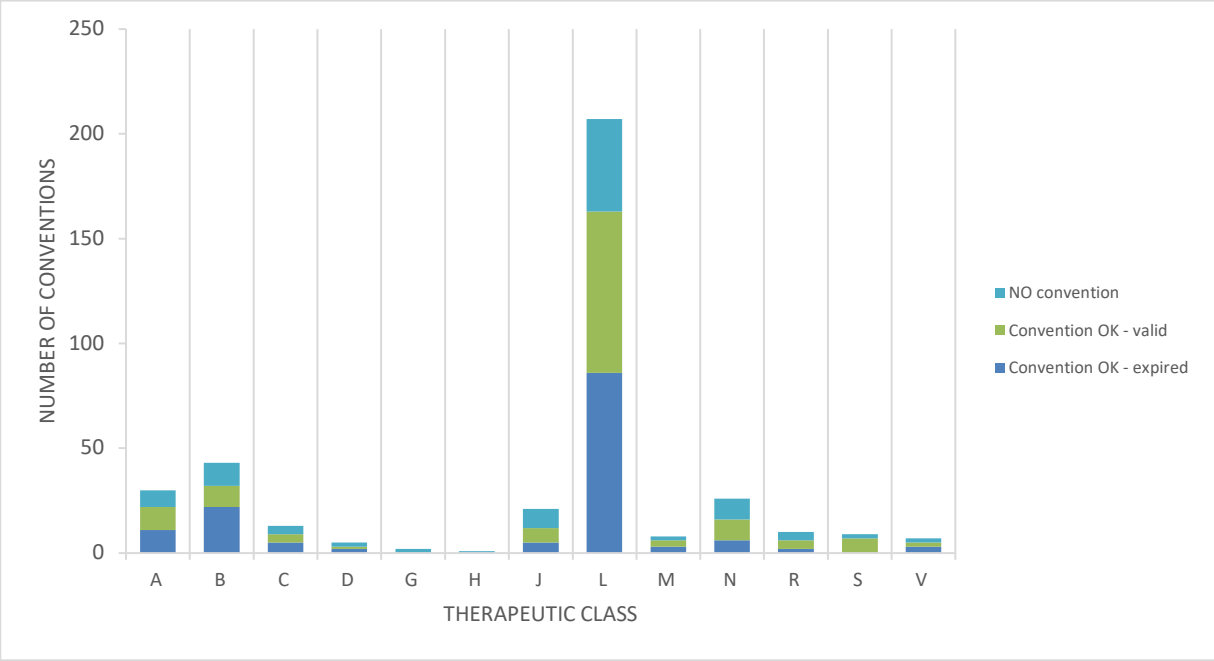
Figure 22: Expired conventions - current situation



CONVENTIONS PER ATC CODE

Figure 23 gives an overview per ATC class (level 1) of the number of requests leading to negotiations since the introduction of this procedure.

Figure 23: Overview of requests for Article 81/111 conventions per ATC class

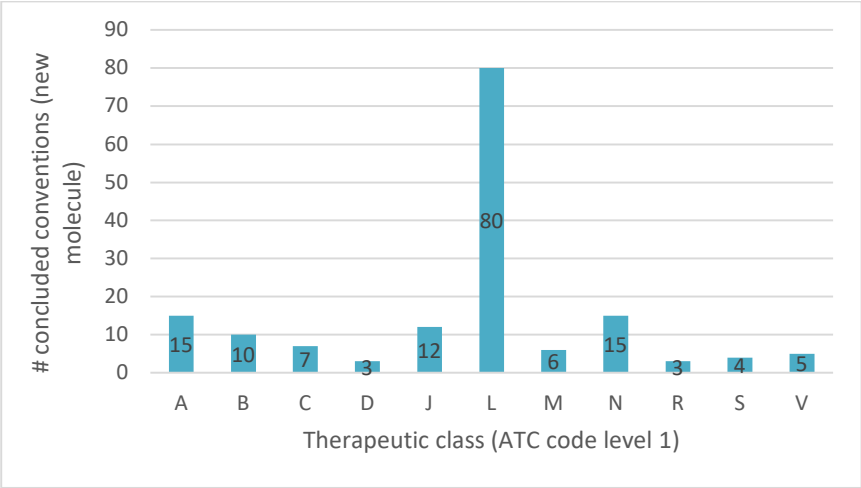


For some pharmaceuticals, more than one indication is reimbursed by means of a convention, so for some pharmaceuticals, more than one convention may be concluded.

Most conventions (54%) were concluded for medicines in ATC class L, 'Antineoplastic and immunomodulating agents'. Next were medicines from ATC class B 'Blood and blood forming organs' (11%).

In terms of molecules, one or more conventions were concluded in the period 2010-2020 for 160 molecules (unique ATC code).

Figure 24: Overview of the number of conventions reached based upon applications under Article 81/111 (new molecule) per ATC class



CONVENTIONS PER STATUS OF CRM OPINION

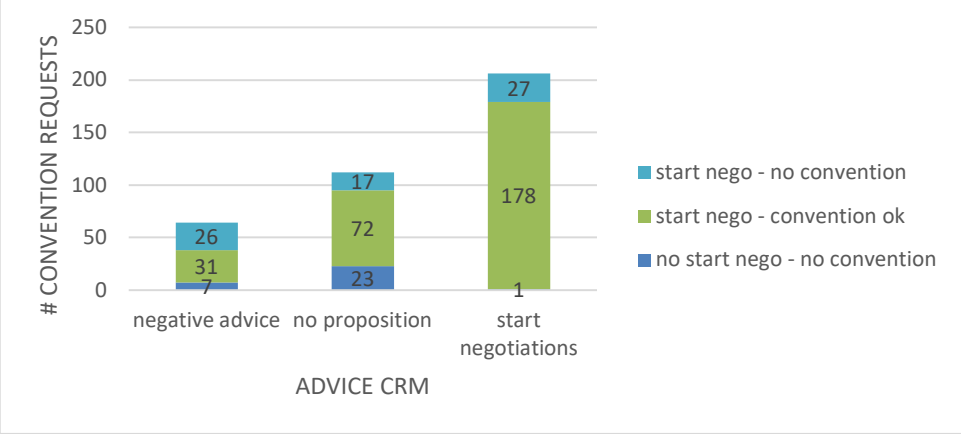
Until 1 April 2014, a company which had received a negative opinion from the CRM could submit a request to enter into negotiations. Since 1 February 2018, this has again become possible, although only after an explicit demand from the Minister for Social Affairs, asking for a company which has received a negative opinion from the CRM to be permitted to lodge a request to launch negotiations.

In 7 of the 64 cases (10.9%) where the CRM had issued a negative opinion, the start of the negotiation procedure was refused by the minister concerned. 31 of the 64 cases (48.4%) where the CRM had issued a negative opinion, eventually resulted in a convention.

A convention was concluded in 178 of the 206 cases (86.4%) where the CRM had issued a proposal to negotiate, and in 72 of the 112 cases (64.3%) on which the CRM did not issue an opinion.

There have also been a limited number of CRM procedures where the Commission proposed the launch of negotiations, but where the company did not submit a request to the Minister for Social Affairs. In these cases, the medicine was listed definitively – but at a reduced price.

Figure 25: Overview of number of Article 81/111 convention requests, by status of CRM opinion



CONVENTIONS, BY TYPE OF REIMBURSEMENT REQUEST SUBMITTED BY THE PHARMACEUTICAL COMPANY

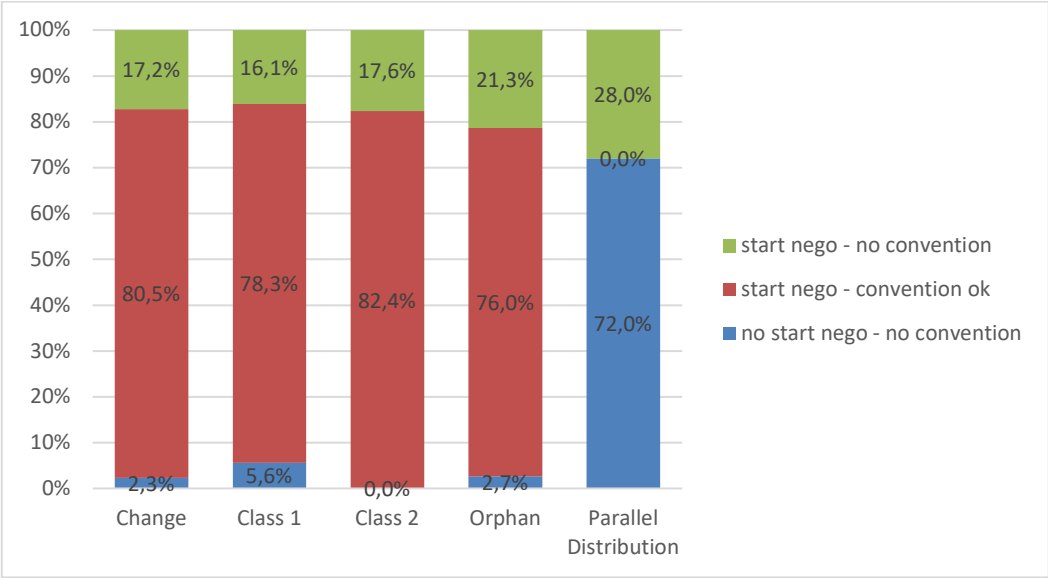
In the case of 78.3% (126/161) of reimbursement requests for which the pharmaceutical company claims therapeutic added value ('Class 1'), a convention is concluded and temporary reimbursement takes place. For 76% (57/75) of requests regarding an orphan drug, a convention is concluded.

In requests for negotiations where no claim of therapeutic added value is made, the pharmaceutical is listed temporarily in 82.4% (28/34) of the cases. In such cases, the reference pharmaceutical is also 'under contract', which probably makes it more likely that agreement will be reached.

80.5% (70/87) of requests for negotiations concerning an amendment to the reimbursement conditions result in a temporary reimbursement: either a new convention is concluded or an existing convention is amended.

In a number of cases the request to launch negotiations is rejected by the Minister for Social Affairs; this was mainly the case for pharmaceuticals submitted as 'parallel distribution' (see below).

Figure 26: Overview of Article 81/111 convention requests, by type of reimbursement request submitted by the pharmaceutical company



NO CONVENTION

Even when the pharmaceutical company has made a request for negotiations to the Minister of Social Affairs, the procedure does not always result in a convention.

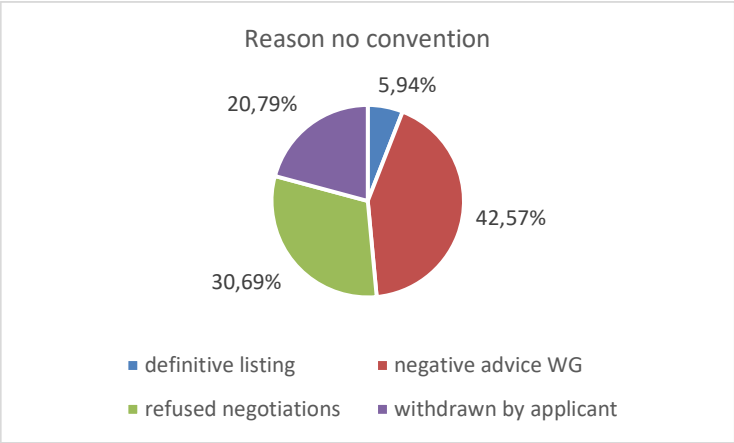
In 5.94% of such cases, the pharmaceutical is included definitively in the list of reimbursable pharmaceuticals without a convention. Often, the list price is directly reduced.

In 30.69% of cases, the Minister decides that it is not the right time to start negotiations. This can be because the clinical data available are not yet mature enough to allow proper discussion of a temporary reimbursement. It is also possible that the applicant submitted an invalid application to start negotiations (submission of the application outside the timeframe mentioned in the Royal Decree of 1 February 2018 or the application does not contain the information mentioned in Article 11, 112 or 113 of the this Decree, ...)

In 42,57 % of the cases, the working group carrying out the negotiations decides that no agreement can be reached, and informs the Minister of this.

In that context, in around 21% of the cases, the pharmaceutical company withdraws from the negotiations in mid-procedure.

Figure 27: Overview of reasons why no convention is concluded

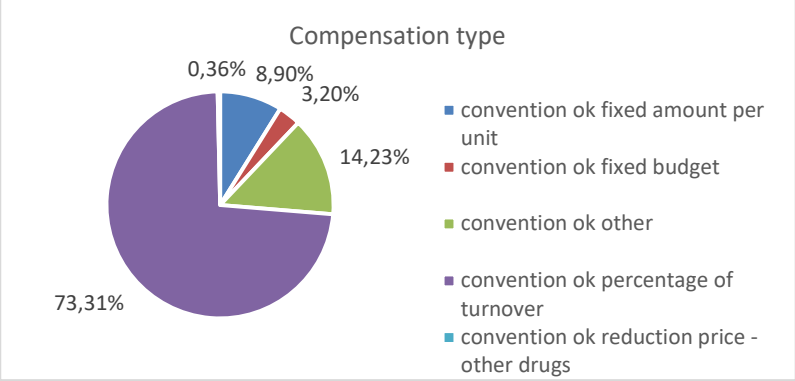


BUDGETARY COMPENSATION MECHANISM

85.71% of the conventions concluded have included only one budgetary compensation mechanism.

- In most of them (73.31%), part of the turnover is repaid. This compensation mechanism can involve repayment of a set percentage of the turnover, or a percentage which increases by pre-determined 'tranche' of turnover. As previously explained, when setting the repayment percentage, account may also be taken of certain aspects. These include the percentage of non-responders, as seen in clinical studies, in which case the compensation mechanism can be described as 'outcomes-based' at the level of the population, insufficient evidence of efficacy or non-appropriate packaging-sizes which could result in wastage.
- In 8.90% of the conventions concluded, the applicant is required to repay a set amount per unit sold.
- In 3.20% of cases, the amount to be repaid corresponds with all or part of the difference between the forecast expenditure and the actual expenditure on the relevant pharmaceutical. For example, a pre-determined amount could be repaid, irrespective of the turnover achieved, or the company could be asked to repay anything above the predicted turnover.
- The percentage of conventions in which the compensation is achieved solely by a reduction in the price of another medicine in the applicant's portfolio is very low (0.36%). This shows that this is not the preferred compensation mechanism, possibly because of its uncertain outcome.

Figure 28: Overview of Article 81/111 convention requests, by budgetary compensation mechanism



The remaining 14.23% of the conventions concluded combined two or more compensation mechanisms.

The use of two or more compensation mechanisms in one convention is complex and logistically more difficult to follow than when one mechanism is applied. One possible advantage of combining compensation mechanisms – and specifically of combinations which include a price reduction for another product – seems to be that a higher level of compensation is possible, since the financial pressure on a company is exerted on not just one product from its portfolio. Such a system, however, also creates greater uncertainty, since it is based on forecasts not just relating to the pharmaceutical being reimbursed on a temporary basis, but also relating to the portfolio product.

Sometimes, moreover, more 'alternative' compensation mechanisms are included in conventions, such as financial compensation to optimise data collection by Sciensano, or compensation on medicines which are not in the applicant's portfolio but have a (therapeutic) link with the drug which is the subject of the convention.

To provide greater budgetary certainty, a 'cap' can be applied – mostly in combination with other compensation mechanisms: a considerable proportion of the amount above this cap has to be repaid. The 'cap' is set at a percentage of the anticipated turnover and varies between conventions, but is often set at less than 100% of the anticipated turnover.

BUDGET CONTROL MECHANISM

As previously reported, there is no separate budget for pharmaceuticals which are reimbursed by virtue of a convention. Conventions are one of the medicines policy tools used to keep tighter control on the budget.

In the section below we describe the evolution over time of expenditure on medicines reimbursed via conventions under Article 81 and following (RD 21.12.2001) and Article 111 and following (new RD 1.2.2018). On the one hand, the situation is presented per calendar year. Given that these data are meaningful, especially in terms of bookkeeping, the situation is also shown cumulatively since the introduction of confidentiality agreements in Belgium.

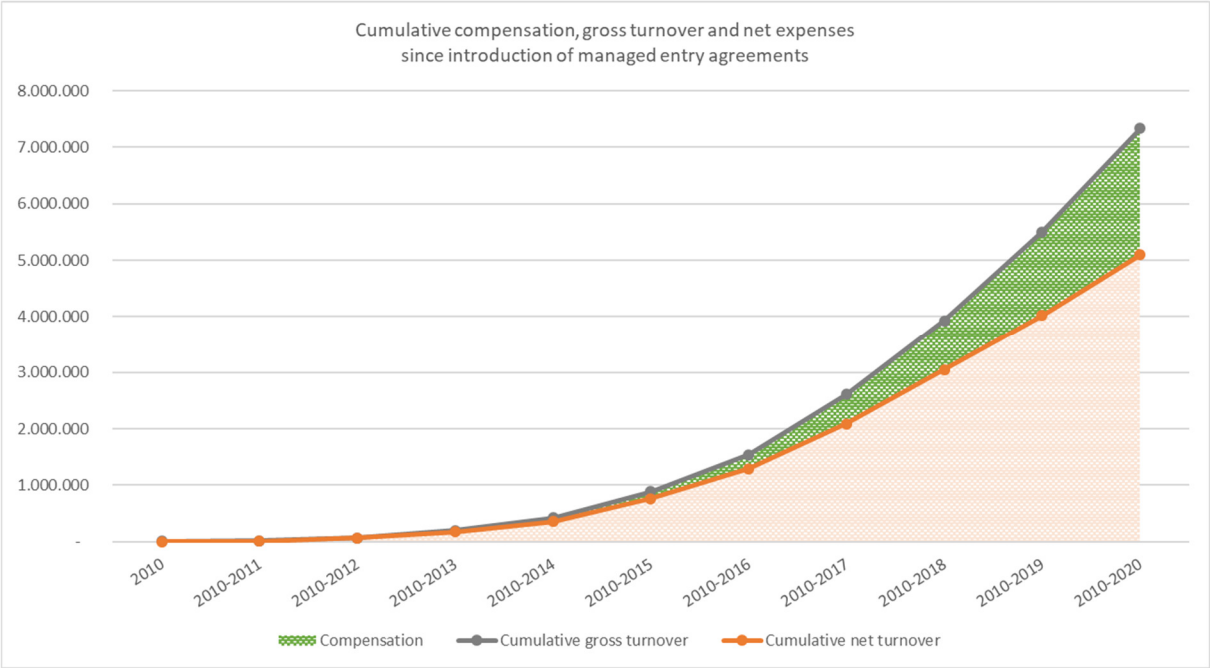
The following points should be borne in mind when interpreting these figures:

- Re-calculation to report the actual 'year of provision of services'.
  Conventions are split into years T in which a refund/compensation is expected from the pharmaceutical company, based on the provisions in the conventions. The pharmaceutical company is mostly required to declare the gross turnover figures (before deduction of the budgetary refund) over a particular period covered by the convention. The conventions run from one date to another, which means that the period covered can spread over two or three calendar years, and the moment of settlement does not necessarily fall in the same calendar year as the period to which the settlement refers. Under the conventions, therefore, (gross) expenditure takes place in a given year 'T', but the repayments happen either fully or partially in the year T+1 or even later in some specific cases (e.g. if a P4P mechanism is being activated), when the company makes the declaration. The tables below contain a proportionate recalculation, to relate the turnover figures and compensation mechanisms back to the actual years in which the turnovers and refunds took place.
- We can only take account here of direct financial compensation mechanisms. Indirect compensation, via price reductions for other pharmaceuticals, is not accounted for (the compensation figures are therefore underestimated).
- With regard to the turnover figures, in some cases the full turnover for the pharmaceutical is used, including the turnover for that pharmaceutical for 'non-contracted' indications. Based on these data, one can therefore not determine a separate budget for pharmaceuticals reimbursed throught an agreement.
- Since October 2016, moreover, when new conventions are concluded or amendments made, efforts are made to collect, in year T, an amount as close as possible to the compensation (repayment) due in the year when the expenditure actually took place (year T), according to the mechanism set out in the convention, as part of the drive towards prepayment of the actual expenditure on pharmaceuticals within the health insurance system. Application of the 'prepayment' system should provide a more accurate picture of the actual net expenditure per calendar year.
- The turnover and refund figures are initially based on known data, i.e. company declarations of turnover, prepayments made, provisional and definitive settlements for expired conventions. Where the data are not known, we use estimates, which acted as a basis for the negotiations. Table 19 shows these figures.
- All these figures refer to ex factory prices. The turnover figures correspond to the expenditure for the health insurance at ex factory prices, so take no account of expenditure on margins, fees or VAT. For practical reasons, the budgetary compensation mechanism in Article 81/111 conventions is mostly determined on the basis of turnover figures for ex factory prices. Besides, for most medicines reimbursed under an Article 81/111 convention, the share of margins and fees is low. These are often medicines which are only reimbursed when delivered by a hospital pharmacy, which means that these margins are subject to a ceiling. The margins are therefore mostly negligible in comparison to the total cost price of these often very expensive pharmaceuticals.
- The data refer to the situation on 25.11.2021, source Pharmaceutical Policy directorate (database on follow-up of Article 81/111 conventions).

Table 34: Overview per calendar year and cumulatively in terms of turnover figures, compensation and net turnover (level ex-factory price, in 000 EUR)

PER CALENDAR YEAR	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Turnover	2,348.6	8,680.4	53,410.8	131,470.2	225,159.6	466,078.9	652,652.1	1,070,132.7	1,315,173.6	1,576,610.7	1,830,257.1
Advance								100,491.4	195,504.2	387,035.7	540,456.9
Balance		1,248.6	2,630.4	23,729.4	41,428.2	56,628.8	121,316.2	172,656.2	162,077.9	218,136.4	213,496.2
Total refund	-	1,248.6	2,630.4	23,729.4	41,428.2	56,628.8	121,316.2	273,147.6	357,582.1	605,172.1	753,953.1
Net	2,348.6	7,431.8	50,780.4	107,740.8	183,731.4	409,450.2	531,335.9	796,985.1	957,591.5	971,438.7	1,076,303.9
Compensation	0,00%	14.38%	4.92%	18.05%	18.40%	12.15%	18.59%	25.52%	27.19%	38.38%	41.19%
CUMULATIVE	2010	2010-2011	2010-2012	2010-2013	2010-2014	2010-2015	2010-2016	2010-2017	2010-2018	2010-2019	2010-2020
Cumulative gross turnover	2,348.6	11,029.0	64,439.8	195,910.0	421,069.6	887,148.5	1,539,800.6	2,609,933.3	3,925,106.9	5,501,717.6	7,331,974.7
Cumulative advence	-							100,491.4	295,995.6	683,031.3	1,223,488.2
Cumulative balance	-	1,248.6	3,879.0	27,608.4	69,036.6	125,665.4	246,981.6	419,637.8	581,715.7	799,852.1	1,013,348.3
Cumulative refund	-	1,248.6	3,879.0	27,608.4	69,036.6	125,665.4	246,981.6	520,129.2	877,711.3	1,482,883.4	2,236,836.5
Cumulative net turnover	2,348.6	9,780.4	60,560.8	168,301.6	352,033.0	761,483.1	1,292,819.0	2,089,804.1	3,047,395.6	4,018,834.2	5,095,138.2
Overall compensation	-	11.32%	6.02%	14.09%	16.40%	14.17%	16.04%	19.93%	22.36%	26.95%	30.51%

Figure 29: Overview of the cumulative gross turnover, compensation and net turnover (level ex-factory price, in 000 EUR) since the introduction of confidentiality agreements in Belgium.



DOSSIER – THE COMMISSION FOR REIMBURSEMENT OF MEDICINES

GENERAL

In this analysis, we assess two of the variables which can be objectively measured, and which seem to be essential to enable access to new, innovative or otherwise, drugs in Belgium: the number of requests for reimbursement (dossiers) submitted, and the Commission proposals and Minister's decisions on the new medicines for which a request has been submitted.

During the evaluation and interpretation of data, a series of important elements must be borne in mind:

1. General elements

- Reimbursement of medicines in Belgium is supply-led, so reimbursement is dependent on a request for reimbursement, submitted by the pharmaceutical company. This is absolutely essential for all reimbursable pharmaceuticals and important for the speed of reimbursement of sometimes innovative new medicines.
- For orphan medicinal products and class 1 requests, the request can be submitted as soon as the applicant has received a positive opinion from the Committee for Medicinal Products for Human Use of the EMA (European Medicines Agency).
  This possibility has to date not been used that often. Between 2016 and 2020, 8.94% of class 1 requests and requests for reimbursability for orphan medicinal products were submitted on the basis of a positive opinion from the EMA's Committee for Medicinal Products for Human Use, before the marketing authorisation was granted (6 requests in 2016, 8 requests in 2017, 6 requests in 2018, 3 request in 2019 and 4 request in 2020).
- On 1 April 2018, the Royal Decree of 21 December 2001, concerning the procedures, terms and conditions for contribution by mandatory insurance for healthcare and benefits towards costs of pharmaceuticals, was repealed and replaced by the Royal Decree of 1 February 2018 concerning the procedures, terms and conditions for contribution by mandatory insurance for healthcare and benefits towards costs of pharmaceuticals. This resulted in a number of changes to the Commission procedures, including the following:
  - a redefining of a number of subclasses,
  - an extension of the sorts of requests which may be processed (new inclusion of line extensions of pharmaceuticals which are already reimbursed),
  - introduction of a specific procedure for generics and copies which could qualify for a partial exemption from application of the patent cliff;
  - introduction of a specific procedure for the listing as reimbursable of the new paediatric forms of pharmaceuticals already reimbursable for adults (subclass 2C; 90-day procedure),
  - introduction of a procedure to amend the reimbursement conditions, in order specifically to extend reimbursement of a pharmaceutical already reimbursed for adults, so that it can be reimbursed for children (90-day procedure),
  - introduction of an option for companies to request the launch of negotiations with a view to concluding a convention for pharmaceuticals on which the CRM has given a negative opinion - solely on the basis of a reasoned proposal from the Minister of Social Affairs;
- In application of Article 1 of the Royal Decree no. 20 of 13 May 2020 on temporary measures in the fight against the COVID-19 pandemic and to ensure the continuity of care in the compulsory healthcare insurance (published in the Belgian Official Gazette on 19 May 2020), the calendars that determine the timeframes for the implementation of the procedures in order to modify the list of reimbursable pharmaceuticals, were suspended as from 13 March 2020. This measure was abolished by Article 1 (3) of the Royal Decree of 28 December 2020 abolishing certain temporary measures of the Royal Decree

no. 20 of 13 May 2020 containing temporary measures in the fight against the COVID-19 pandemic and to ensure the continuity of care in the compulsory healthcare insurance, and of the Royal Decree no. 21 of 14 May 2020 temporarily adapting the reimbursement conditions and administrative rules in the compulsory healthcare insurance as a result of the COVID-19 pandemic, and the calendars resumed on 1 April 2021.

2. Specific elements for this analysis

- The data reported come from the administrative database used by the secretariat of the Commission for Reimbursement of Medicines for the permanent monitoring of procedures and deadlines. For the analysis of the number of dossiers, we considered all the data on dossiers submitted between 1 January 2003 and 31 December 2020.
- For this analysis, we take account only of unique dossiers. This means that, in the case of simultaneous requests lodged for various dosages/packages of pharmaceuticals, the dossiers are taken together if the company responsible, the type of dossier, the day '0' (day of the request), active ingredient, Commission proposal and the ministerial decision are all identical.
- This analysis does not differentiate between first requests and renewed requests (limited number), i.e. any 'unique' dossier is regarded in the analysis as a 'new dossier'.
- The analyses do not take account of dossiers dealt with purely at an administrative level, i.e. without the involvement of the Commission, where the procedure is limited to 60 days.

The number of dossiers submitted in 2019 and 2020 via the CRM procedure (Royal Decree of 21 December 2001 concerning the procedures, terms and conditions for contribution by mandatory insurance for healthcare and benefits towards costs of pharmaceuticals and the Royal Decree of 1 February 2018 concerning the procedures, terms and conditions for contribution by mandatory insurance for healthcare and benefits towards costs of pharmaceuticals) is lower than the average number of dossiers submitted every year during the last 10 years, with considerable differences between the types of request (see Figure 30). In 2017, the number of dossiers submitted was higher than the average number of dossiers submitted each year for the last 10 years. In 2017, there was an increase in the overall number of dossiers submitted compared to 2016, largely due to a steep increase in the number of class 1 dossiers submitted, but also to an increased number of dossiers to amend the reimbursement conditions (procedures launched by a firm or by the CRM itself). In 2018, we can see that the number of dossiers submitted reached the level of 2012, and that the fall continues in 2019. The fall in numbers observed in 2019 compared to 2018 is largely due to a reduction in the number of class 2 dossiers submitted, but also to a steep fall in the number of dossiers asking to amend the reimbursement (procedures started by a company or by the CRM itself). In 2020, an increase in the overall number of dossiers submitted has been observed compared to 2019. This is mainly due to an increase in the number of dossiers submitted in class 1, an increase in the number of dossiers for admission to the reimbursement of pharmaceuticals subject to parallel import/distribution as well as an increase in the number of dossiers with a request for an increase in the reimbursement base.

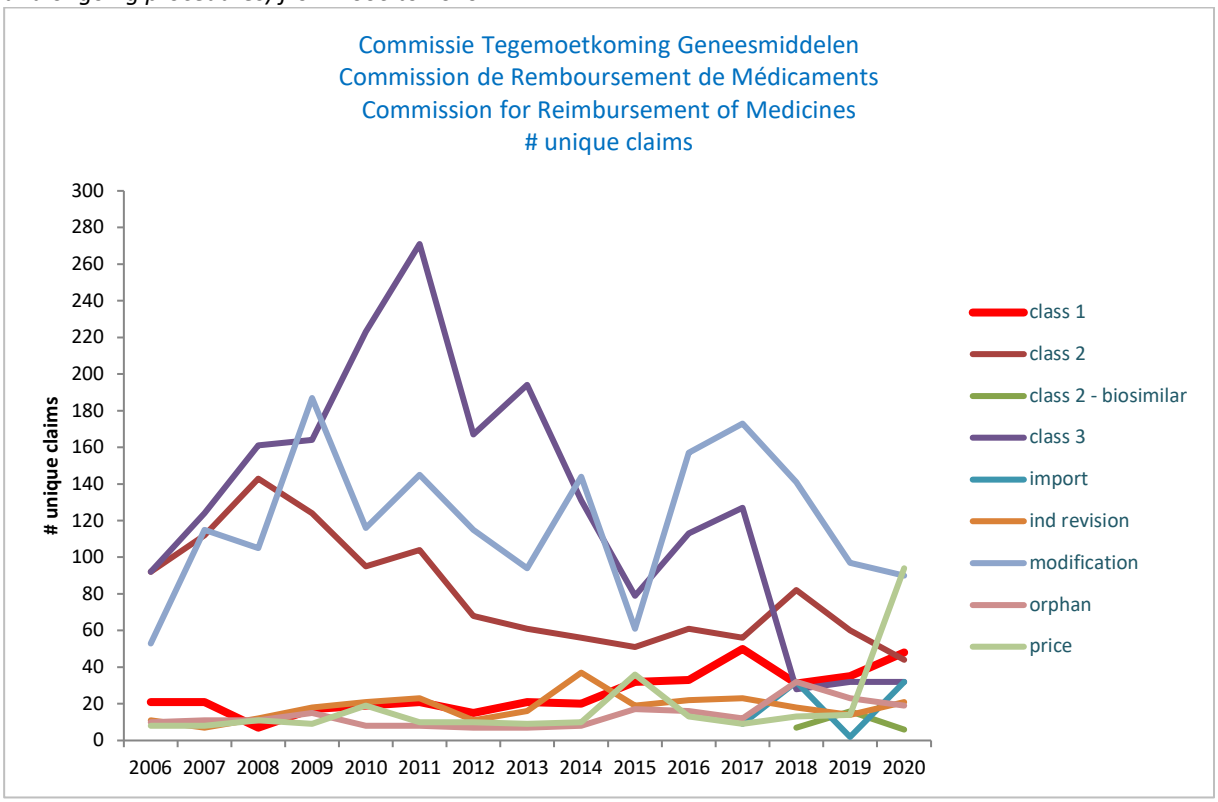
It should be noted that:

- After reaching a low point in 2008, the number of class 1 requests has grown since 2009 to 50 requests in 2017, 31 in 2018, 38 in 2019 and 48 demandes in 2020.
- The number of orphan drug requests is considerably higher in 2018 and 2019 than the numbers observed since 2010: between 2010 and 2014 there were 7 or 8 orphan drug requests per year, while in 2015, 2016 and 2017, there were 17,16 and 12 respectively, then 32 in 2018 and 23 in 2019. In 2020, there were 19 applications for orphan drugs.
- The number of applications in class 2 has remained fairly stable in recent years (51 applications in 2015, 61 in 2016, 56 in 2017, 82 in 2018 and 60 in 2019). This number is significantly lower in 2020 (44 applications in 2020).
- The number of class 3 requests – non-administrative procedure – has reached in 2018 its lowest point since entry into force of the Royal Decree concerning the procedures, terms and conditions for contribution by mandatory insurance for healthcare and benefits towards costs of pharmaceuticals (79 requests in 2015, 113 in 2016, 127 in 2017, 28 in 2018, 32 in 2019 and 32 in 2020).
- The high number of requests to amend the reimbursement arrangements is striking in certain years, particularly in 2007, 2009, 2011, 2014, 2016 and 2017; these requests may ask for an extension of indications as well as more technical corrections. So pay attention: the figures for the second half of 2007 cover all amendments for simvastatin, with a move from category C to category B. Similarly, in 2009, there were many pricing changes for a large number of dossiers (contrast agents), administrative simplifications (transfer of sartans and ACE inhibitors to chapter I – reformulation of the reimbursement conditions to achieve greater consistency for the EPOs). In 2011, at the initiative of the CRM, the reimbursement conditions were changed for many dossiers (medicines used to treat Parkinson's disease, pharmaceuticals based on paclitaxel, etc.), and also in 2014 (docetaxel-based pharmaceuticals, oxaliplatin, anastrozole, etc.), in 2016 (pharmaceuticals based on gemcitabine, irinotecan, growth hormones, etc.), and in 2017 (pharmaceuticals based on COX-2 selective nonsteroidal anti-inflammatory drugs, piroxicam-based pharmaceuticals, aliskiren-based pharmaceuticals, etc.).

The following were NOT added to the data:

- for 2010, 228 completed 'class 3 – administrative procedure' dossiers, nor 898 'Article 97 procedures - administrative proposals for amendments/corrections to the list';
- for 2011, 231 completed 'class 3 – administrative procedure' dossiers nor 201 'Article 97 procedures - administrative proposals for amendments/corrections to the list';
- for 2012, 214 completed 'class 3 – administrative procedure' dossiers nor 114 'Article 97 procedures - administrative proposals for amendments/corrections to the list';
- for 2013, 246 completed 'class 3 – administrative procedure' dossiers nor 373 'Article 97 procedures - administrative proposals for amendments/corrections to the list';
- for 2014, 142 completed 'class 3 – administrative procedure' dossiers nor 227 'Article 97 procedures - administrative proposals for amendments/corrections to the list';
- for 2015, 146 completed 'class 3 – administrative procedure' dossiers nor 264 'Article 97 procedures - administrative proposals for amendments/corrections to the list';
- for 2016, 109 completed 'class 3 – administrative procedure' dossiers, 55 completed 'parallel import - administrative procedure' dossiers nor 188 'Article 97 procedures - administrative proposals for amendments/corrections to the list';
- for 2017, 132 completed 'class 3 – administrative procedure' dossiers, 84 completed 'parallel import - administrative procedure' dossiers nor 344 'Article 97 procedures - administrative proposals for amendments/corrections to the list';
- for 2018, 112 completed 'class 3 – administrative procedure' dossiers, 53 completed 'parallel import - administrative procedure' dossiers nor 160 'Article 97 procedures/Article 130 - administrative proposals for amendments/corrections to the list';
- for 2019, 187 completed 'class 3/classe 2 – administrative procedure' dossiers, 22 completed 'parallel import - administrative procedure' dossiers nor 509 'Article 97/article 130 procedures - administrative proposals for amendments/corrections to the list';
- for 2020, 205 completed 'class 3/class 2 - administrative procedure' dossiers, 99 completed 'parallel introduction - administrative procedure' dossiers nor 139 'procedures Article 97/Article 130- administrative proposals for amendments/corrections to the list'.

Figure 30: Number of requests per year (unique dossiers – including completed procedures, cancelled requests and ongoing procedures) from 2006 to 2020



The Royal Decree of 21 December 2001 concerning the procedures, terms and conditions for reimbursement by the compulsory healthcare and benefits insurance towards costs of pharmaceuticals, states that the minister's decisions on the requests for reimbursement of new pharmaceuticals must be notified to the applicants within 180 calendar days from the day of submission of the request (day '0'), not counting any suspensions of the procedures. This is also stated in the Royal Decree of 1 February 2018 concerning the procedures, terms and conditions for reimbursement by the compulsory healthcare and benefits insurance towards costs of pharmaceuticals.

The minister decides on the basis of a proposal from the Commission for Reimbursement of Medicines, which must formulate a proposal within 150 days of the request.

The minister must not deviate from the Commission proposal, except for budgetary or social reasons, and may only take this decision him or herself if the Commission has not made a proposal within the 150 days (the company may request a suspension of the procedure at two stages: the evaluation and the proposal stage).

Since 1 July 2014, the Commission may make three types of proposal:

- a positive proposal
  or
- a negative proposal
  or
- in some cases, a proposal to launch a procedure under Article 81bis of the Royal Decree of 21 December 2001, whereby the Commission proposes to an applicant the launch of negotiations with a view to concluding a convention with the NIHDI on the temporary placing of a pharmaceutical on the list of reimbursable pharmaceuticals (or for temporary listing of a new therapeutic indication of a pharmaceutical already on the list of reimbursable pharmaceuticals). Since 1 April 2018, this type of proposal has been replaced by a proposal to launch a procedure under Article 112 of the Royal Decree of 1 February 2018. Currently, the CRM may issue such a proposal for applications submitted in class 1, applications submitted in class 2B or class 2C if the reference pharmaceutical is the subject of a contract, orphan medicinal products, applications for reimbursement for pharmaceuticals of which the reference pharmaceutical is the subject of a contract, applications for reimbursement for parallel imported or distributed pharmaceuticals of which the reference pharmaceutical is the subject of a contract, the biosimilar medicinal products of which the reference pharmaceutical is the subject of a contract, the applications for amendment of the reimbursement conditions with regard to the reimbursement of a new indication for which there is a therapeutic or social need, as well as the applications for amendment of the reimbursement conditions with regard to the extension of the reimbursement of an indication already reimbursed for adults to children for a pharmaceutical that is the subject of a contract.

The Commission proposals are adopted with a two-thirds majority – not counting abstentions during the vote. In other words, if there is no two thirds majority among those eligible to vote who have chosen NOT to abstain during the voting, either for a proposal to place a (new) medicine on the list, or NOT to place it on the list, then the Commission is deemed NOT to have made a proposal. Any member eligible to vote but who has declared a conflict of interest concerning the dossier, must not vote even though he/she is generally entitled to vote in the CRM.

Table 35 shows the frequency, in 2015-2019, of negative, positive or so-called 'Article 81bis proposals' by the Commission, for the various types of request. It also shows how often there is no two-thirds majority in favour of a proposal of these types. Annex 1 to this report contain detailed data on the various years.

It is clear that for class 1 applications and applications concerning the admission to the reimbursement of parallel imported or distributed pharmaceuticals, reaching a two-thirds majority for a proposal is more rare (there's no proposal from the Commission for 18% of class 1 applications and 50% of applications concerning the admission to the reimbursement of parallel imported or distributed pharmaceuticals).

Table 35: Number of unique requests for inclusion in the list of reimbursable pharmaceuticals versus proposals by the Commission for Reimbursement of Medicines (2016-2020)

2016-2020									
	Positive		rt.81 bis/art. 112		negative		no proposition		total
	number	%	number	%	number	%	number	%	number
class 1	27	18	75	51	19	13	26	18	147
class 2	163	72	14	6	31	14	19	8	227
class 2 – biosim	25	100	-	-	-	-	-	-	25
class 3	170	67	-	-	62	25	20	8	252
orphan	10	14	44	62	11	15	6	8	71
parallel import long	2	4	16	30	9	17	27	50	54
modification	346	73	54	11	51	11	24	5	475
Individual revision	44	53	-	-	33	40	6	7	83
price increase	98	86	-	-	6	5	10	9	114
suppression	13	59	-	-	9	41	-	-	22
exception	9	75	-	-	2	17	1	8	12
Total	**907**	**61**	**203**	**14**	**233**	**16**	**139**	**9**	**1482**

Table 36 shows, for the period 2016-2020, and for the various types of request, the frequency of positive proposals, proposals to launch a procedure under Article 81bis of the Royal Decree of 21 December 2001 or under Article 112 of the Royal Decree of 1 February 2018, or negative proposals followed by the Minister. For cases where the Commission did not make a proposal, we investigate how often the Minister took postive or negative decisions. Annex 1 to this report also contain detailed data on the individual years.

Table 36: Ministerial decisions based on the CRM proposal (2016-2020)

2016-2020							
	positive decision Min		negative decision Min		no decision Min (pos)		**total**
CTG CRM proposal	number	%	number	%	number	%	**number**
class 1	**109**	74.1	**38**	25.9	**0**	0.0	**147**
pos	26	96.3	1	3.7	0	0.0	27
neg	4	21.1	15	78.9	0	0.0	19
no proposition	16	61,5	10	38.5	0	0.0	26
art. 81bis/112	63	84.0	12	16.0	0	0.0	75
class 2	**208**	91,6	**18**	7.9	**1**	0.4	**227**
pos	163	100.0	0	0.0	0	0.0	163
neg	18	58.1	12	38.7	1	3.2	31
no proposition	17	89.5	2	10.5	0	0.0	19
art. 81bis/112	10	71.4	4	28.6	0	0.0	14
class 2 - biosim	**25**	100.0	**0**	0.0	0	0.0	**25**
pos	25	100.0	0	0.0	0	0.0	25
class 3	**227**	90.1	**18**	7.1	**7**	2.8	**252**
pos	169	99.4	0	0.0	1	0.6	170
neg	41	66.1	18	29.0	3	4.8	62
no proposition	17	85.0	0	0.0	3	15.0	20
parallel import Long	**2**	3,7	**52**	96.3	**0**	0.0	**54**
pos	2	100.0	0	0.0	0	0.0	2
neg	0	0.0	9	100.0	0	0.0	9
no proposition	0	0.0	27	100.0	0	0.0	27
art. 81bis/112	0	0.0	16	100.0	0	0.0	16
modification	**404**	85.1	**64**	13.5	**7**	1.5	**475**
pos	343	99.1	1	0.3	2	0.6	346
neg	8	15.7	41	80.4	2	3.9	51
no proposition	16	66.7	6	25.0	2	8.3	24
art. 81bis/112	37	68.5	16	29.6	1	1.9	54
orphan	**48**	67.6	**23**	32.4	**0**	0.0	**71**
pos	10	100.0	0	0.0	0	0.0	10
neg	2	18.2	9	81.8	0	0.0	11
no proposition	4	66.7	2	33.3	0	0.0	6
art. 81bis/112	32	72.7	12	27.3	0	0.0	44
ind revision	**48**	57.8	**35**	42.2	**0**	0.0	**83**
pos	44	100.0	0	0.0	0	0.0	44
neg	1	3.0	32	97.0	0	0.0	33
no proposition	3	50.0	3	50.0	0	0.0	6

price	**107**	93.9	**7**	6.1	**0**	0.0	**114**
pos	98	100.0	0	0.0	0	0.0	98
neg	1	16.7	5	83.3	0	0.0	6
no proposition	8	80.0	2	20.0	0	0.0	10
suppression	**12**	57.1	**6**	28.6	**3**	14.3	**21**
pos	11	84.6	0	0.0	2	15.4	13
neg	1	12.5	6	75.0	1	12.5	8
exception	**11**	91.7	**1**	8.3	**0**	0.0	**12**
pos	9	100.0	0	0.0	0	0.0	9
neg	1	50.0	1	50.0	0	0.0	2
no proposition	1	100.0	0	0.0	0	0.0	1
total	**1201**	81.1	**262**	17.7	**18**	1.2	**1481**

This table shows that in most cases, the Minister follows the Commission's proposals.

The Minister's decision is positive in more than 65% of the cases on which the Commission has not formulated a proposal (in 6.3% of all types of dossier).

For requests submitted in class 1, in 4 cases the Minister overruled a negative proposal from the Commission (i.e. in 20% of class 1 dossiers on which a negative proposal was formulated).

For requests regarding the listing of an orphan medicinal product, in 2 cases the Minister overruled a negative proposal from the Commission (i.e. in 18.2% of cases where a negative proposal was made regarding the listing of an orphan medinal product).

ANNEX 1. CRM ACTIVITY. OVERVIEW OF THE RESULTS OF PROCEDURES (RD 21.12.2001/ RD 1.2.2018) CONCERNING REQUESTS TO AMEND THE LIST OF REIMBURSABLE PHARMACEUTICALS 2016-2020

CRM PROPOSALS PER TYPE OF REQUEST

Table 37: Number of unique requests for inclusion in the list of reimbursable pharmaceuticals versus proposals of the Commission for Reimbursement of Medicines (2016)

2016									
	Positive		art.81 bis/art. 112		negative		no proposition		total
	number	%	number	%	number	%	number	%	number
class 1	8	27	15	50	1	3	6	20	30
class 2	33	73	-	-	5	11	7	16	45
class 2 – biosim	1	100	-	-	-	-	-	-	1
class 3	68	65	-	-	21	20	15	14	104
orphan	3	21	6	43	3	21	2	14	14
parallel import long	-	-	-	-	-	-	-	-	-
modification	72	70	15	15	9	9	7	7	103
Individual revision	15	79	-	-	2	11	2	11	19
price increase	9	82	-	-	2	18	-	-	11
suppression	-	-	-	-	-	-	-	-	-
exception	-	-	-	-	-	-	-	-	-
Total	**209**	**64**	**36**	**11**	**41**	**13**	**41**	**13**	**327**

Table 38: Number of unique requests for inclusion in the list of reimbursable pharmaceuticals versus proposals of the Commission for Reimbursement of Medicines (2017)

2017									
	Positive		art.81 bis/art. 112		negative		no proposition		total
	number	%	number	%	number	%	number	%	number
class 1	8	20	18	44	10	24	5	12	41
class 2	31	67	-	-	8	17	7	15	46
class 2 – biosim	-	-	-	-	-	-	-	-	-
class 3	55	63	-	-	29	33	3	3	87
orphan	2	20	6	60	1	10	1	10	10
parallel import long	-	-	-	-	8	89	1	11	9
modification	63	66	8	8	19	20	5	5	95
Individual revision	8	42	-	-	8	42	3	16	19
price increase	4	50	-	-	-	-	5	50	8
suppression	-	-	-	-	-	-	-	-	-
exception	2	40	-	-	2	40	1	20	5
Total	**173**	**54**	**32**	**10**	**85**	**27**	**30**	**9**	**320**

Table 39: Number of unique requests for inclusion in the list of reimbursable pharmaceuticals versus proposals of the Commission for Reimbursement of Medicines (2018)

2018									
	Positive		art.81 bis/art. 112		negative		no proposition		total
	number	%	number	%	number	%	number	%	number
class 1	1	5	9	41	5	23	7	32	22
class 2	44	72	5	8	8	13	4	7	61
class 2 – biosim	6	100	-	-	-	-	-	-	6
class 3	13	68	-	-	6	32	-	-	19
orphan	2	9	14	61	5	22	2	9	23
parallel import long	1	4	-	-	-	-	24	96	25
modification	93	73	18	14	13	10	4	3	128
Individual revision	9	50	-	-	8	44	1	6	18
price increase	10	91	-	-	-	-	1	9	11
suppression	2	67	-	-	1	33	-	-	3
exception	2	100	-	-	-	-	-	-	2
Total	**183**	**58**	**46**	**14**	**46**	**14**	**43**	**14**	**318**

Table 40: Number of unique requests for inclusion in the list of reimbursable pharmaceuticals versus proposals of the Commission for Reimbursement of Medicines (2019)

2019									
	Positive		art.81 bis/art. 112		negative		no proposition		total
	number	%	number	%	number	%	number	%	number
class 1	5	16	20	63	1	3	6	19	32
class 2	34	71	4	8	9	19	1	2	48
class 2 – biosim	13	100	-	-	-	-	-	-	13
class 3	16	73	-	-	4	18	2	9	22
orphan	2	13	12	80	1	7	-	-	15
parallel import long	-	-	-	-	1	50	1	50	2
modification	67	77	7	8	7	8	6	7	87
Individual revision	6	43	-	-	8	57	-	-	14
price increase	8	73	-	-	2	18	1	9	11
suppression	-	-	-	-	2	100	-	-	2
exception	5	100	-	-	-	-	-	-	5
Total	**156**	**62**	**43**	**17**	**35**	**14**	**17**	**7**	**251**

Table 41: Number of unique requests for inclusion in the list of reimbursable pharmaceuticals versus proposals of the Commission for Reimbursement of Medicines (2020)

2020									
	Positive		art.81 bis/art. 112		negative		no proposition		total
	number	%	number	%	number	%	number	%	number
class 1	10	19	15	33	3	6	8	15	54
class 2	55	73	9	12	10	13	1	1	75
class 2 – biosim	18	100	-	-	-	-	-	-	18
class 3	34	81	-	-	6	14	2	5	42
orphan	3	13	18	75	2	8	1	4	24
parallel import long	1	5	16	80	1	5	2	10	20
modification	118	79	13	9	10	7	8	5	149
Individual revision	12	44	-	-	15	56	-	-	27
price increase	75	89	-	-	6	7	3	4	84
suppression	11	58	-	-	8	42	-	-	19
exception	5	100	-	-	-	-	-	-	5
Total	**342**	**66**	**89**	**17**	**61**	**12**	**25**	**5**	**517**

DECISIONS OF THE MINISTER BASED ON THE CRM PROPOSAL

Table 42: Ministerial decisions based on the CRM proposal (unique dossiers 2016)

2016							
	positive decision Min		negative decision Min		no decision Min (pos)		**total**
CTG CRM proposal	number	%	number	%	number	%	**number**
class 1	**27**	90.0	**3**	10.0	**0**	0.0	**30**
pos	8	100.0	0	0.0	0	0.0	8
neg	0	0.0	1	100.0	0	0.0	1
no proposition	5	83.3	1	16.7	0	0.0	6
art. 81bis/112	14	93.3	1	6.7	0	0.0	15
class 2	**40**	88.9	**5**	11.1	**0**	0.0	**45**
pos	33	100.0	0	0.0	0	0.0	33
neg	1	20.0	4	80.0	0	0.0	5
no proposition	6	85.7	1	14.3	0	0.0	7
class 2 biosim	**1**	100.0	**0**	0.0	**0**	0.0	**1**
pos	1	100.0	0	0.0	0	0.0	1
class 3	**97**	93.3	**5**	4.8	**2**	1.9	**104**
pos	68	100.0	0	0.0	0	0.0	68
neg	16	76.2	5	23.8	0	0.0	21
no proposition	13	86.7	0	0.0	2	13.3	15
modification	**94**	91.3	**7**	6.8	**2**	1.9	**103**
pos	71	98.6	0	0.0	1	1.4	72
neg	2	22.2	7	77.8	0	0.0	9
no proposition	6	85.7	0	0.0	1	14.3	7
art. 81bis/112	15	100.0	0	0.0	0	0.0	15
orphan	**10**	71.4	**4**	28.6	**0**	0.0	**14**
pos	3	100.0	0	0.0	0	0.0	3
neg	1	33.3	2	66.7	0	0.0	3
no proposition	1	50.0	1	50.0	0	0.0	2
art. 81bis/112	5	83.3	1	16.7	0	0.0	6
ind revision	**18**	94.7	**1**	5.3	**0**	0.0	**19**
pos	15	100.0	0	0.0	0	0.0	15
neg	1	50.0	1	50.0	0	0.0	2
no proposition	2	100.0	0	0.0	0	0.0	2
price	**11**	100.0	**0**	0.0	**0**	0.0	**11**
pos	9	100.0	0	0.0	0	0.0	9
no proposition	2	100.0	0	0.0	0	0,0	2
total	**298**	91.1	**25**	7.6	**4**	1,2	**327**

Table 43: Ministerial decisions based on the CRM proposal (unique dossiers 2017)

2017							
	positive decision Min		negative decision Min		no decision Min (pos)		**total**
CTG CRM proposal	number	%	number	%	number	%	**number**
class 1	**27**	65.9	**14**	34.1	**0**	0.0	**41**
pos	8	100.0	0	0.0	0	0.0	8
neg	4	40.0	6	60.0	0	0.0	10
no proposition	1	20.0	4	80.0	0	0.0	5
art. 81bis/112	14	77.8	4	22.2	0	0.0	18
class 2	**41**	89.1	**4**	8.7	**1**	2.2	**46**
pos	31	100.0	0	0.0	0	0.0	31
neg	4	50.0	3	37.5	1	12.5	8
no proposition	6	85.7	1	14.3	0	0.0	7
class 3	**77**	88.5	**6**	6.9	**4**	4.6	**87**
pos	55	100.0	0	0.0	0	0.0	55
neg	20	69.0	6	20.7	3	10.3	29
no proposition	2	66.7	0	0.0	1	33.3	3
parallel import Long	**0**	0.0	**9**	100.0	**0**	0.0	**9**
neg	0	0.0	8	100.0	0	0.0	8
no proposition	0	0.0	1	100.0	0	0.0	1
modification	**72**	75.8	**19**	20.0	**4**	4.2	**95**
pos	61	96.8	1	1.6	1	1.6	63
neg	1	5.3	16	84.2	2	10.5	19
no proposition	4	80.0	1	20.0	0	0.0	5
art. 81bis/112	6	75.0	1	12.5	1	12.5	8
orphan	**9**	90.0	**1**	10.0	**0**	0.0	**10**
pos	2	100.0	0	0.0	0	0.0	2
neg	0	0.0	1	100.0	0	0.0	1
no proposition	1	100.0	0	0.0	0	0.0	1
art. 81bis/112	6	100.0	0	0.0	0	0.0	6
ind revision	**9**	47.4	**10**	52.6	**0**	0.0	**19**
pos	8	100.0	0	0.0	0	0.0	8
neg	0	0.0	8	100.0	0	0.0	8
no proposition	1	33.3	2	66.7	0	0.0	3
price	**6**	75.0	**2**	25.0	**0**	0.0	**8**
pos	4	100.0	0	0.0	0	0.0	4
no proposition	2	50.0	2	50.0	0	0.0	4
exception	**4**	80.0	**1**	20.0	**0**	0.0	**5**

pos	2	100.0	0	0.0	0	0.0	2
neg	1	50.0	1	50.0	0	0.0	2
no proposition	1	100.0	0	0.0	0	0.0	1
total	**245**	76.6	**66**	20.6	**9**	2.8	**320**

Table 44: Ministerial decisions based on the CRM proposal (unique dossiers 2018)

2018							
	positive decision Min		negative decision Min		no decision Min (pos)		**total**
CTG CRM proposal	number	%	number	%	number	%	**number**
class 1	**7**	31.8	**15**	68.2	**0**	0.0	**22**
pos	1	100.0	0	0.0	0	0.0	1
neg	0	0.0	5	100.0	0	0.0	5
no proposition	3	42.9	4	57.1	0	0.0	7
art. 81bis/112	3	33.3	6	66.7	0	0.0	9
class 2	**55**	90.2	**6**	9.8	**0**	0.0	**61**
pos	44	100.0	0	0.0	0	0.0	44
neg	6	75.0	2	25.0	0	0.0	8
no proposition	4	100.0	0	0.0	0	0.0	4
art. 81bis/112	1	20.0	4	80.0	0	0.0	5
class 2 - biosim	**6**	100.0	**0**	0.0	**0**	0.0	**6**
pos	6	100.0	0	0.0	0	0.0	6
class 3	**14**	73.7	**4**	21.1	**1**	5.3	**19**
pos	12	92.3	0	0.0	1	7.7	13
neg	2	33.3	4	66.7	0	0.0	6
parallel import Long	**1**	4.0	**24**	96.0	**0**	0.0	**25**
pos	1	100.0	0	0.0	0	0.0	1
no proposition	0	0.0	24	100.0	0	0.0	24
modification	**99**	77.3	**28**	21.9	**1**	0.8	**128**
pos	93	100.0	0	0.0	0	0.0	93
neg	2	15.4	11	84.6	0	0.0	13
no proposition	0	0.0	3	75.0	1	25.0	4
art. 81bis/112	4	22.2	14	77.8	0	0.0	18
orphan	**7**	30.4	**16**	69.6	**0**	0.0	**23**
pos	2	100.0	0	0.0	0	0.0	2
neg	0	0.0	5	100.0	0	0.0	5
no proposition	1	50.0	1	50.0	0	0.0	2
art. 81bis/112	4	28.6	10	71.4	0	0.0	14
ind revision	**9**	50.0	**9**	50.0	**0**	0.0	**18**
pos	9	100.0	0	0.0	0	0.0	9
neg	0	0.0	8	100.0	0	0.0	8
no proposition	0	0.0	1	100.0	0	0.0	1
price	**11**	100.0	**0**	0.0	**0**	0.0	**11**
pos	10	100.0	0	0.0	0	0.0	10
no proposition	1	100.0	0	0.0	0	0.0	1

suppression	**0**	0.0	**0**	0.0	**3**	100.0	**3**
pos	0	0.0	0	0.0	2	100.0	2
neg	0	0.0	0	0.0	1	100.0	1
exception	**2**	100.0	**0**	0.0	**0**	0.0	**2**
pos	2	100.0	0	0.0	0	0.0	2
total	**211**	66.4	**102**	32.1	**5**	1.6	**318**

Table 45: Ministerial decisions based on the CRM proposal (unique dossiers 2019)

2019					
	positive decision Min		negative decision Min		**total**
CTG CRM proposal	number	%	number	%	**number**
class 1	**30**	93.8	**2**	6.3	**32**
pos	5	100.0	0	0.0	5
neg	0	0.0	1	100.0	1
no proposition	5	83.3	1	16.7	6
art. 81bis/112	20	100.0	0	0.0	20
class 2	**46**	95.8	**2**	4.2	**48**
pos	34	100.0	0	0.0	34
neg	7	77.8	2	22.2	9
no proposition	1	100.0	0	0.0	1
art. 81bis/112	4	100.0	0	0.0	4
class 2 - biosim	**13**	100.0	**0**	0.0	**13**
pos	13	100.0	0	0.0	13
class 3	**19**	86.4	**3**	13.6	**22**
pos	16	100.0	0	0.0	16
neg	1	25.0	3	75.0	4
no proposition	2		0	0.0	2
parallel import Long	**0**	0.0	**2**	100.0	**2**
neg	0	0.0	1	100.0	1
no proposition	0	0.0	1	100.0	1
modification	**80**	92.0	**7**	8.0	**87**
pos	67	100.0	0	0.0	67
neg	3	42.9	4	57.1	7
no proposition	4	66.7	2	33.3	6
art. 81bis/112	6	85.7	1	14.3	7
orphan	**15**	100.0	**0**	0.0	**15**
pos	2	100.0	0	0.0	2
neg	1	100.0	0	0.0	1
art. 81bis/112	12	100.0	0	0.0	12
ind revision	**6**	42.9	**8**	57.1	**14**
pos	6	100.0	0	0.0	6
neg	0	0.0	8	100.0	8
price	**9**	81.8	**2**	18.2	**11**
pos	8	100.0	0	0.0	8
neg	0	0.0	2		2
no proposition	1	100.0	0	0.0	1
suppression	**0**	0.0	**1**	100.0	**1**
neg	0	0.0	1	100.0	1
exception	**5**	100.0	**0**	0.0	**5**
pos	5	100.0	0	0.0	5
total	**223**	89.2	**27**	10.8	**250**

Table 46: Ministerial decisions based on the CRM proposal (unique dossiers 2020)

2020					
	positive decision Min		negative decision Min		**total**
CTG CRM proposal	number	%	number	%	**number**
class 1	**18**	81.8	**4**	18.2	**22**
pos	4	80.0	1	20.0	5
neg	0	0.0	2	100.0	2
no proposition	2	100.0	0	0.0	2
art. 81bis/112	12	92.3	1	7.7	13
class 2	**26**	96.3	**1**	3.7	**27**
pos	21	100.0	0	0.0	21
neg	0	0.0	1	100.0	1
art. 81bis/112	5	100.0	0	0.0	5
class 2 - biosim	**5**	100.0	**0**	0.0	**5**
pos	5	100.0	0	0.0	5
class 3	**20**	100.0	**0**	0.0	**20**
pos	18	100.0	0	0.0	18
neg	2	100.0	0	0.0	2
parallel import Long	**1**	5.6	**17**	94.4	**18**
pos	1		0	0.0	1
no proposition	0	0.0	1	100.0	1
art. 81bis/112	0	0.0	16	100.0	16
modification	**59**	95.2	**3**	4.8	**62**
pos	51	100.0	0	0.0	51
neg	0	0.0	3	100.0	3
no proposition	2	100.0	0	0.0	2
art. 81bis/112	6	100.0	0	0.0	6
orphan	**7**	77.8	**2**	22.2	**9**
pos	1	100.0	0	0.0	1
neg	0	0.0	1	100.0	1
no proposition	1		0	0.0	1
art. 81bis/112	5	83.3	1	16.7	6
ind revision	**6**	46.2	**7**	53.8	**13**
pos	6	100.0	0	0.0	6
neg	0	0.0	7	100.0	7
price	**70**	95.9	**3**	4.1	**73**
pos	67	100.0	0	0.0	67
neg	1	25.0	3		4
no proposition	2	100.0	0	0.0	2
suppression	**12**	70.6	**5**	29.4	**17**
pos	11	100.0	0	0.0	11
neg	1	16.7	5	83.3	6
total	**224**	84.2	**42**	15.8	**266**

ANNEX 2. SAVING MEASURES 2020

Saving measures 2020

Implementation of measures with regard to old medicines / biological medicines

- **1.1.2020:**
  - Molecules 12 years
    - Bexarotene
    - Nabumetone
  - Molecules 15 years
    - Agalsidase beta
    - Methylphenidate
- **1.4.2020:**
  - Molecules 12 years
    - Agalsidase alpha
    - Erlotinib
    - Idursulfase
    - Mitotane
    - Posaconazole
  - Molecules 15 years: -
  - Molecules 18 years
    - Coagulation factor VIII, recombinant (octocog alpha) (ADVATE)
- **1.7.2020:**
  - Molecules 12 years
    - Cinacalcet
    - Hexaminolevulinate
    - Nelarabine
  - Biosimilar: -
- **1.10.2020:**
  - Molecules 12 years
    - Clofarabine
    - Dibotermine alpha
    - Mecasermin
    - Natalizumab
  - Biosimilar: -

Application of the reference price system

- **1.1.2020:**
  - Amlodipine + Valsartan + Hydrochlorothiazide
  - Atazanavir
  - Hydrocortisone (exception)
  - Valsartan + Amlodipine

- **1.4.2020:**
  - Pramipexole (SIFROL)

- **1.7.2020:**
  - Entecavir
  - Erlotinib
  - Tacrolimus (end exception)

- **1.10.2020:**
  - Bupropion
  - Mitomycin C
  - Sodium oxybate

MD INDEX (took effect on: 1 January 2020)

The basic fee for pharmacists was indexed on 1 January 2020. The amount increased from €4.33 to €4.37 (excluding VAT).
The margin for the pharmacist was also indexed at 6.54%.
The maximum amounts of the personal share are not indexed.

Group review asthma - COPD (1 April 2020)

Transfer of a large number of pharmaceuticals from chapters II and IV to chapter I
Changes to the reimbursement conditions of §§ 3790000, 8300000, 9410000, 9650000 of chapter IV.
Price drops for certain active ingredients (R03BB04, R03BB05, R03BB06, R03BB07, R03AL03, R03AL04, R03AL05, R03AL06, R03AL08, R03AL09, R03DC03).

Group review trastuzumab (1 May 2020)

Price drop of approximately 11% for certain trastuzumab-based molecules.

Group review Lipefilgrastim (1 May 2020)

Price drop of about 38% for LONQUEX pharmaceuticals.

Cost-saving measure (1 July 2020)

1.

The price drops as part of the measure taken with regard to 'old medicines' after 15 and 18 years are henceforth applied after 12 years of reimbursability.
The reduction percentage after 12 years of reimbursability as part of the measure taken with regard to 'old medicines' increases from 17% to 19.75%.
The reduction percentage after 18 years of reimbursability as part of the measure taken with regard to 'old medicines', specifically biological ones, increases from 15% to 20%.

For pharmaceuticals that were previously already subject to the measure taken with regard to 'old medicines', regularisations were applied (3.31% for medicines with 12 years of reimbursability, 5.88% for 18 years and the application of the price drops 15 years/18 years if they were not yet implemented).

2.

Removal of the safety margin for pharmaceuticals in the reference price system. From now on, only pharmaceuticals belonging to the Fa or Fb category can have a price that differs from their reimbursement base.

Influenza vaccines

Price increase (ex-factory price) to €9.22 (1 August 2020)
A change of category B instead of category Cs and reimbursement extended to people aged 50 to 64 for the 2020-2021 season due to COVID-19 (1 October 2020).

ANNEX 3. GRAPHICAL PRESENTATION OF THE EVOLUTION OF THE EXPENDITURE, THE CONSUMPTION (DDD) AND NUMBER OF PATIENTS TREATED FOR SOME CLASSES OF MEDICINES (PUBLIC PHARMACIES)

Figure 31: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class L04A immunosuppressants

Figure 32: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class L04A immunosuppressants

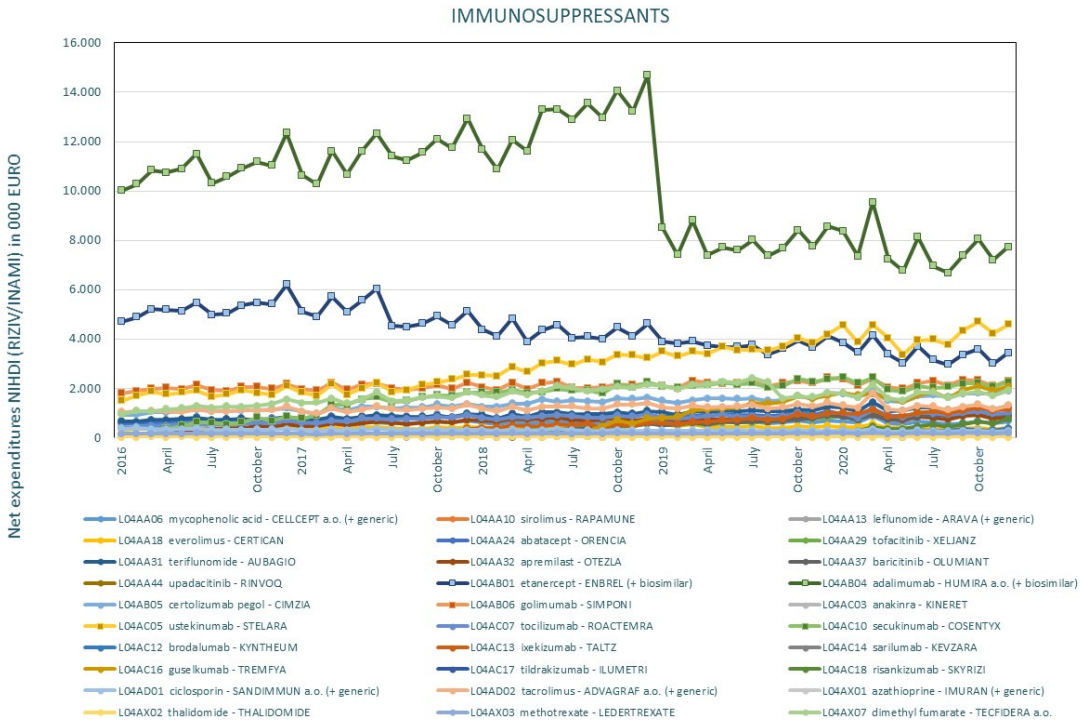


Figure 33: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class L04A immunosuppressants

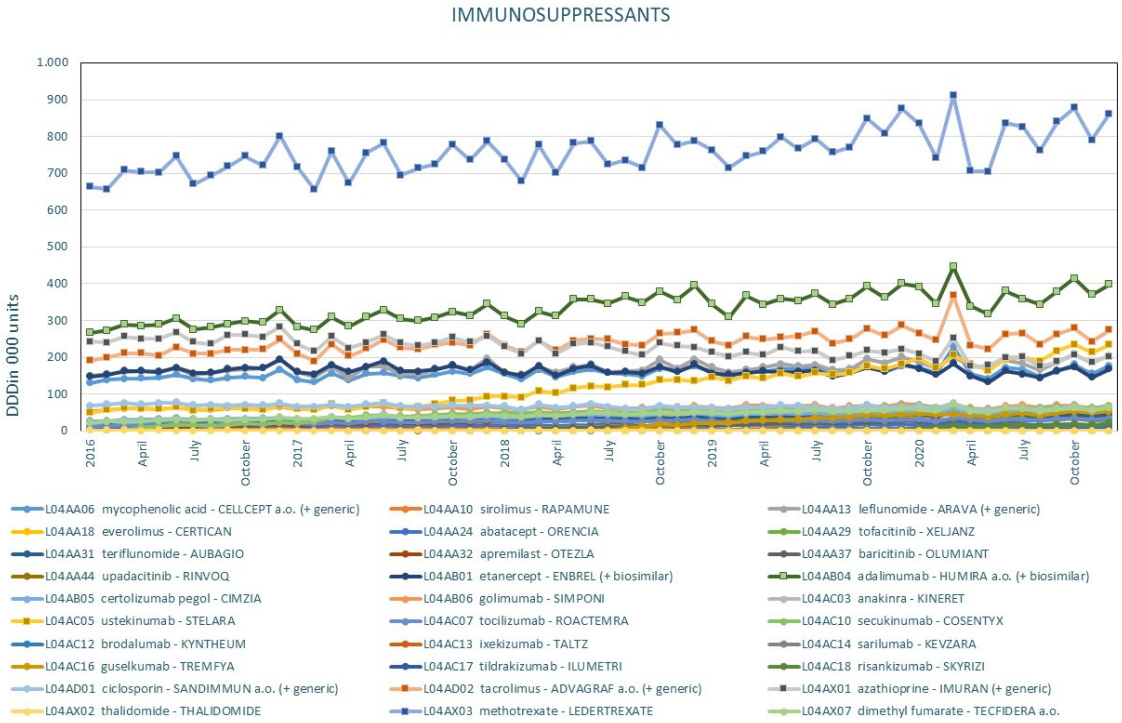


Figure 34: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class L04A immunosuppressants

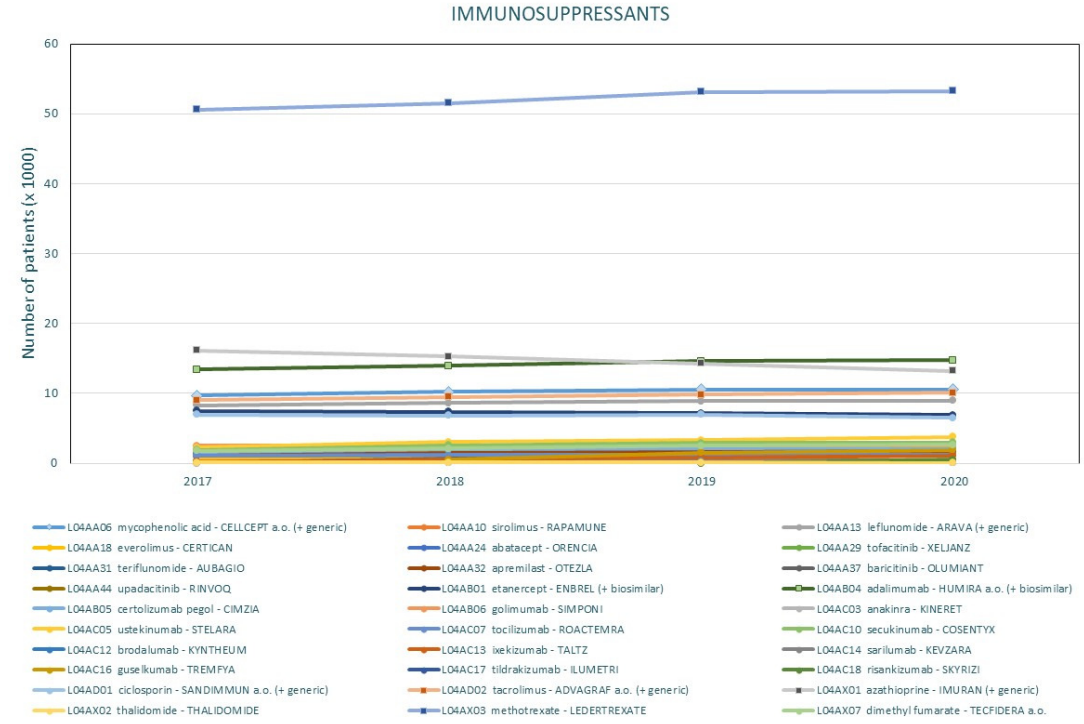


Figure 35: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class L04A immunosuppressants

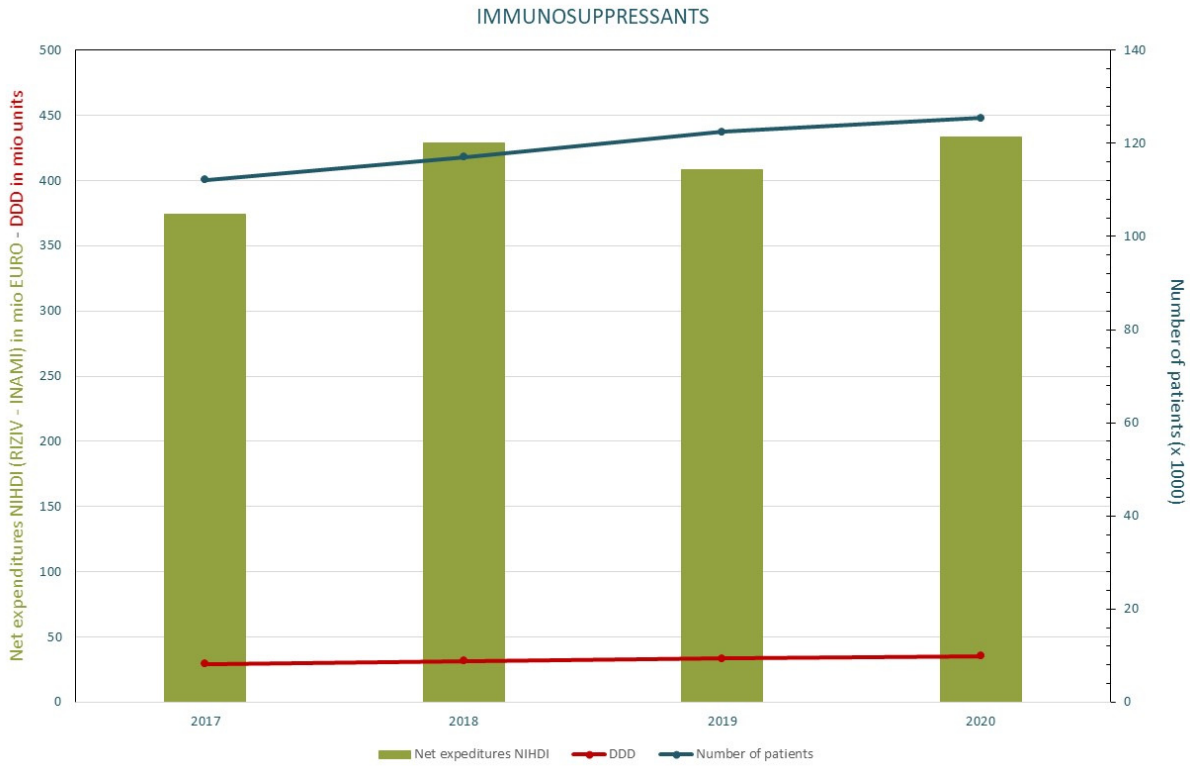


Figure 36: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class B01A antithrombotic agents

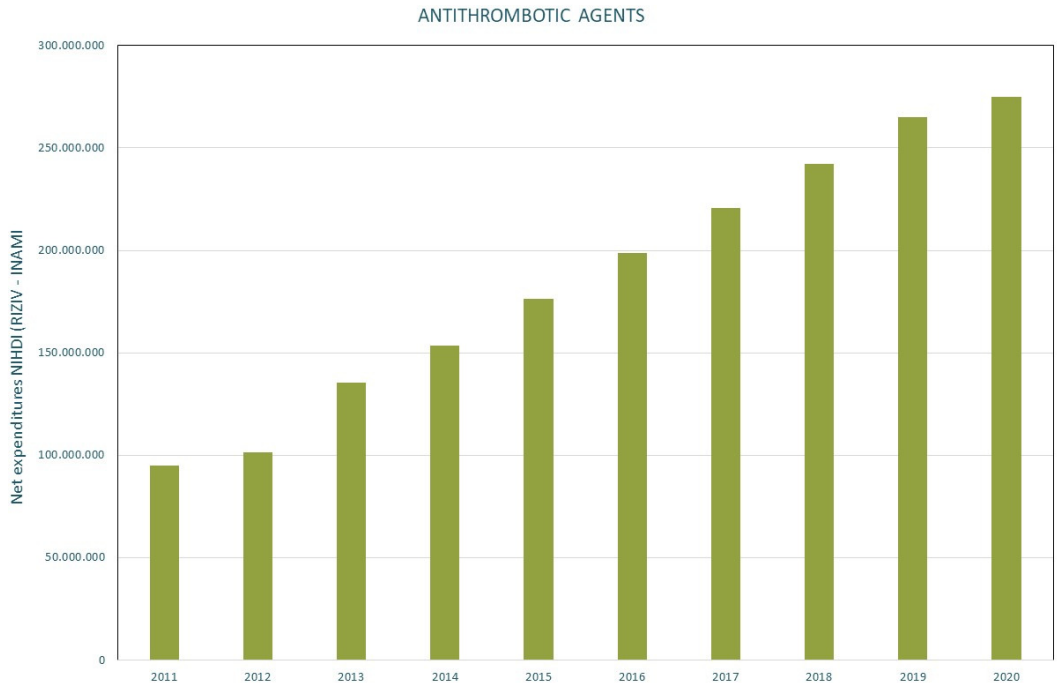


Figure 37: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class B01A antithrombotic agents

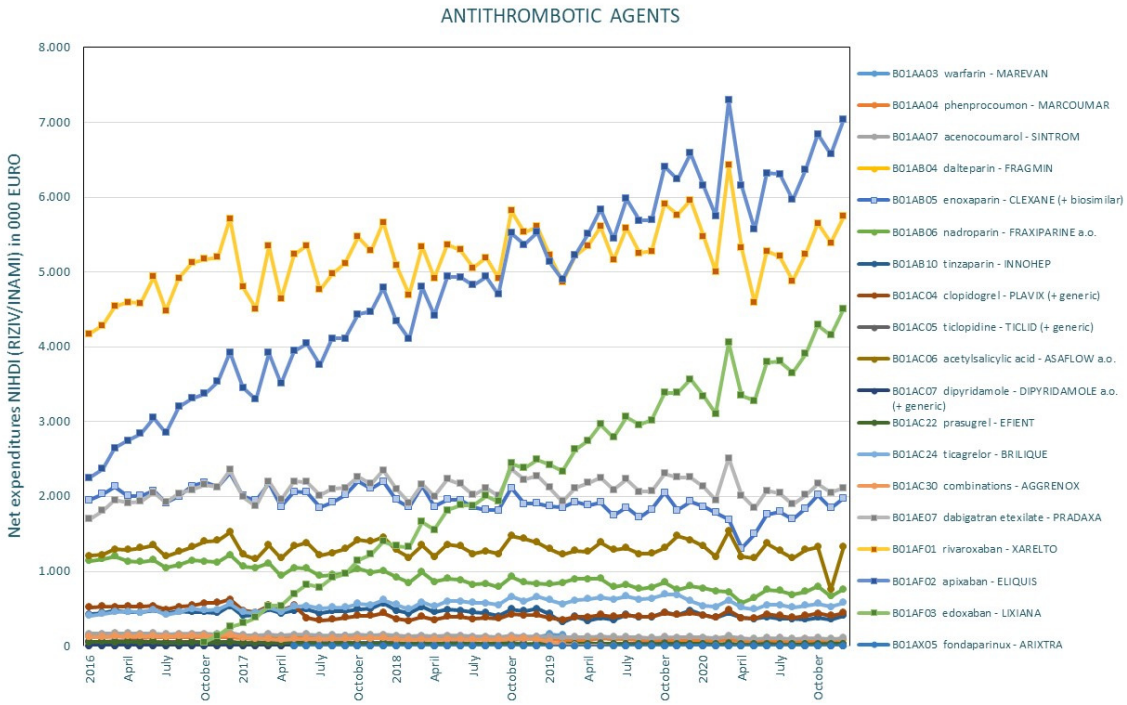


Figure 38: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class B01A antithrombotic agents

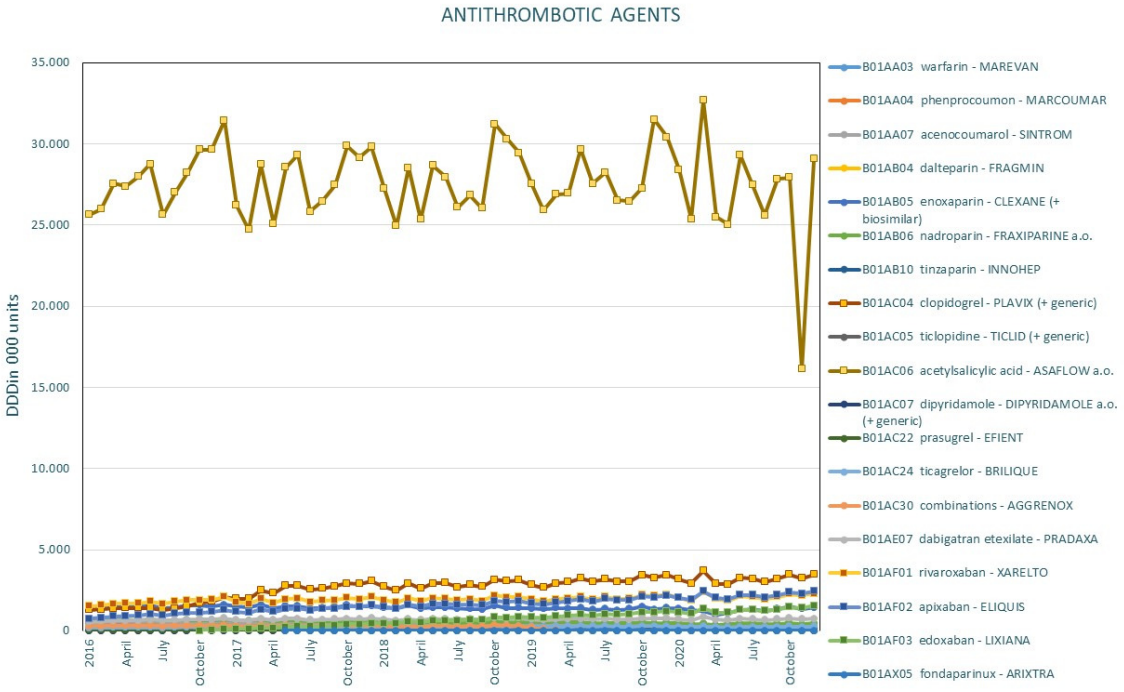


Figure 39: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class B01A antithrombotic agents

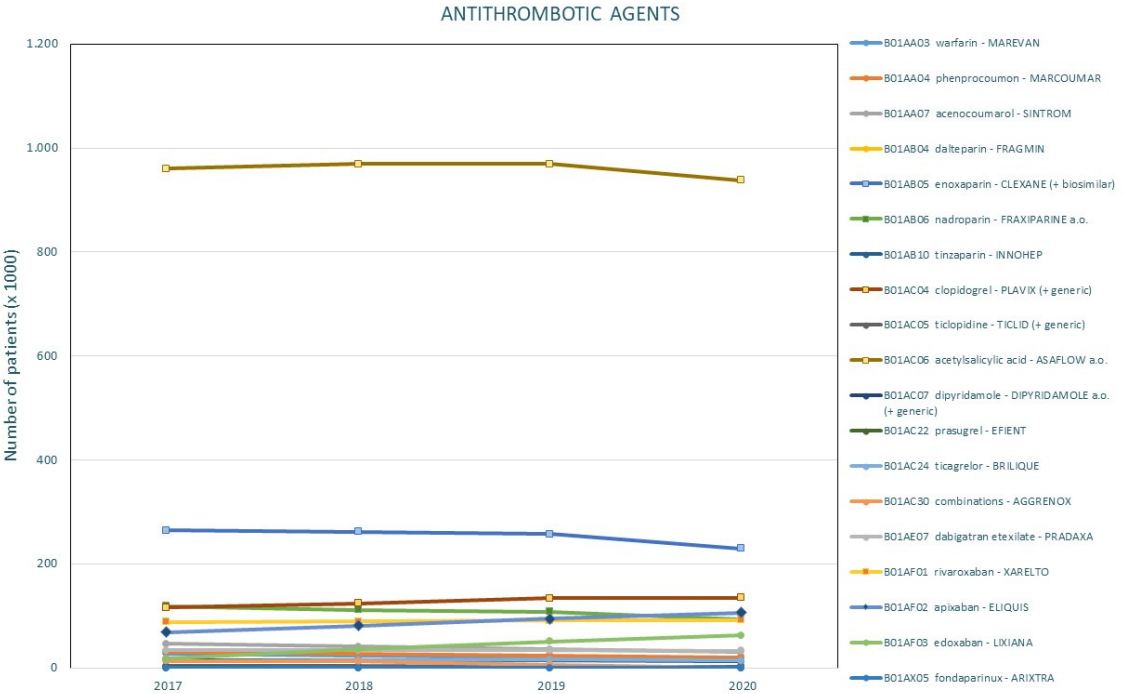
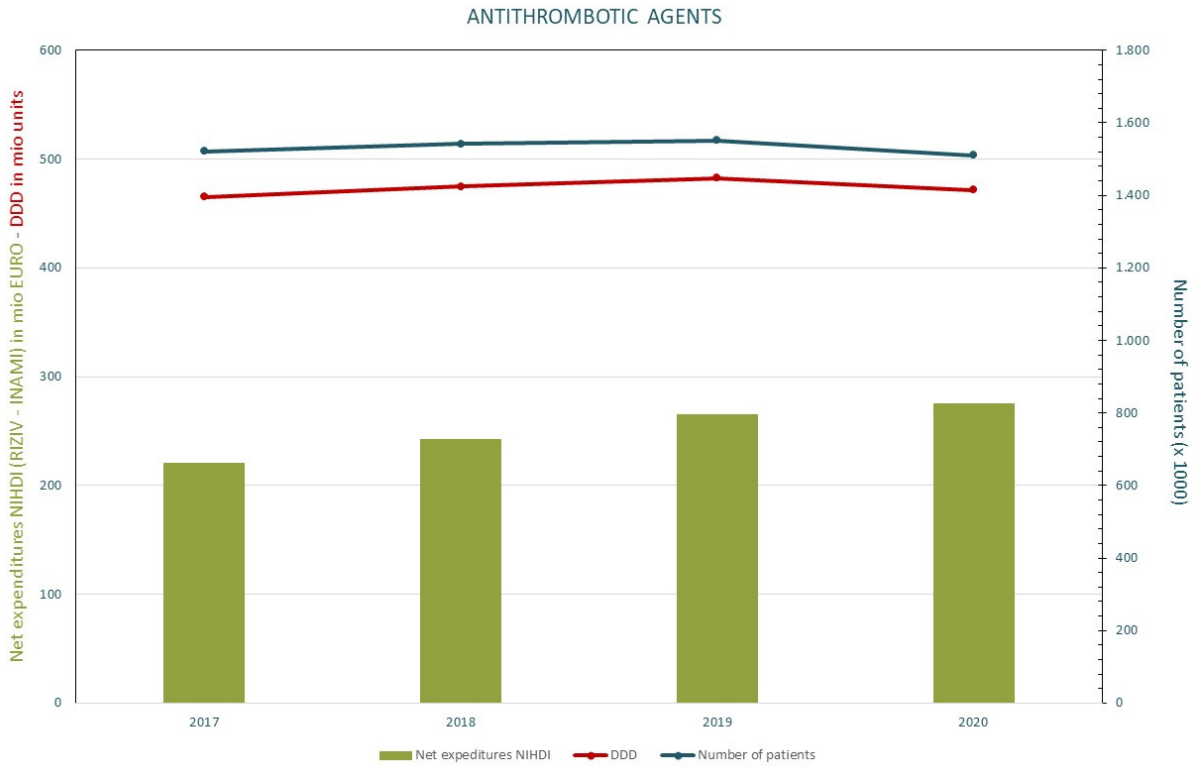


Figure 40: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class B01A antithrombotic agents



A10B – BLOOD GLUCOSE LOWERING DRUGS, EXCLUDING INSULINS

Figure 41: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class A10B blood glucose lowering drugs, excluding insulins

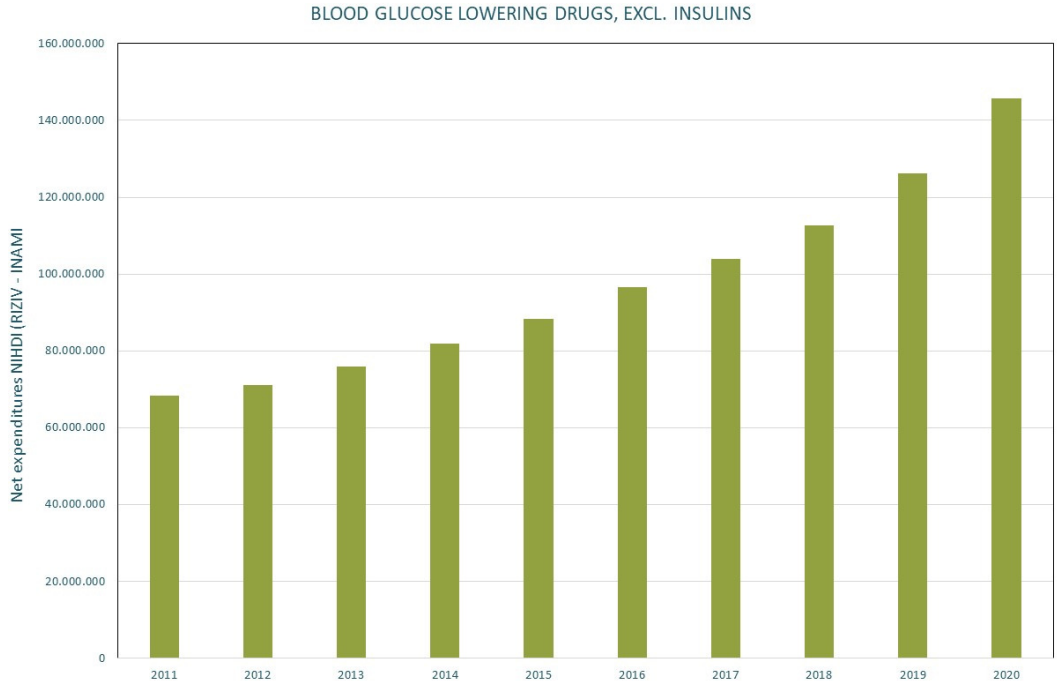


Figure 42: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class A10B blood glucose lowering drugs, excluding insulins

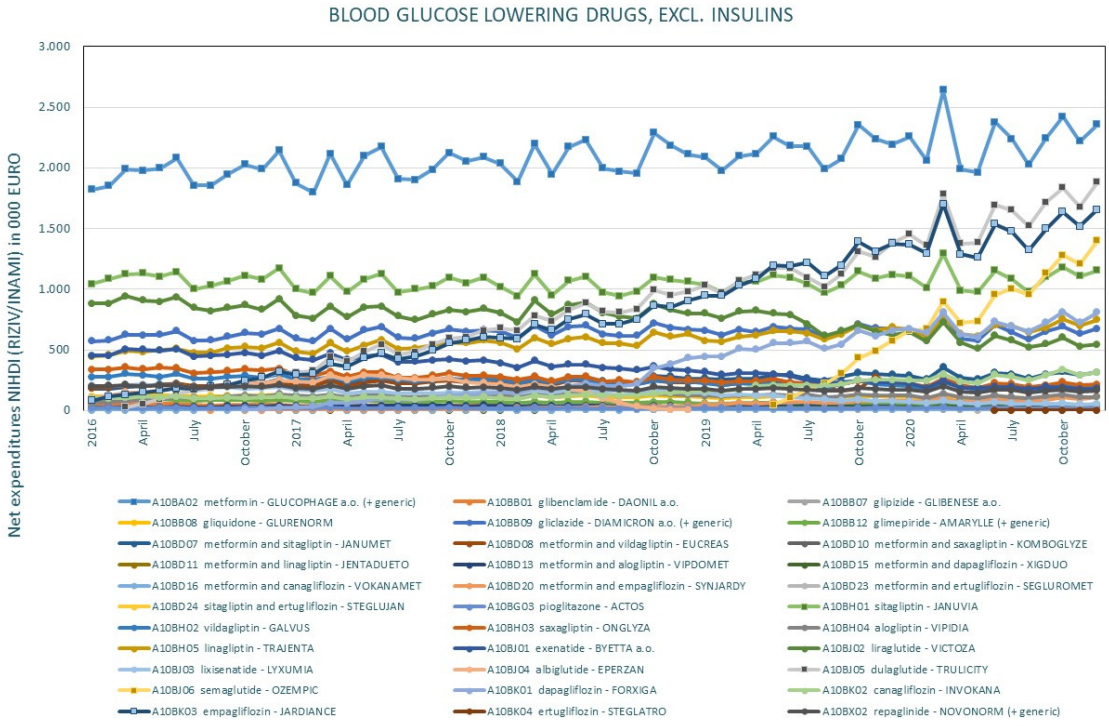


Figure 43: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class A10B blood glucose lowering drugs, excluding insulins

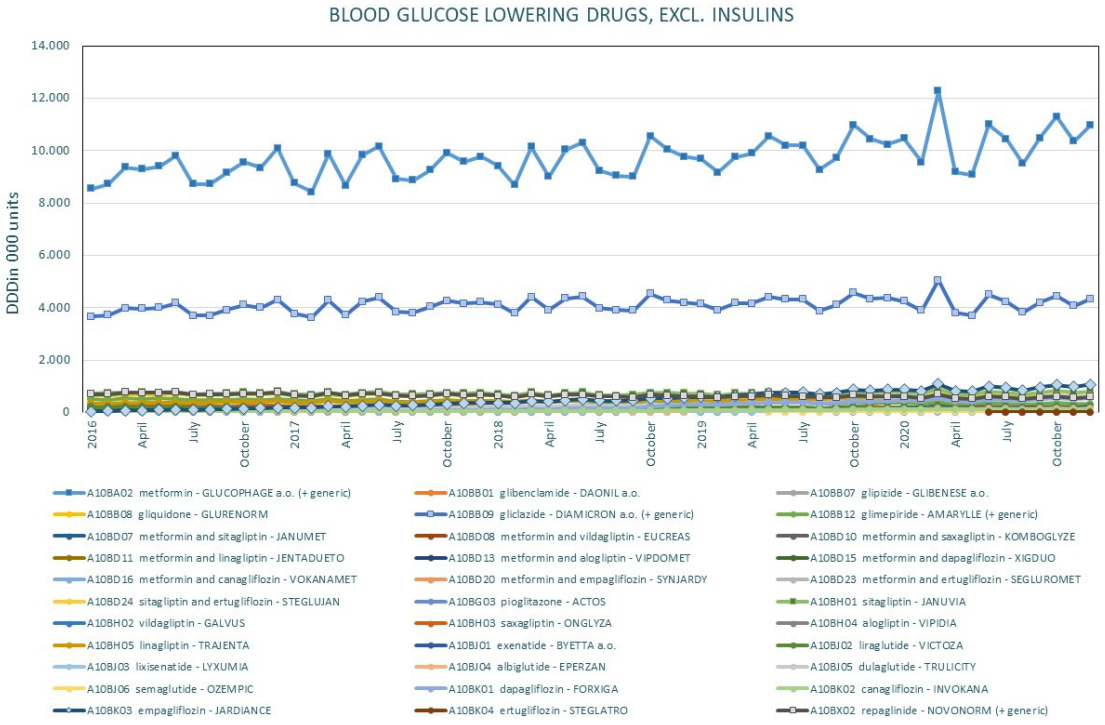


Figure 44: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class A10B blood glucose lowering drugs, excluding insulins

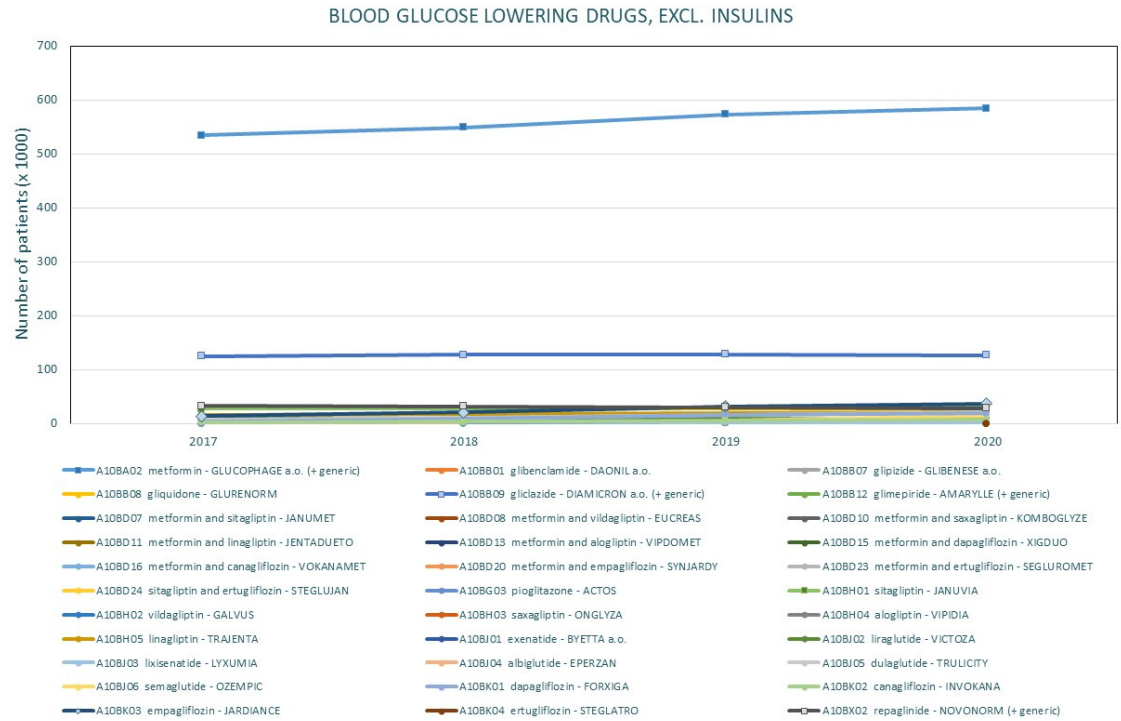


Figure 45: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class A10B blood glucose lowering drugs, excluding insulins

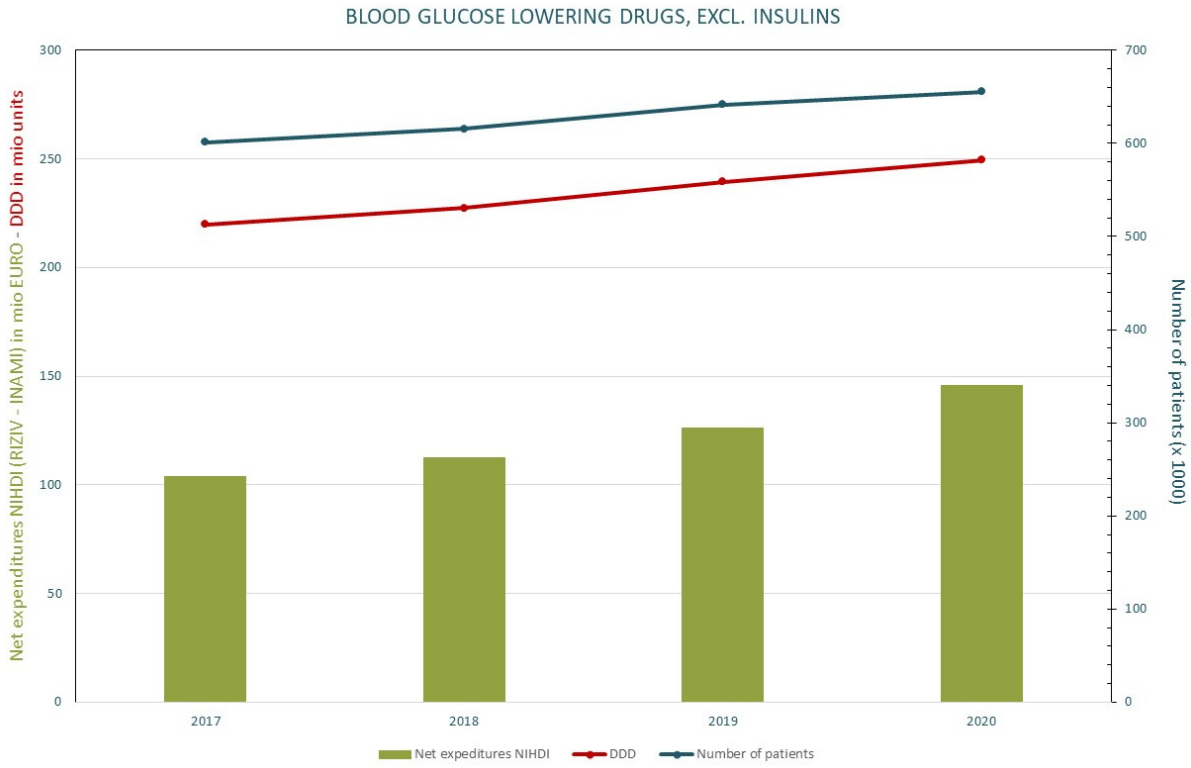


Figure 46: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class J05A direct acting antivirals

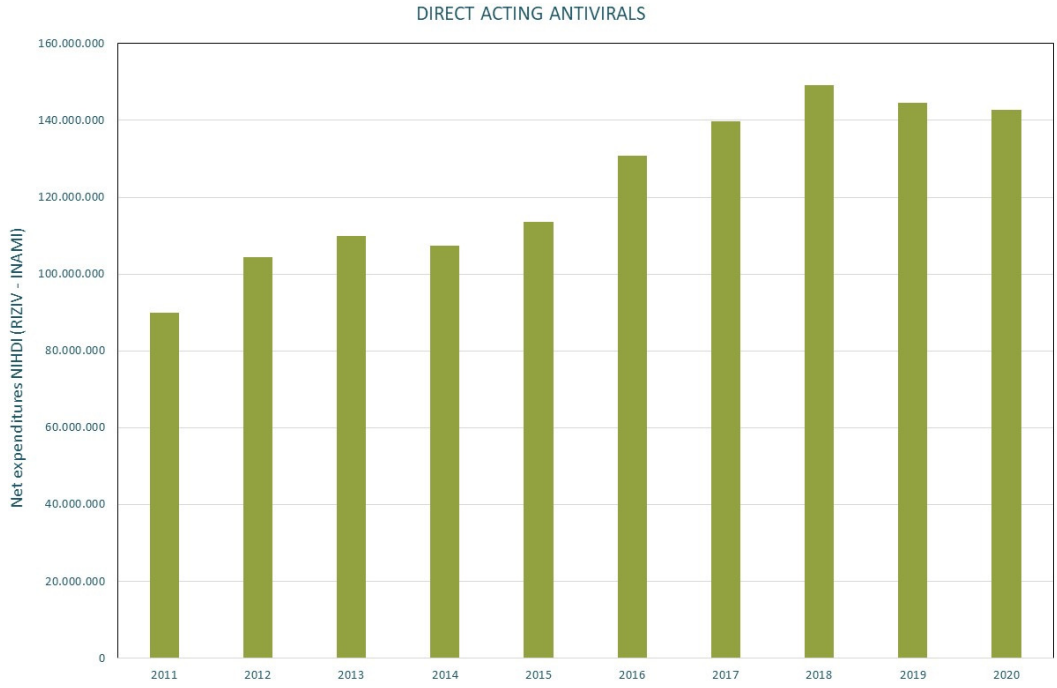


Figure 47: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class J05A direct acting antivirals

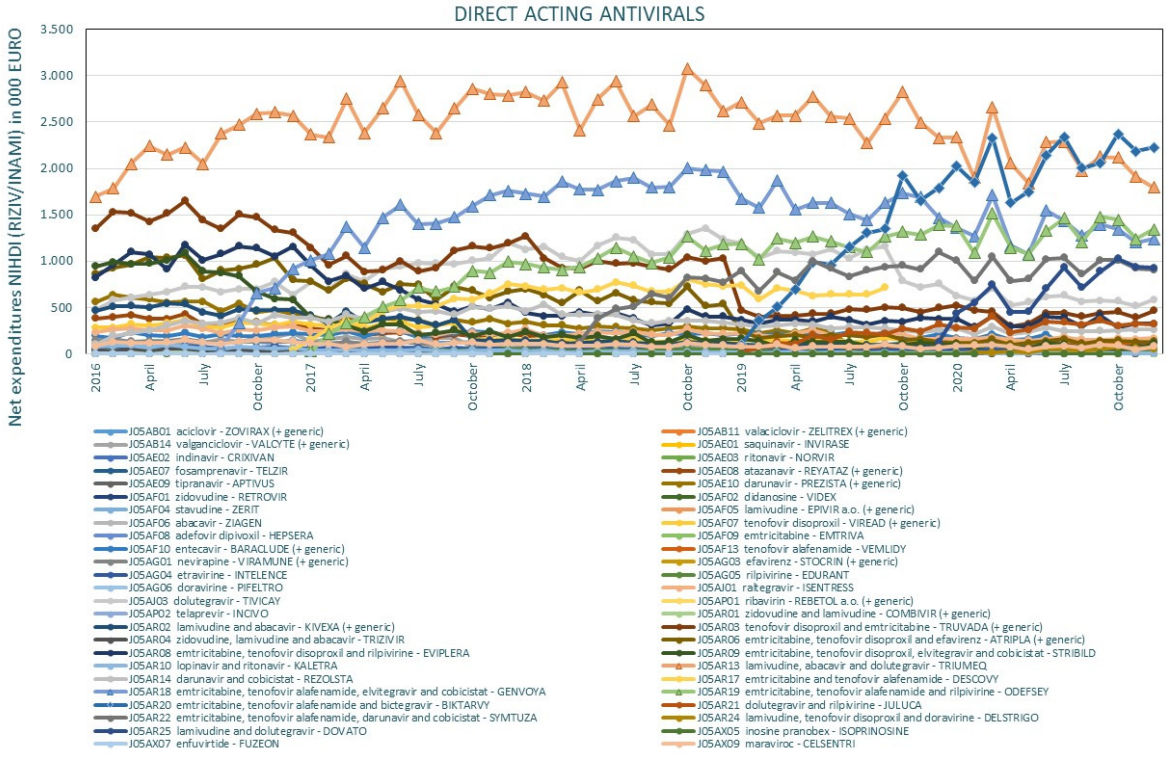


Figure 48: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class J05A direct acting antivirals

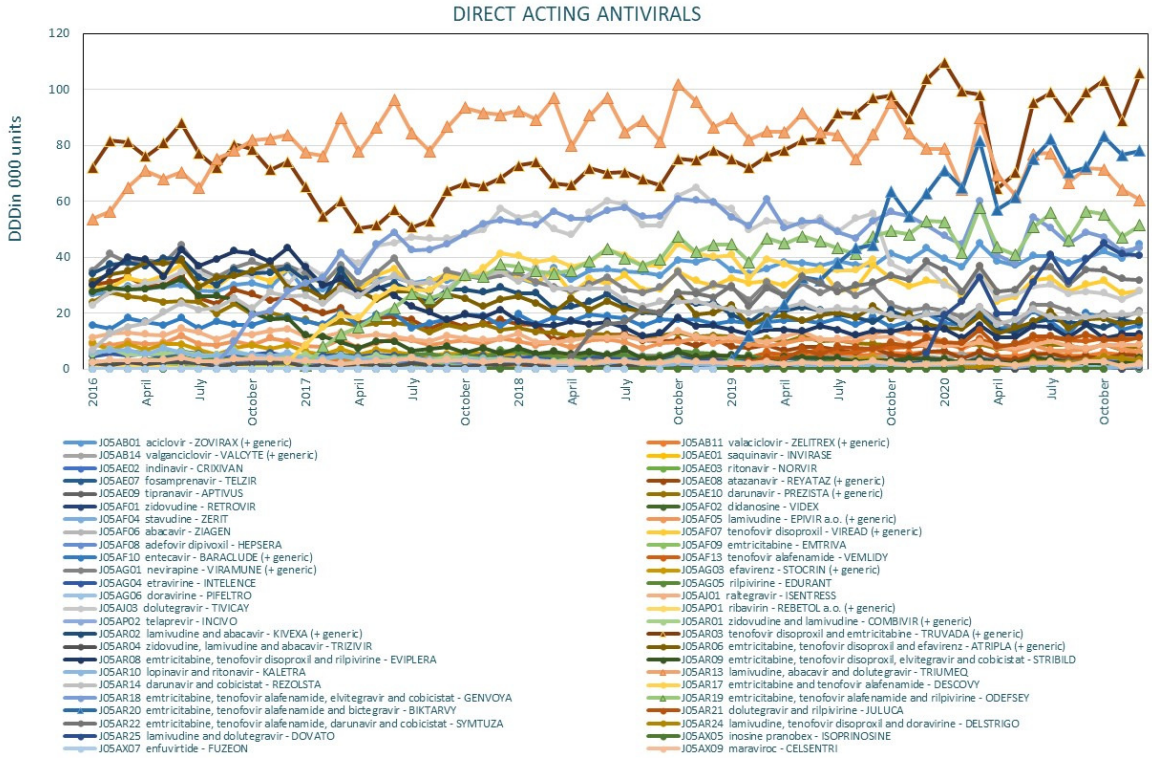


Figure 49: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class J05A direct acting antivirals

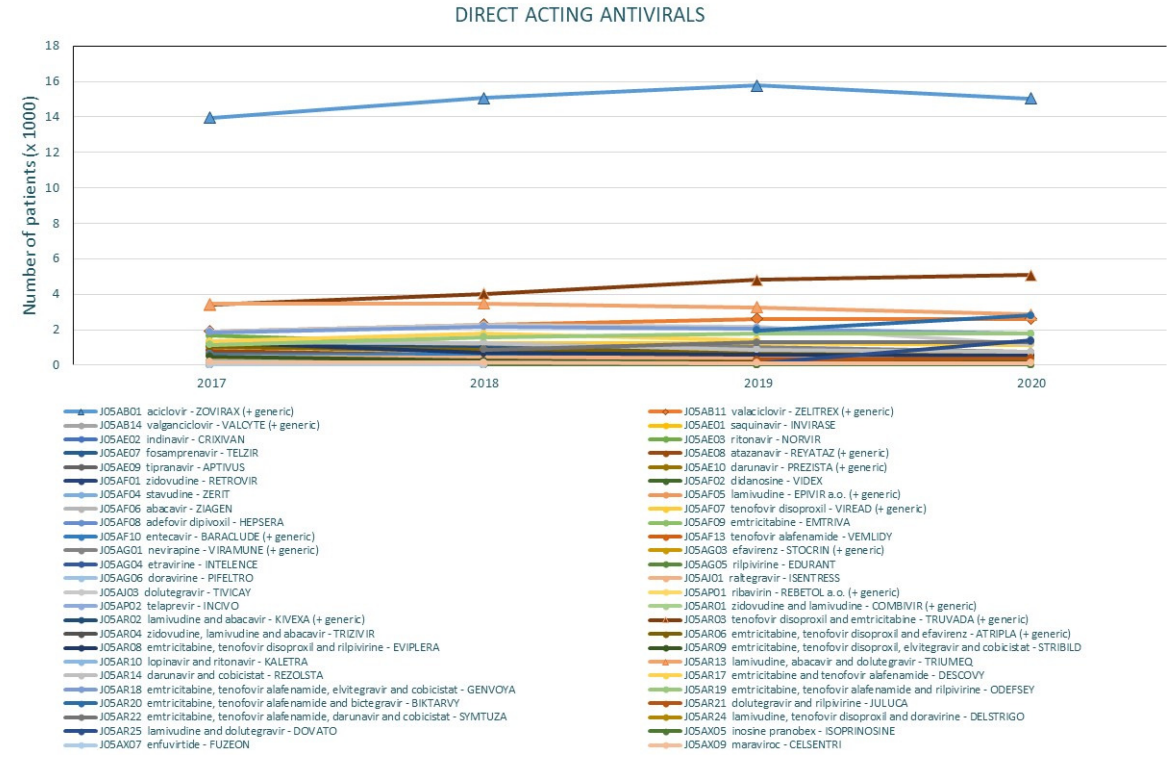


Figure 50: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class J05A direct acting antivirals

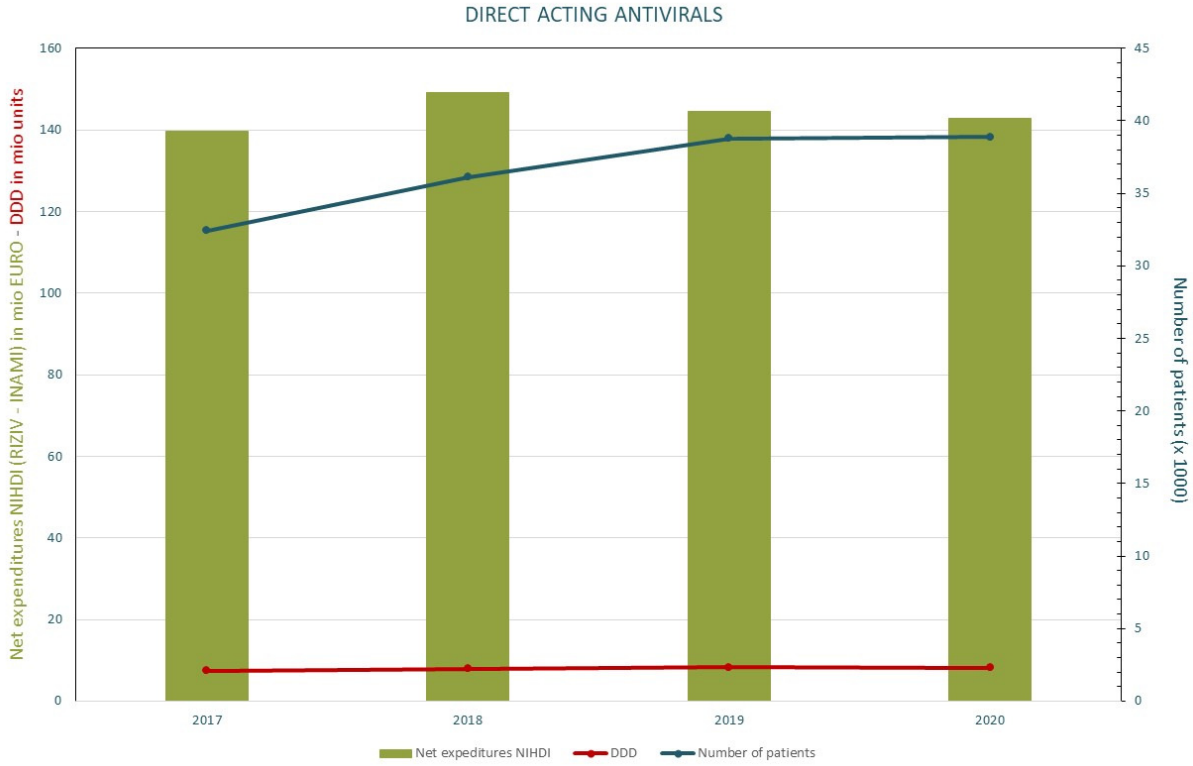


Figure 51: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class R03A adrenergics, inhalants

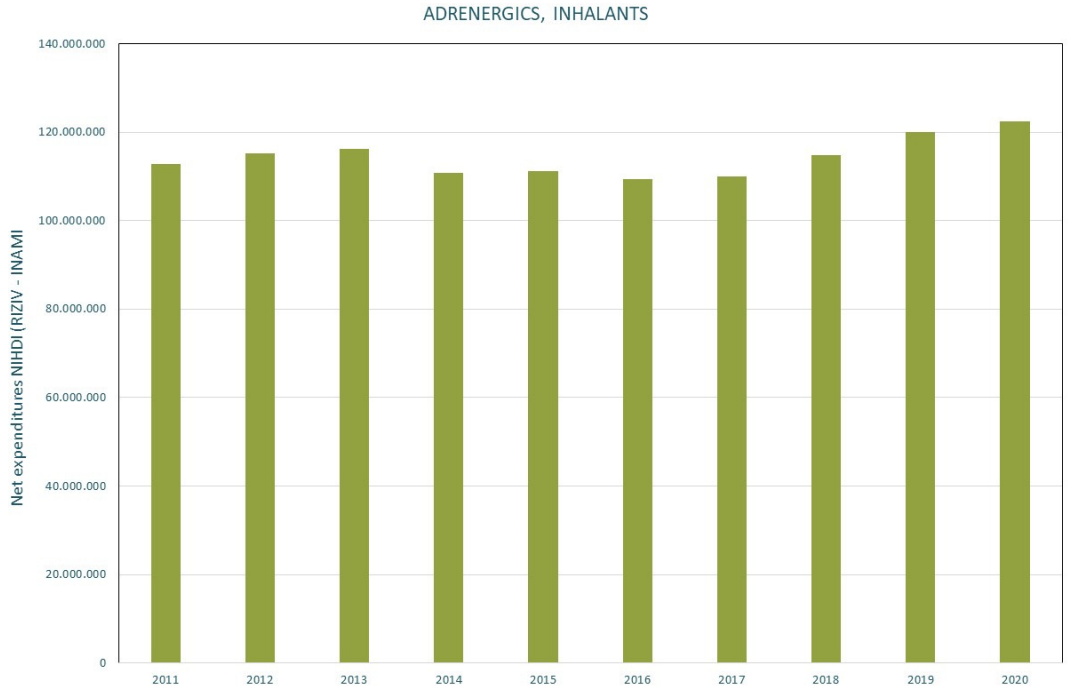


Figure 52: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class R03A adrenergics, inhalants

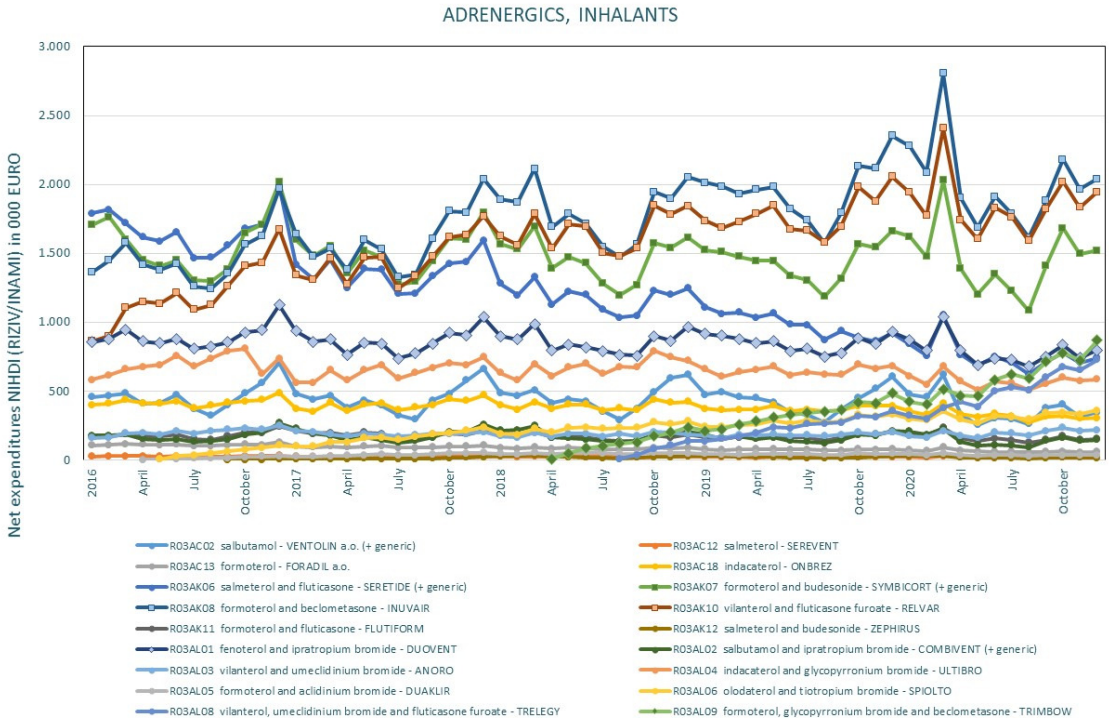


Figure 53: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class R03A adrenergics, inhalants

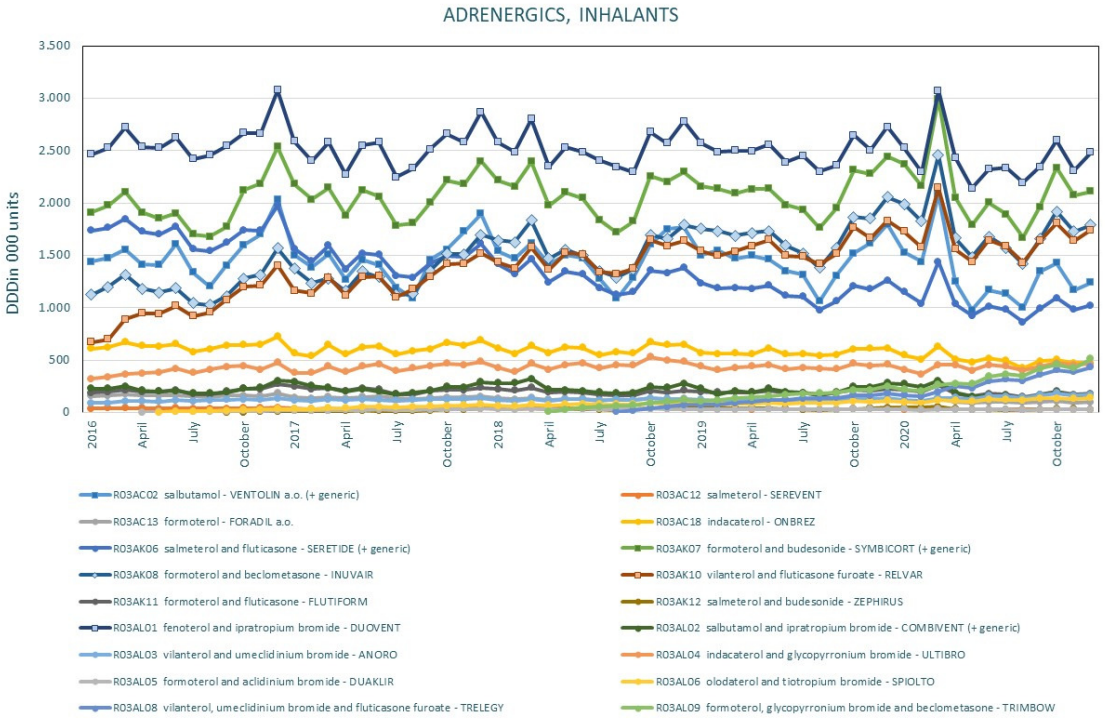


Figure 54: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class R03A adrenergics, inhalants

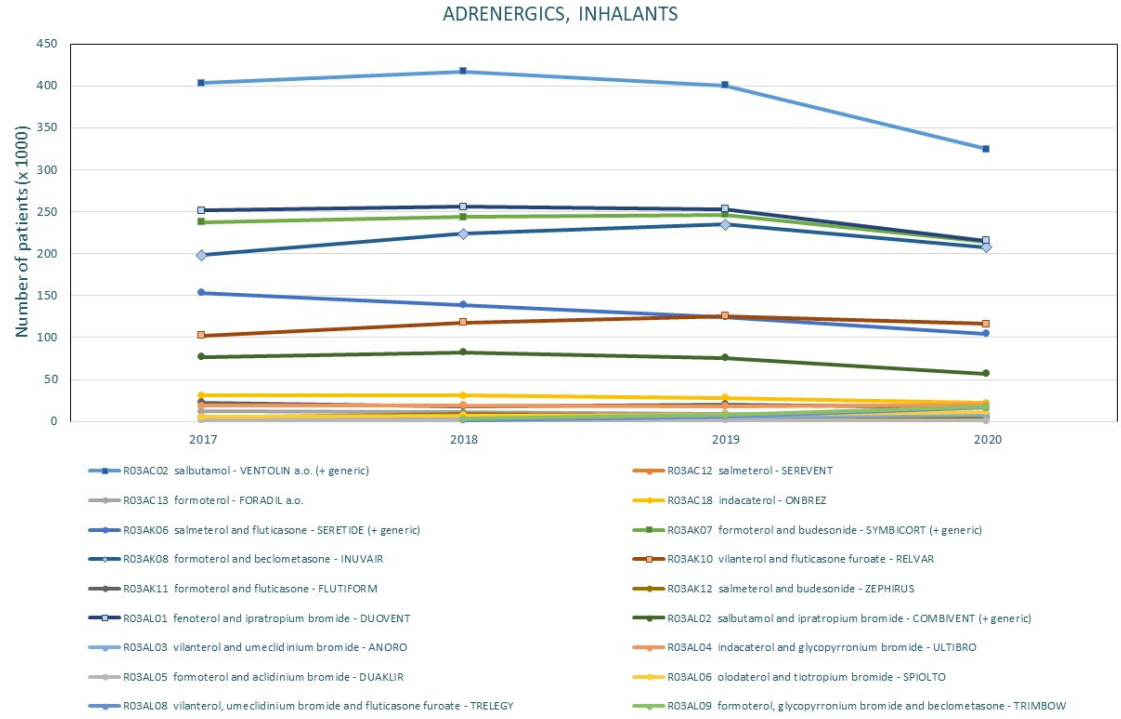


Figure 55: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class R03A adrenergics, inhalants

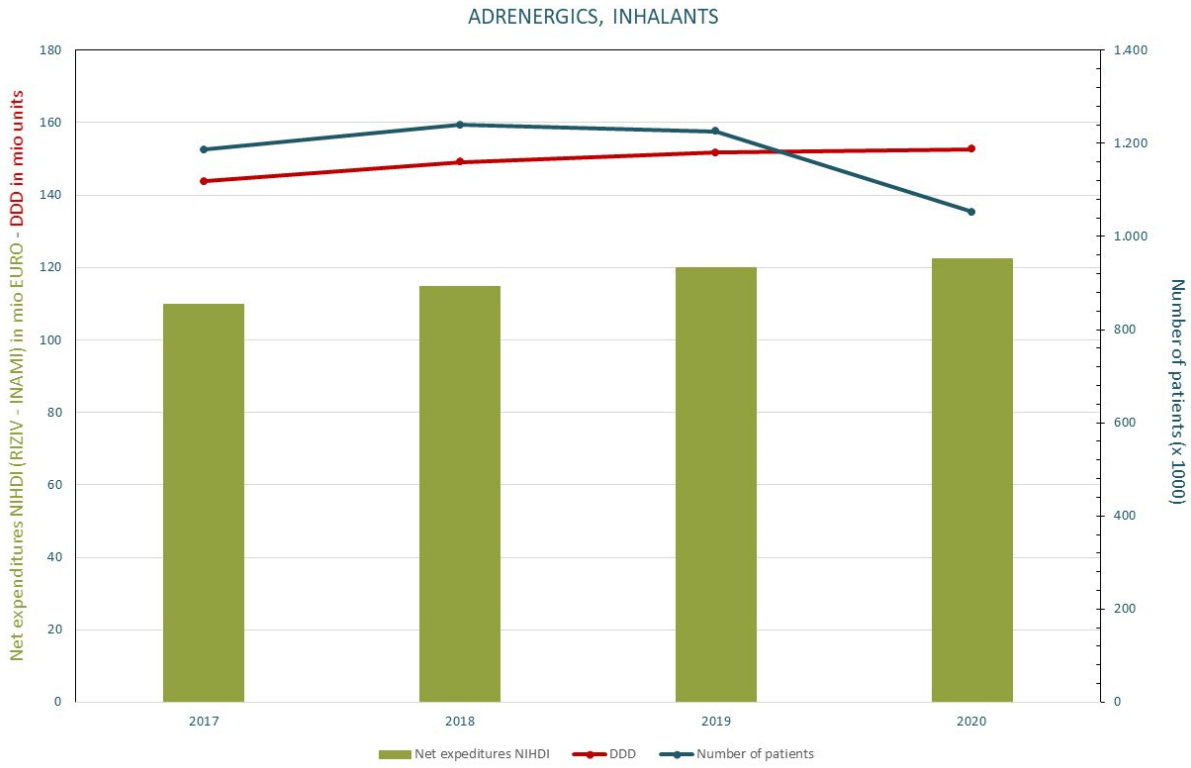


Figure 56: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class A02B drugs for peptic ulcer and reflux disease

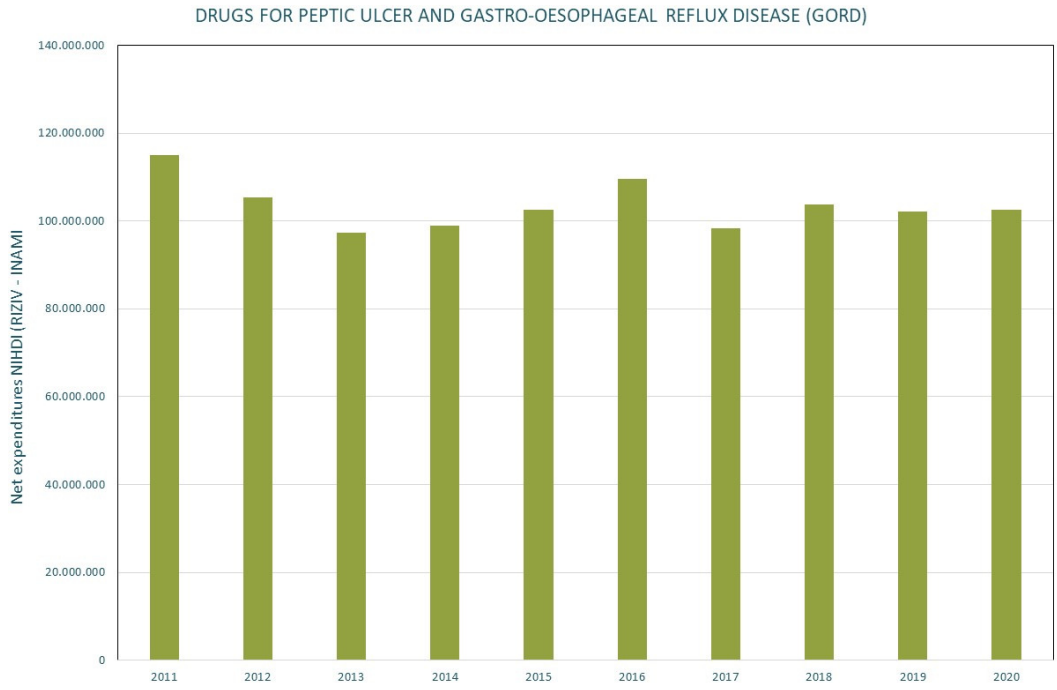


Figure 57: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class A02B drugs for peptic ulcer and reflux disease

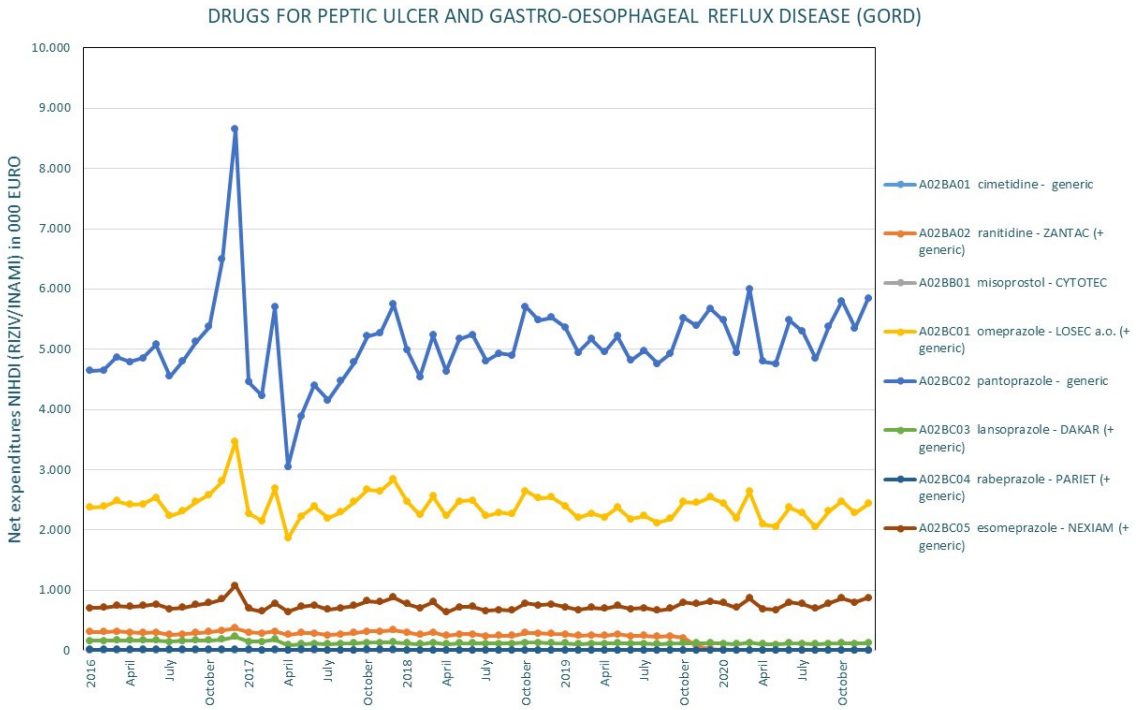


Figure 58: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class A02B drugs for peptic ulcer and reflux disease

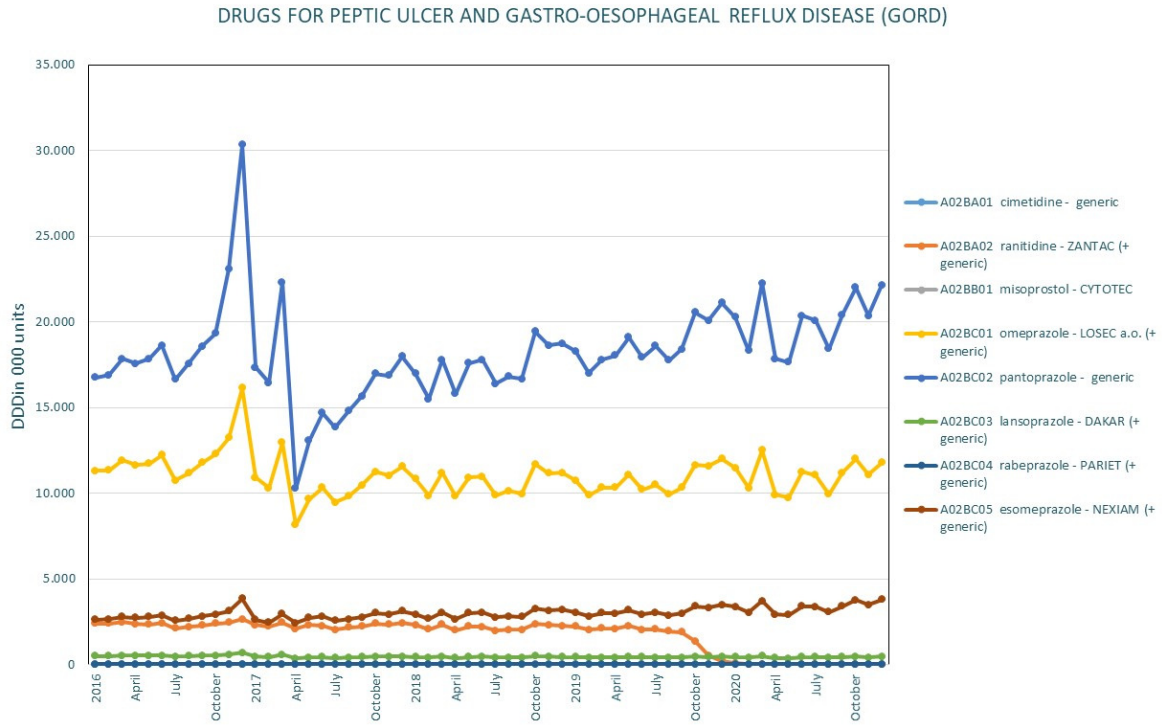


Figure 59: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class A02B drugs for peptic ulcer and reflux disease

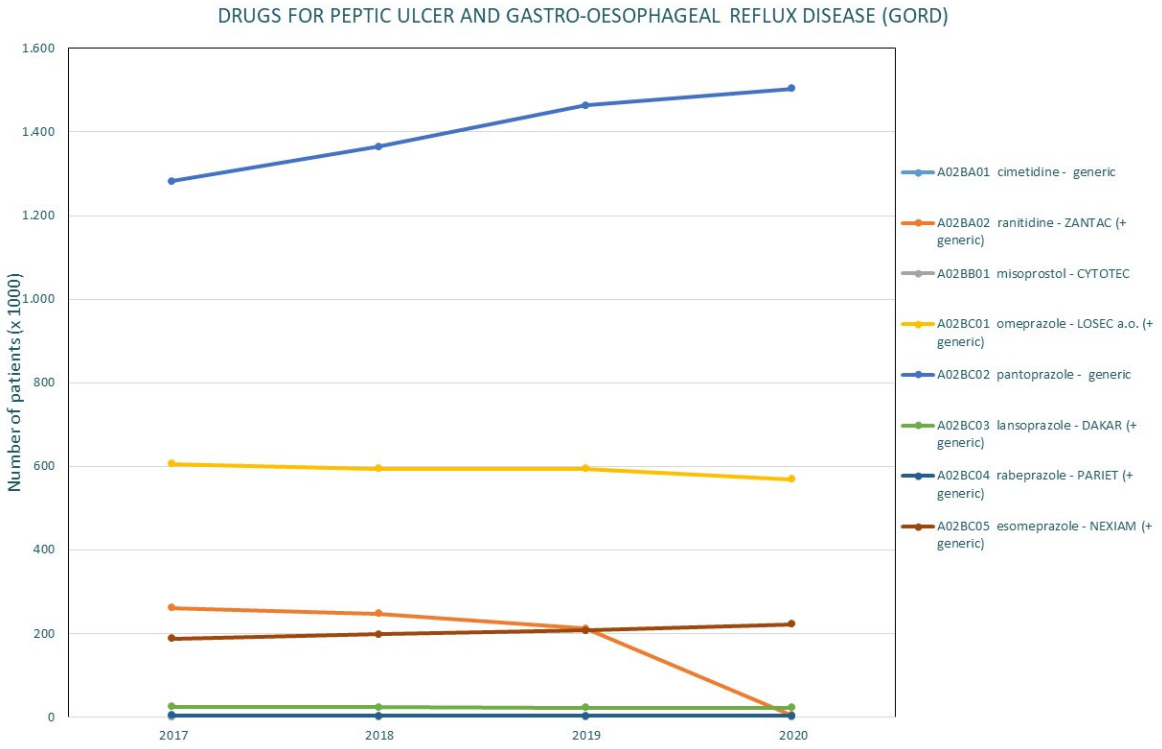
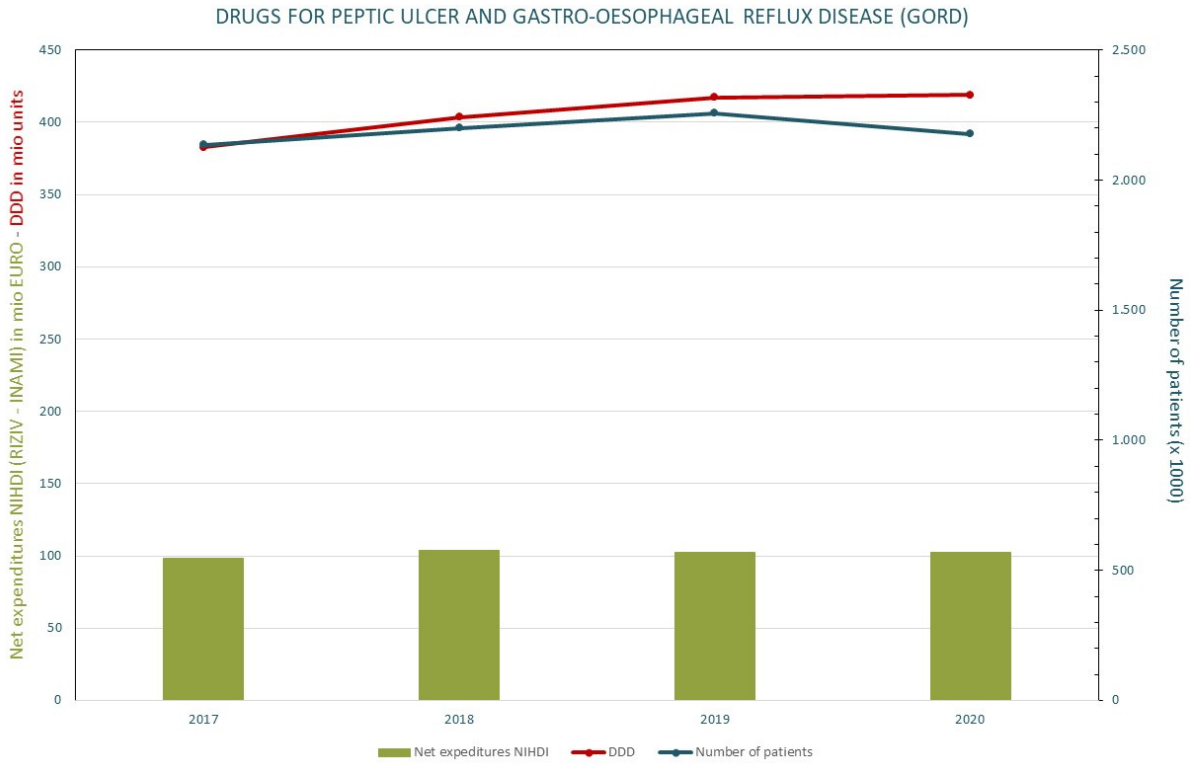


Figure 60: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class A02B drugs for peptic ulcer and reflux disease



B02B – VITAMIN K AND OTHER HAEMOSTATICS

Figure 61: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class B02B vitamin K and other hemostatics

Figure 62: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class B02B vitamin K and other hemostatics

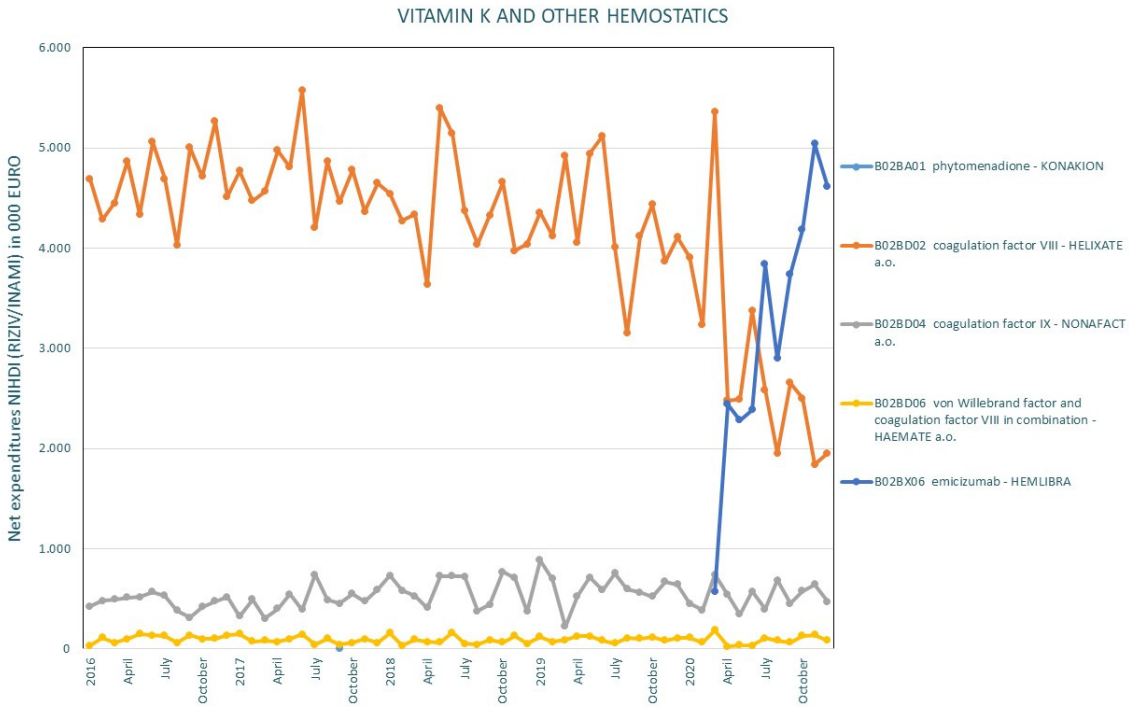


Figure 63: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class B02B vitamin K and other hemostatics

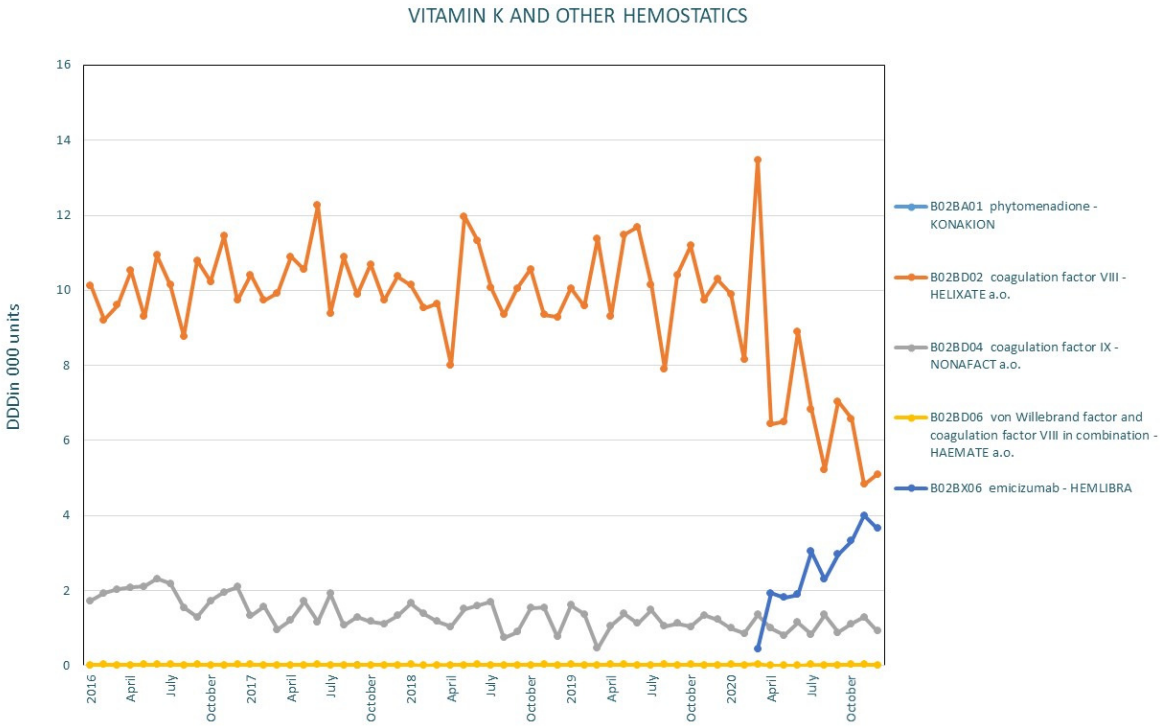


Figure 64: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class B02B vitamin K and other hemostatics

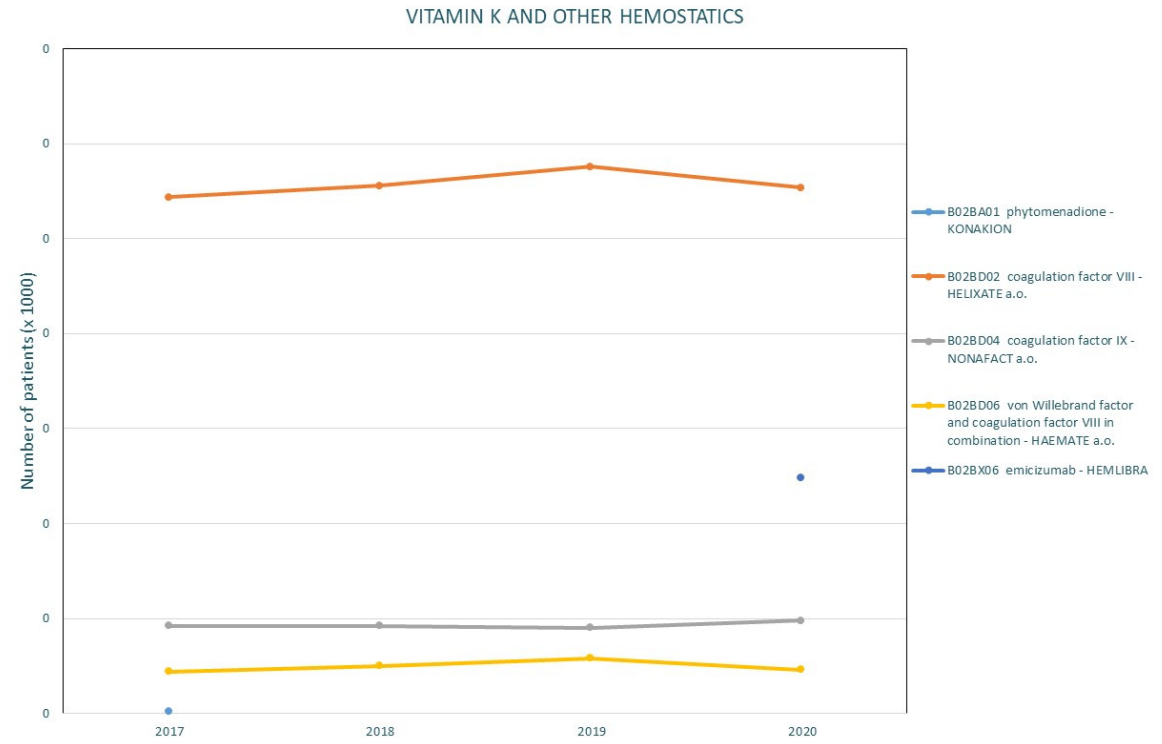


Figure 65: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class B02B vitamin K and other hemostatics

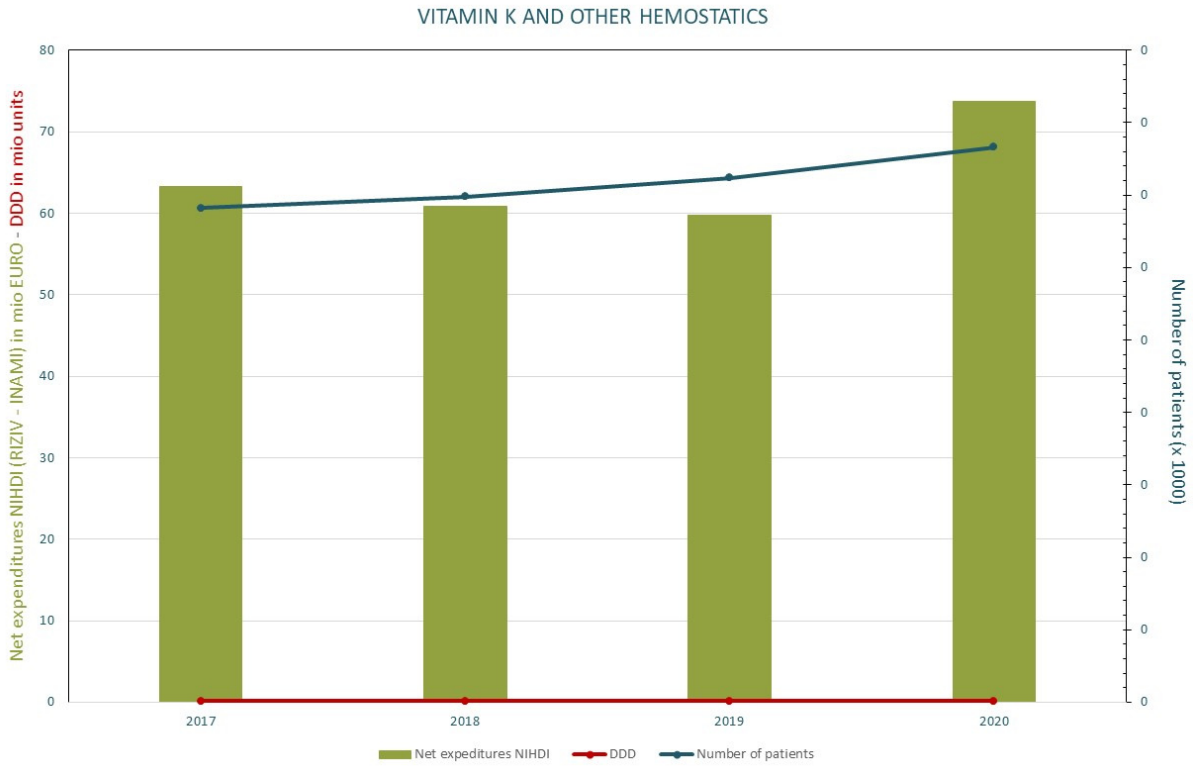


Figure 66: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class R03D other systemic drugs for obstructive airway diseases

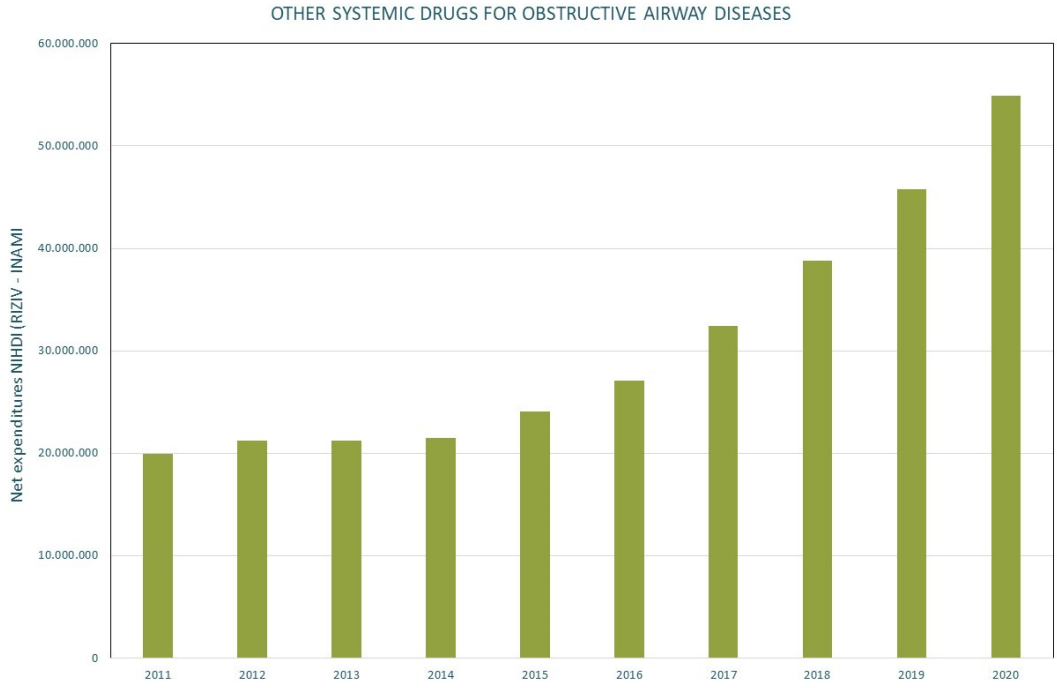


Figure 67: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class R03D other systemic drugs for obstructive airway diseases

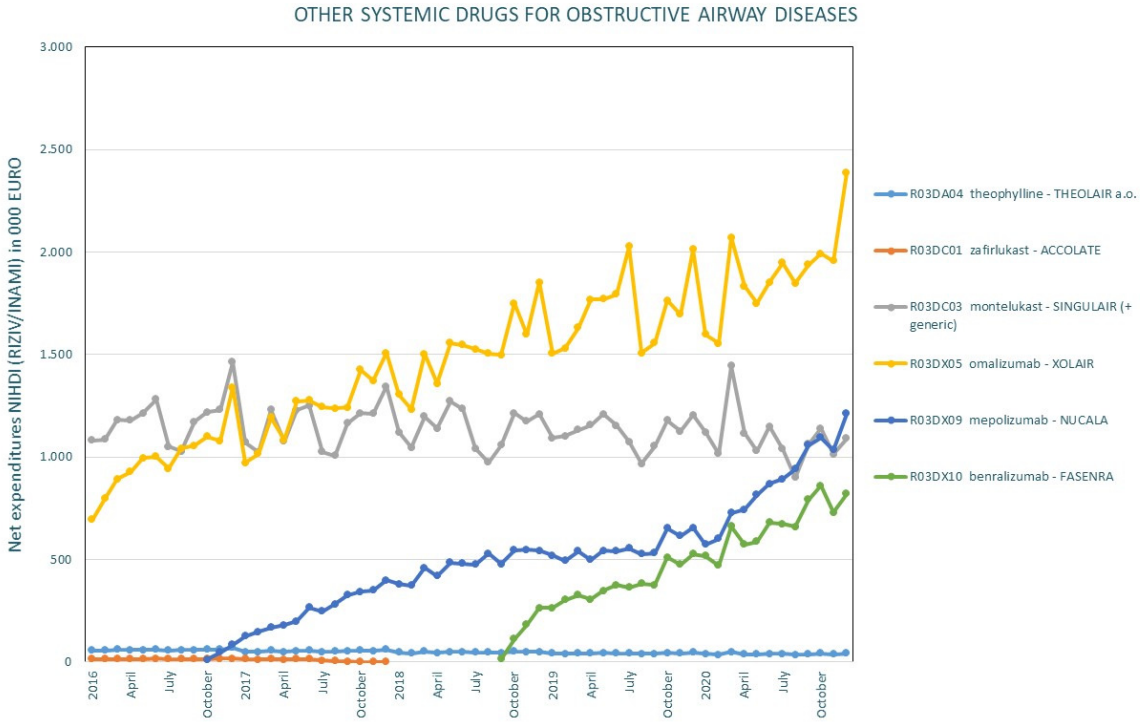


Figure 68: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class R03D other systemic drugs for obstructive airway diseases

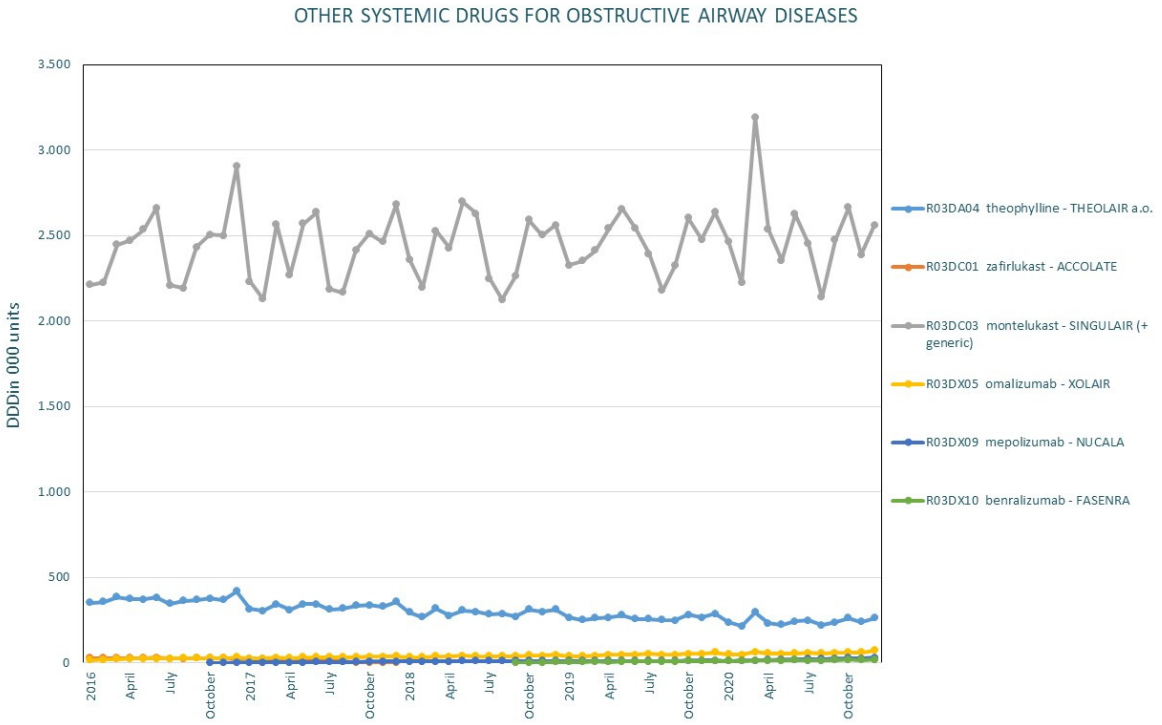


Figure 69: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class R03D other systemic drugs for obstructive airway diseases

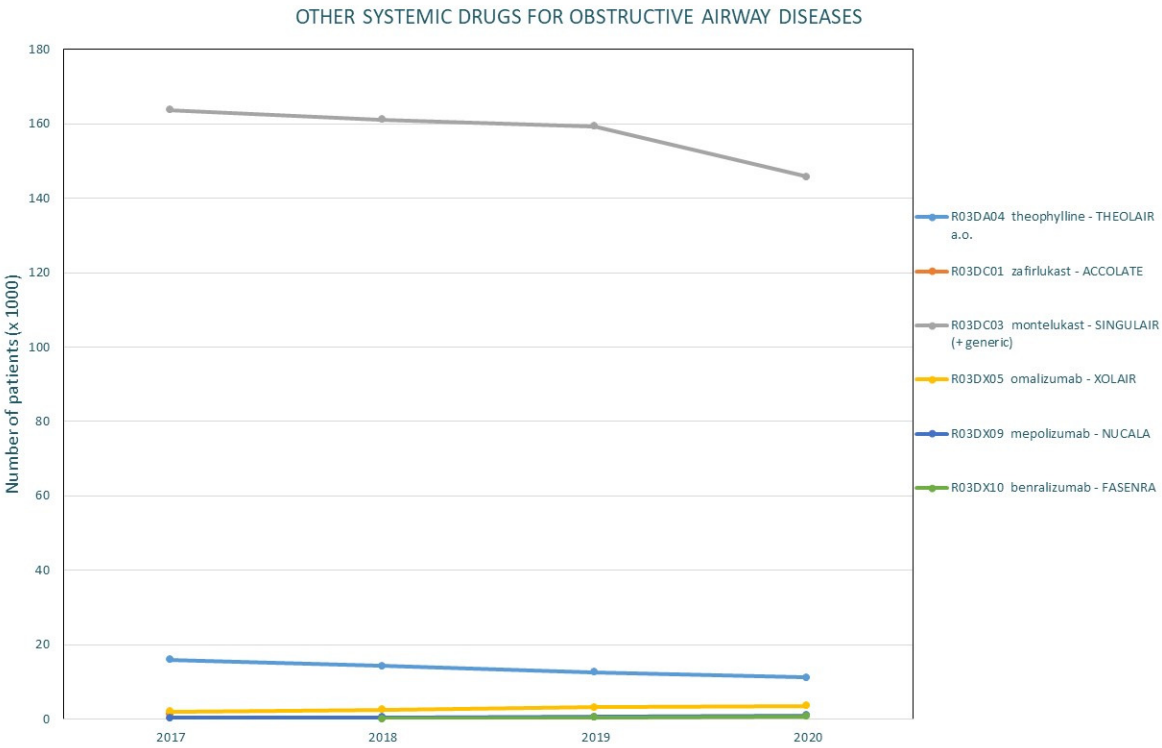


Figure 70: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class R03D other systemic drugs for obstructive airway diseases

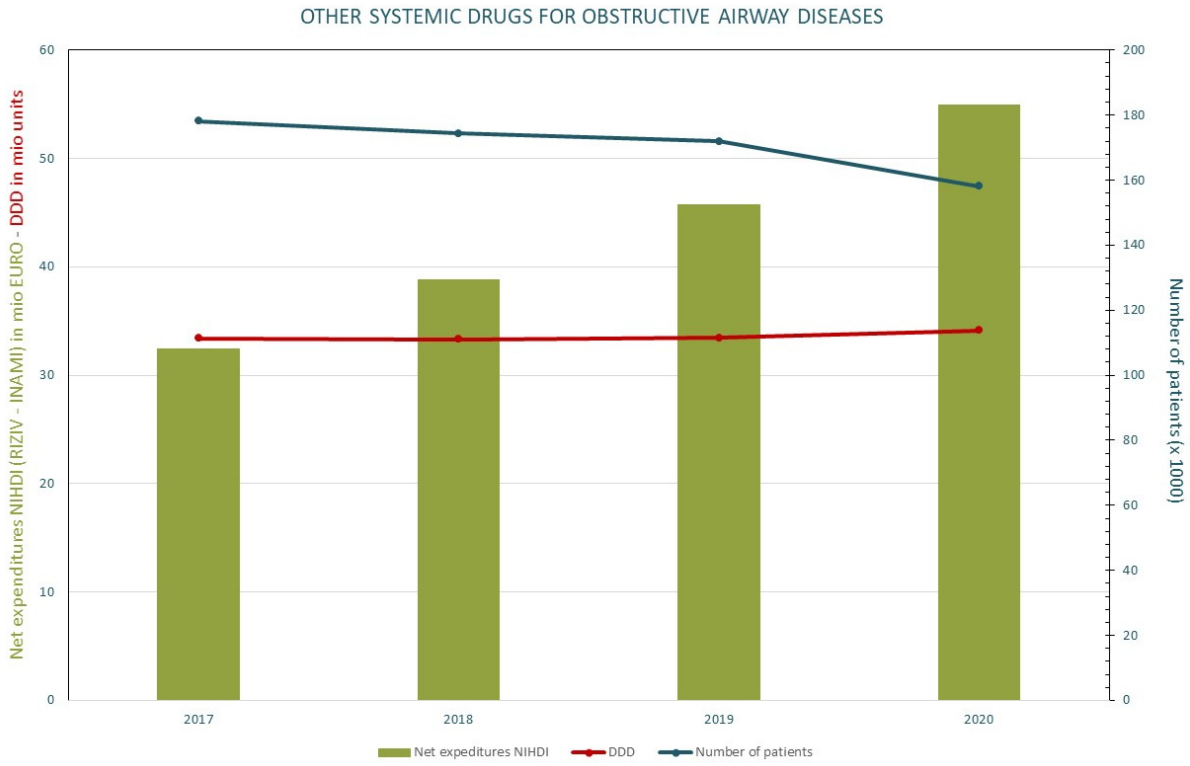


Figure 71: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class J07B antiviral vaccines

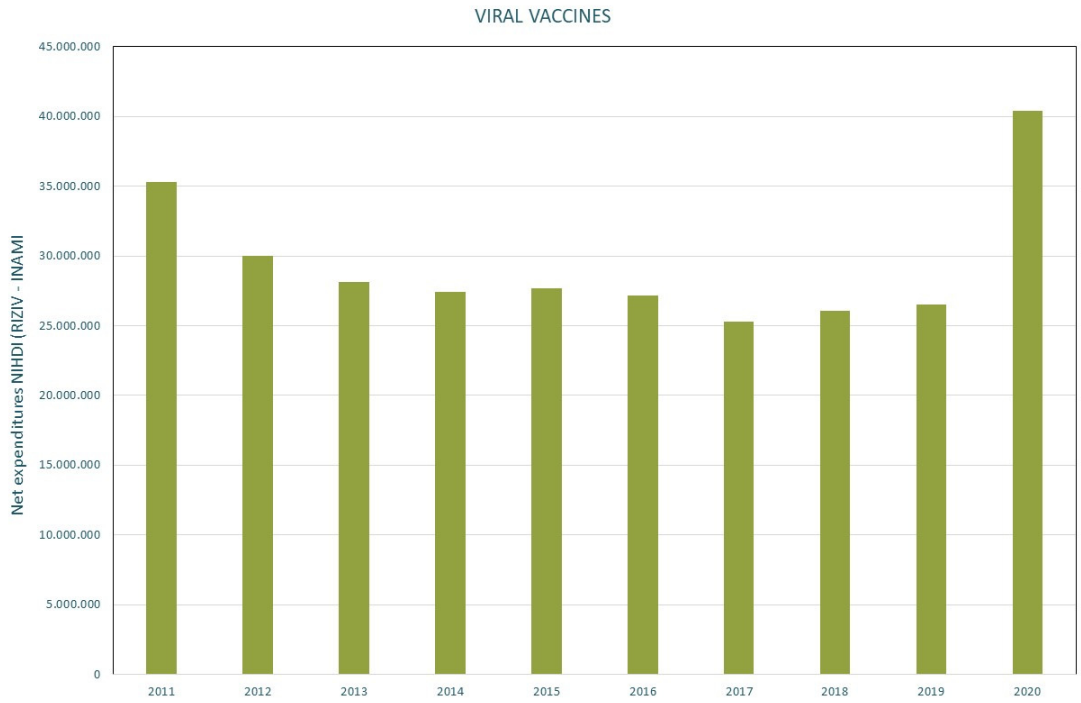


Figure 72: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class J07B antiviral vaccines

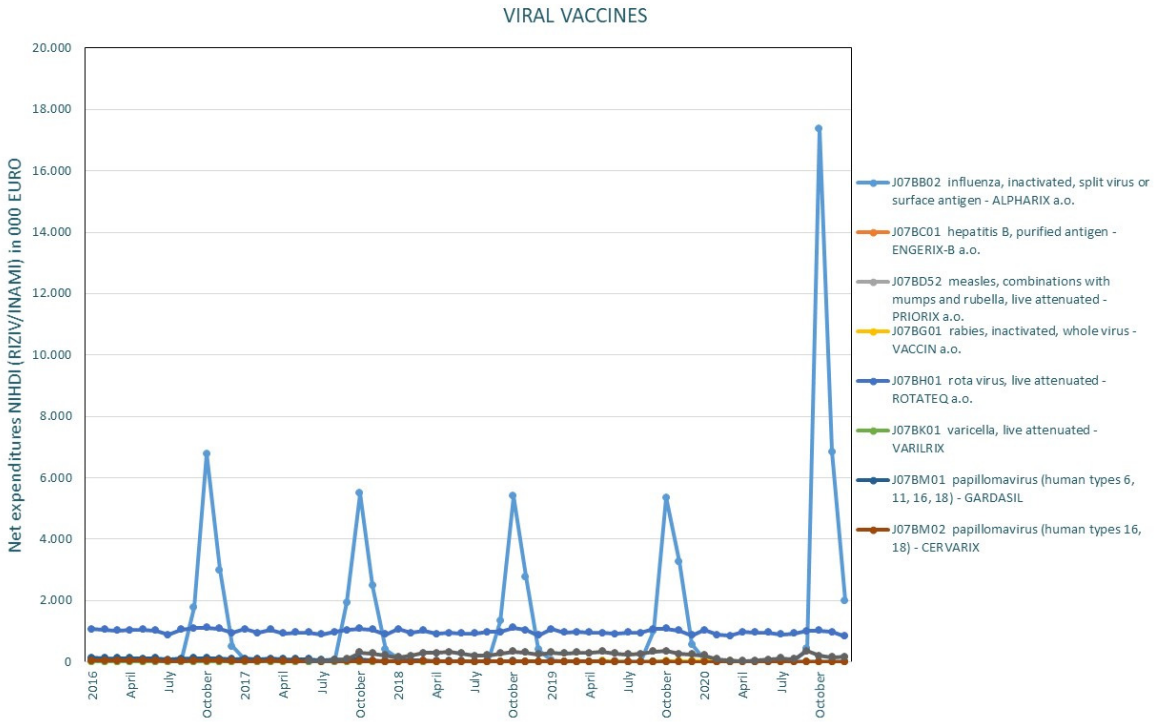


Figure 73: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class J07B antiviral vaccines

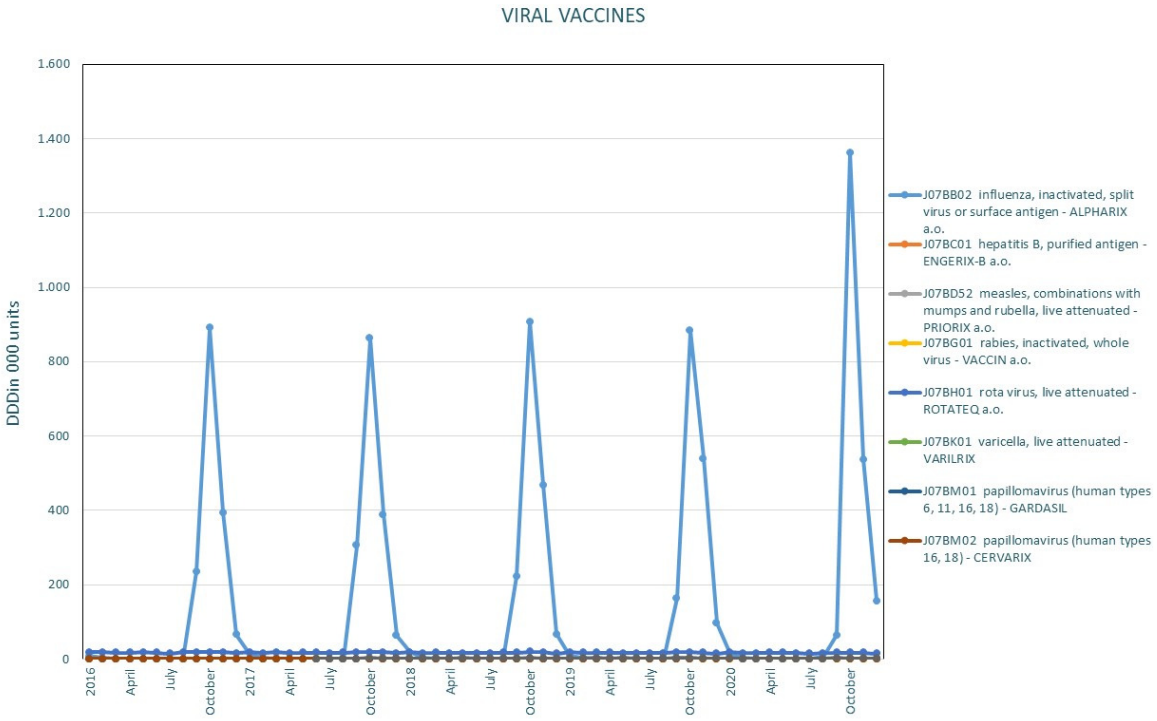


Figure 74: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class J07B antiviral vaccines

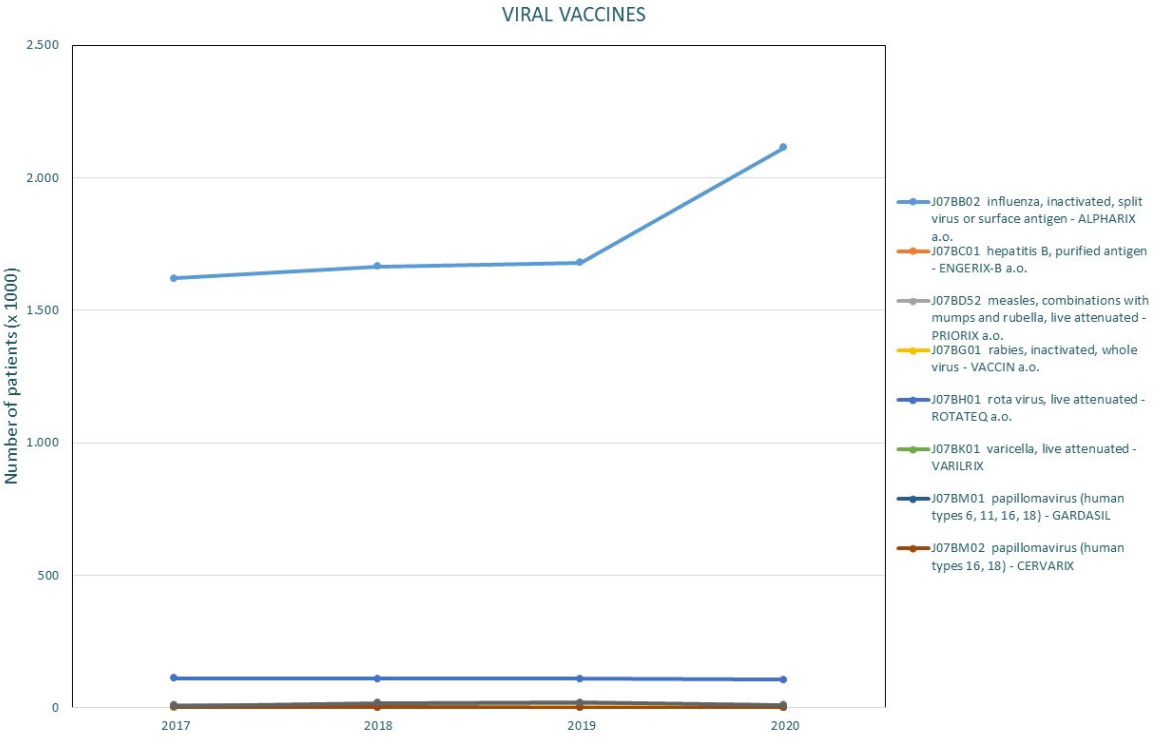


Figure 75: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class J07B antiviral vaccines

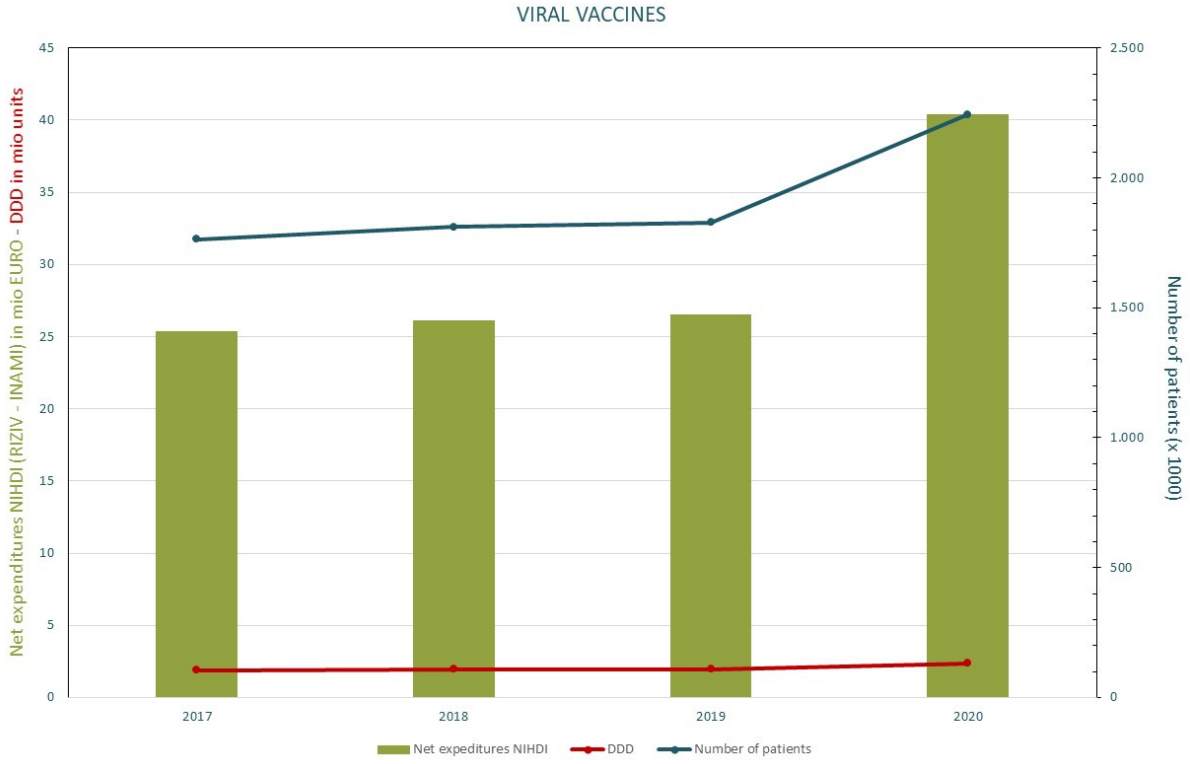


Figure 76: Evolution of NIHDI net annual expenditure (public pharmacies 2011-2020) for ATC class R03B other drugs for obstructive airway diseases, inhalants

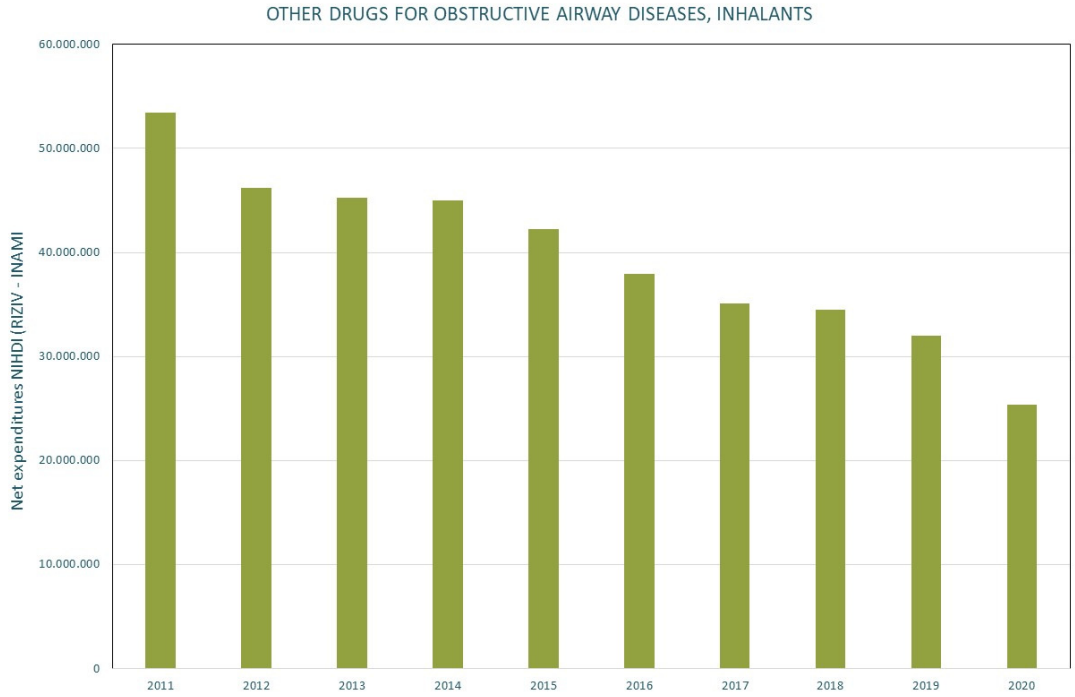


Figure 77: Evolution of NIHDI net monthly expenditure (public pharmacies 2016-2020) for ATC class R03B other drugs for obstructive airway diseases, inhalants

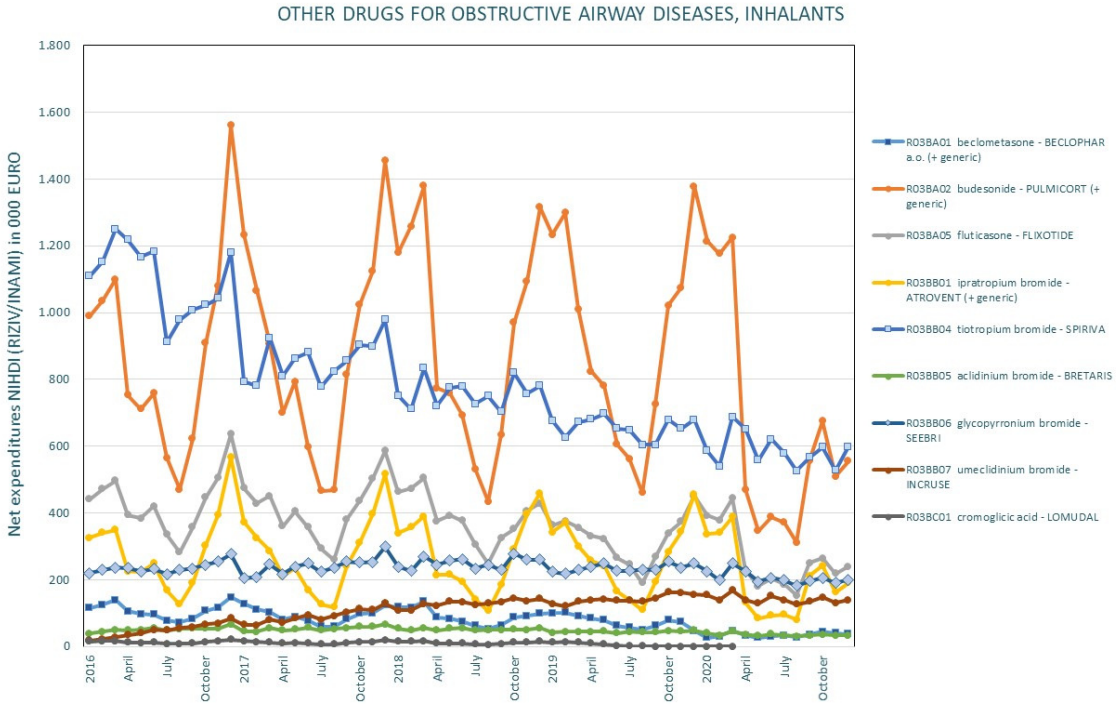


Figure 78: Evolution of number of DDDs per month (public pharmacies 2016-2020) for ATC class R03B other drugs for obstructive airway diseases, inhalants

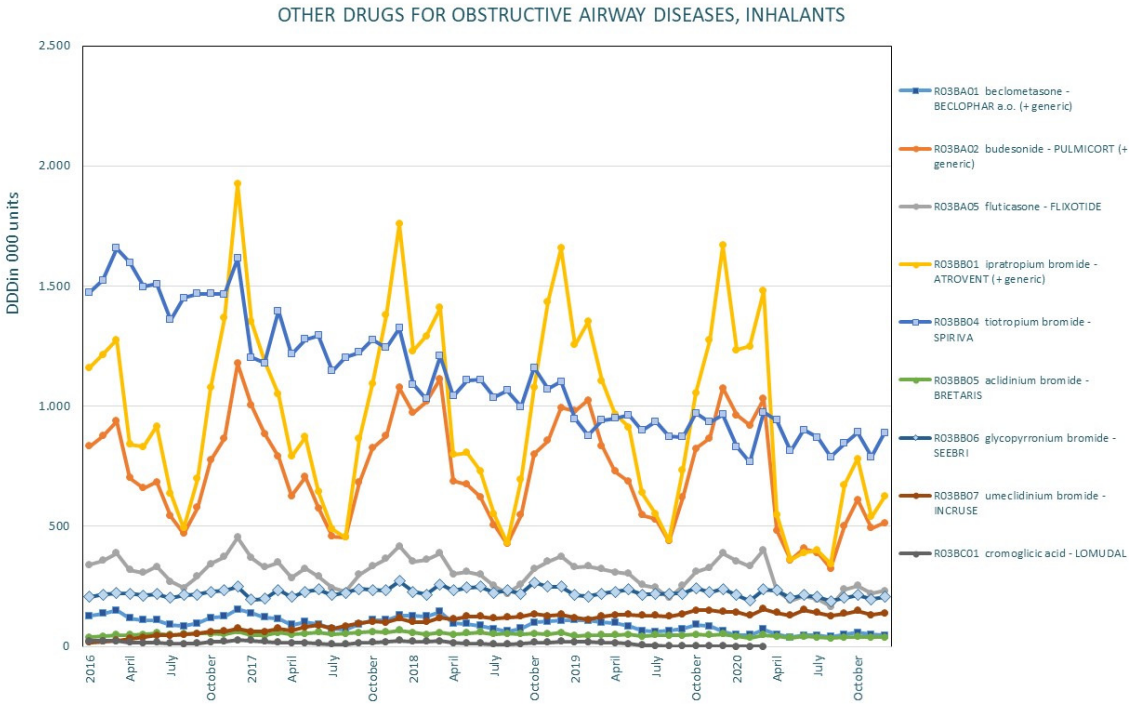


Figure 79: Evolution of number of patients per year (public pharmacies 2017-2020) for ATC class R03B other drugs for obstructive airway diseases, inhalants

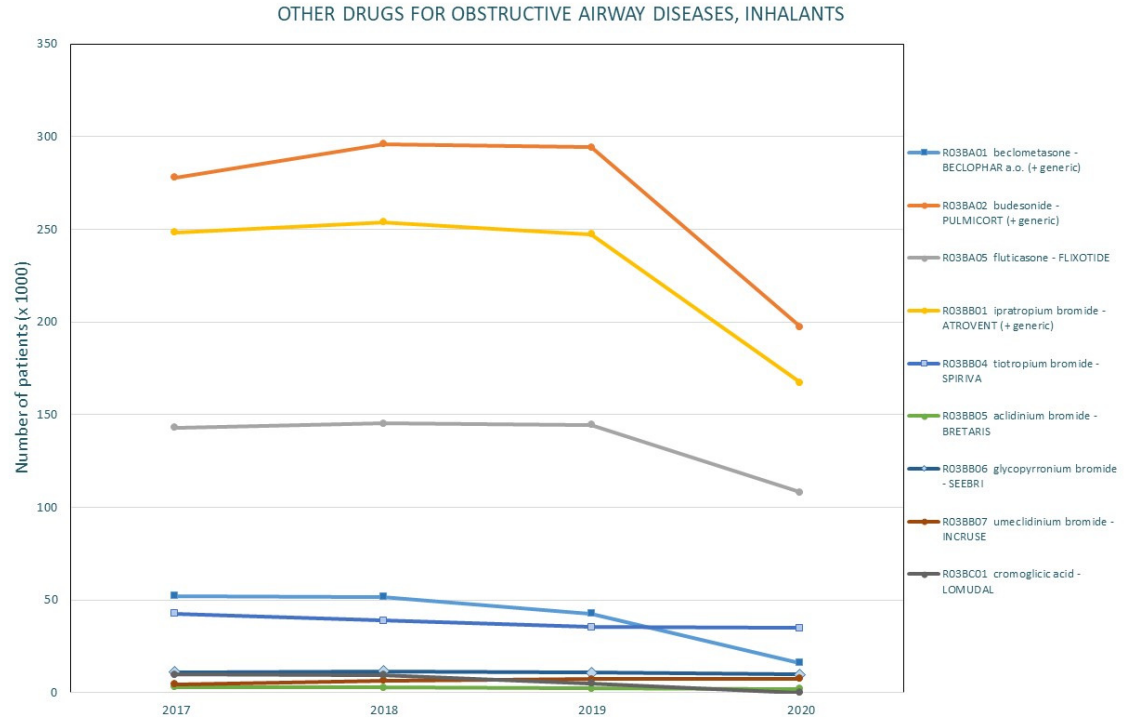
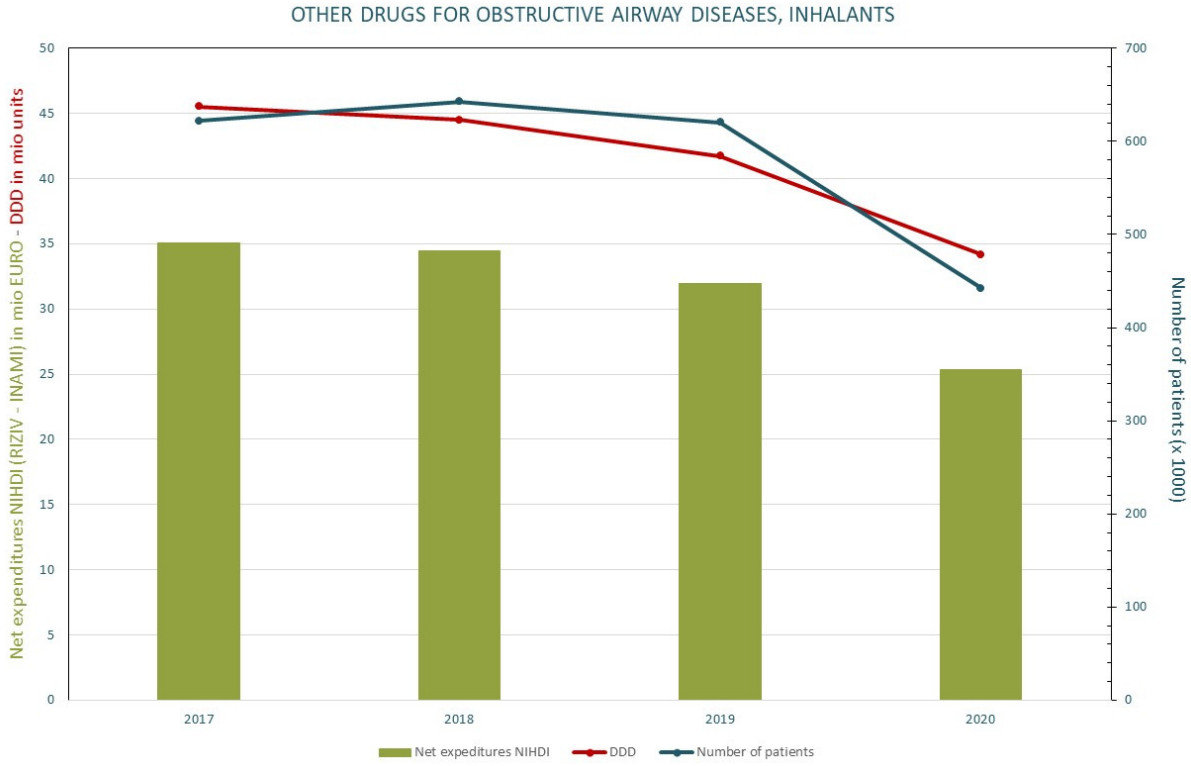


Figure 80: Evolution of NIHDI net annual expenditure, number of patients and number of DDDs (public pharmacies 2017-2020) for ATC class R03B other drugs for obstructive airway diseases, inhalants



ANNEX 4. GRAPHICAL PRESENTATION OF THE EVOLUTION OF THE EXPENDITURE, THE CONSUMPTION (DDD) AND NUMBER OF PATIENTS TREATED FOR SOME CLASSES OF MEDICINES (HOSPITALS)

Figure 81: Evolution of NIHDI net annual expenditure and number of DDDs (hospitals (all patients) 2011-2020) for ATC class L01X other antineoplastic agents

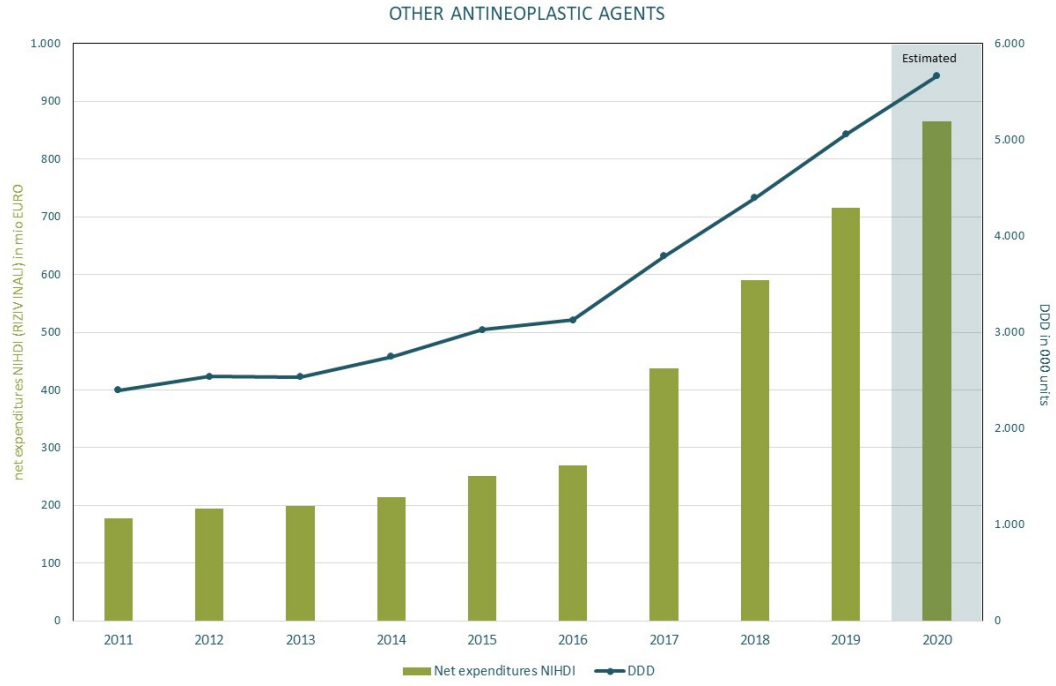


Figure 82: Evolution of NIHDI net quarterly expenditure (hospitals (all patients) 2016-2020) for ATC class L01X other antineoplastic agents - Top 10

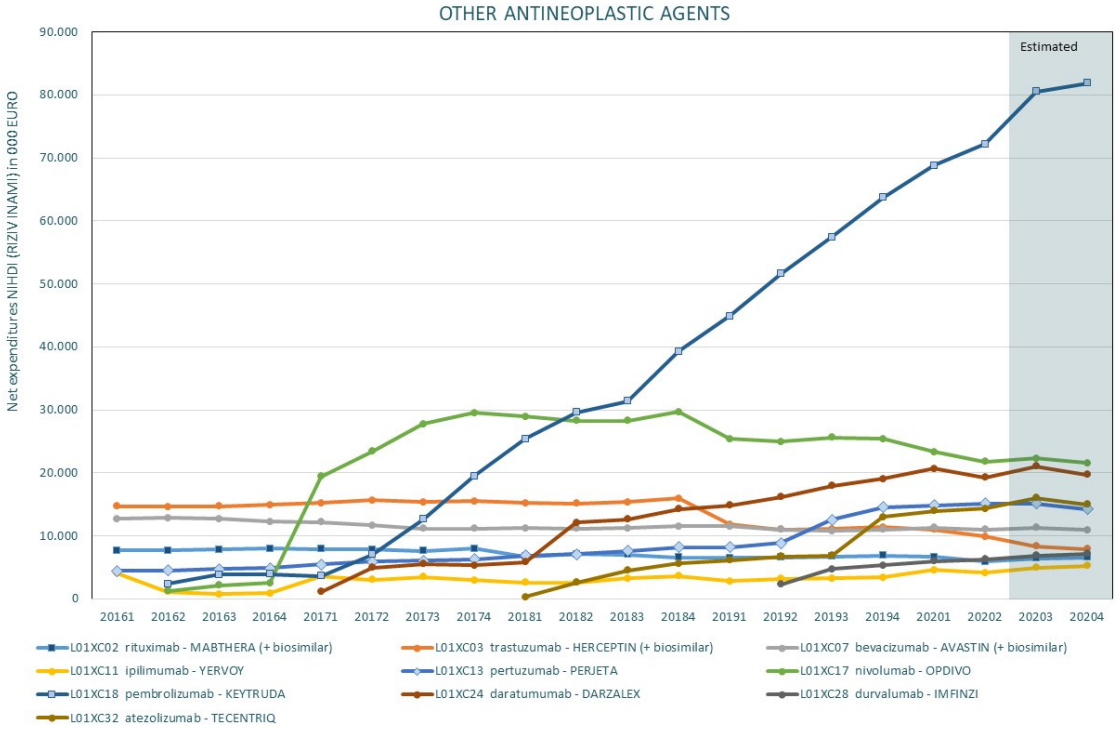


Figure 83: Evolution of number of DDDs per quarter (hospitals (all patients) 2016-2020) for ATC class L01X other antineoplastic agents

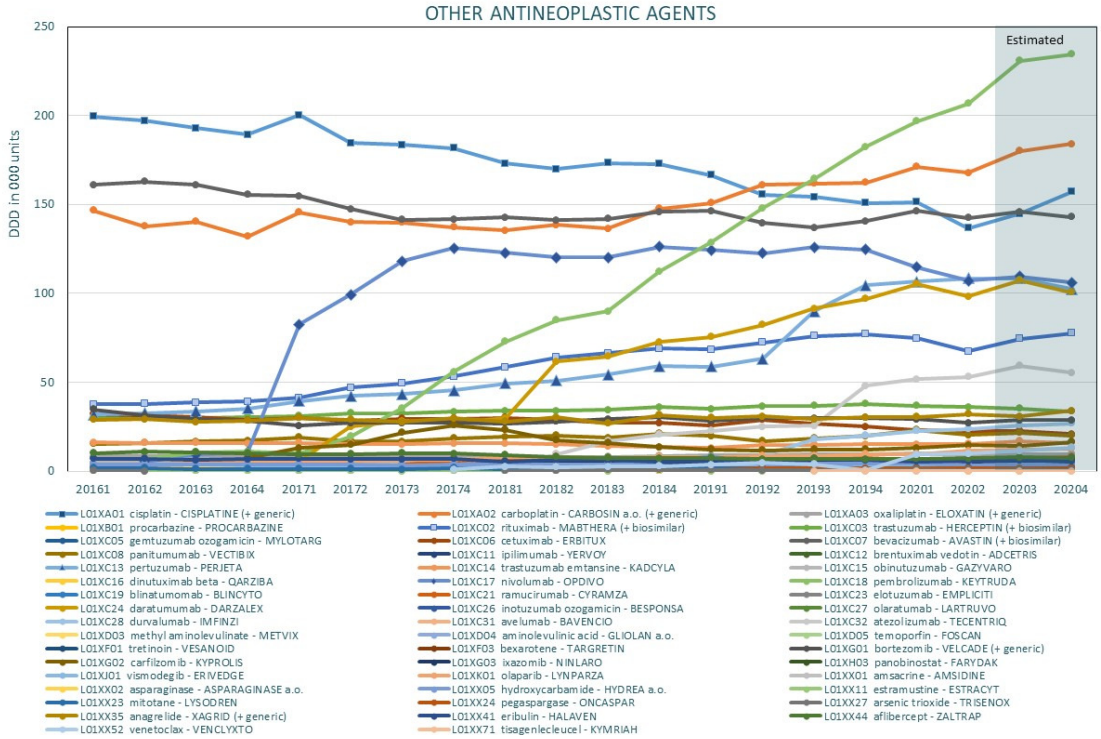


Figure 84: Evolution of NIHDI net annual expenditure and number of DDDs (hospitals (all patients) 2011-2020) for ATC class L04A immunosuppressants

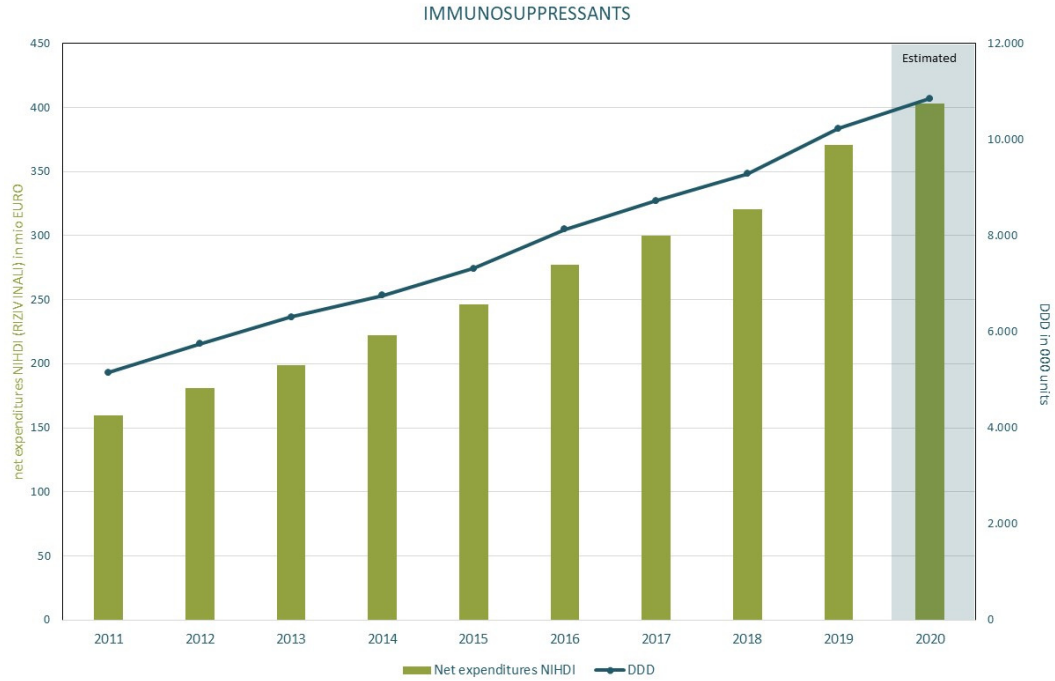


Figure 85: Evolution of NIHDI net quarterly expenditure (hospitals (all patients) 2016-2020) for ATC class L04A immunosuppressants

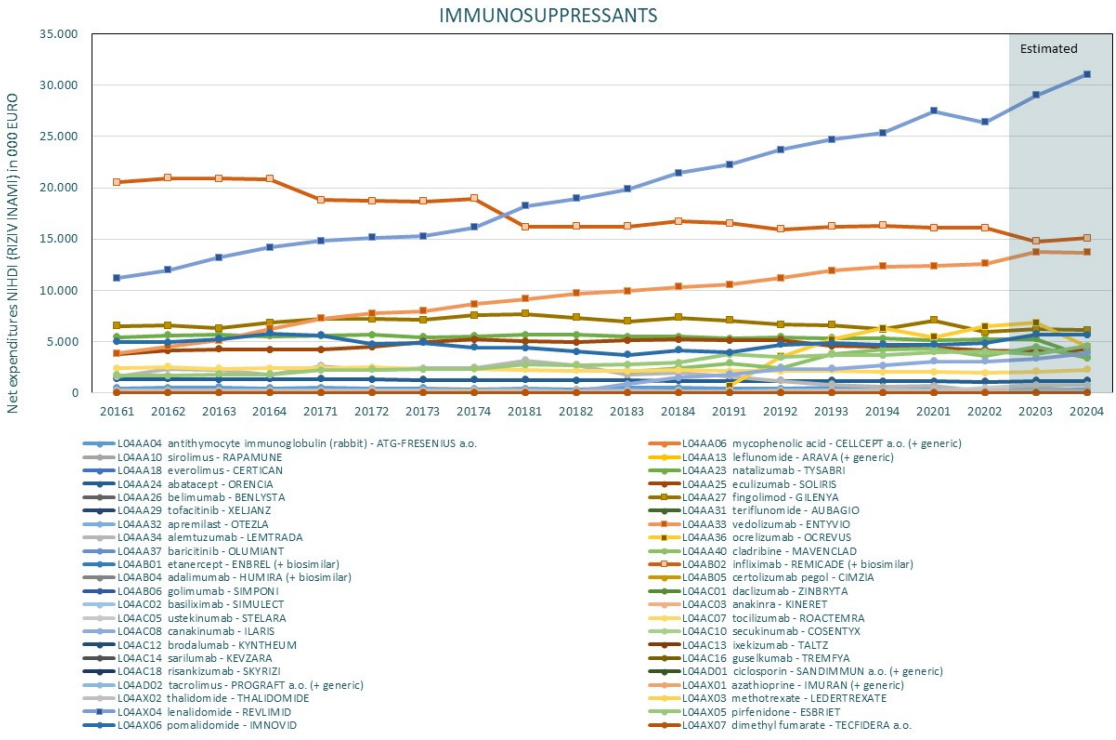


Figure 86: Evolution of number of DDDs per quarter (hospitals (all patients) 2016-2020) for ATC class L04A immunosuppressants

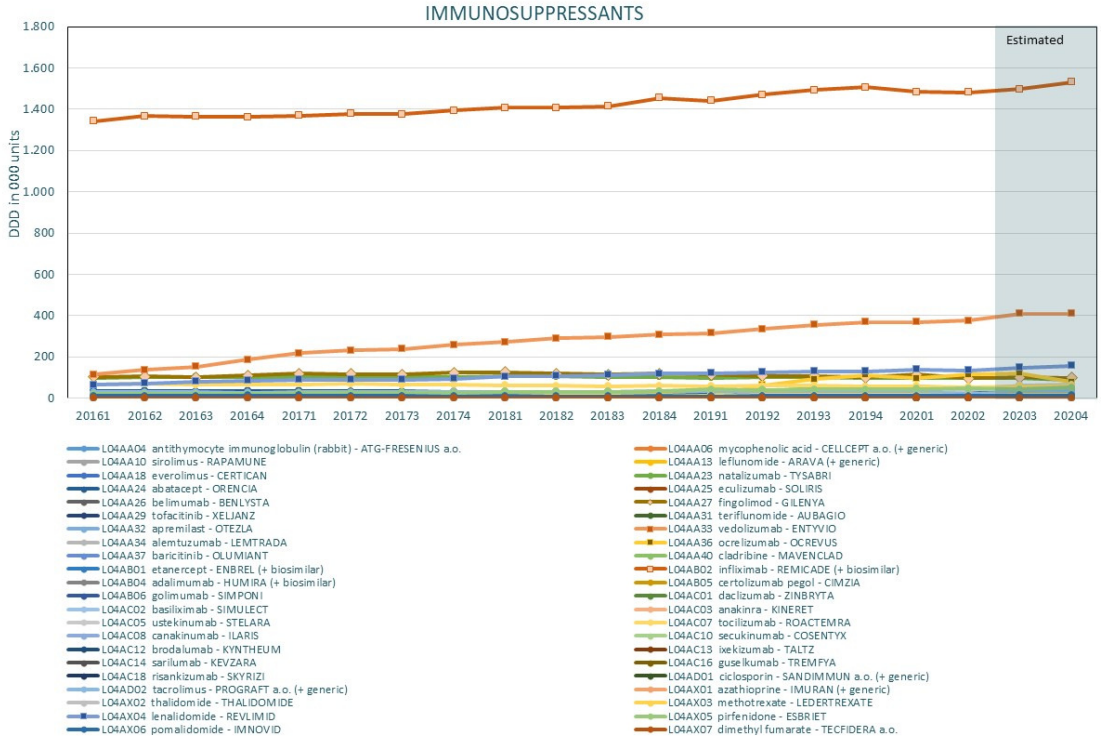


Figure 87: Evolution of NIHDI net annual expenditure and number of DDDs (hospitals (all patients) 2011-2020) for ATC class L01E protein kinase inhibitors

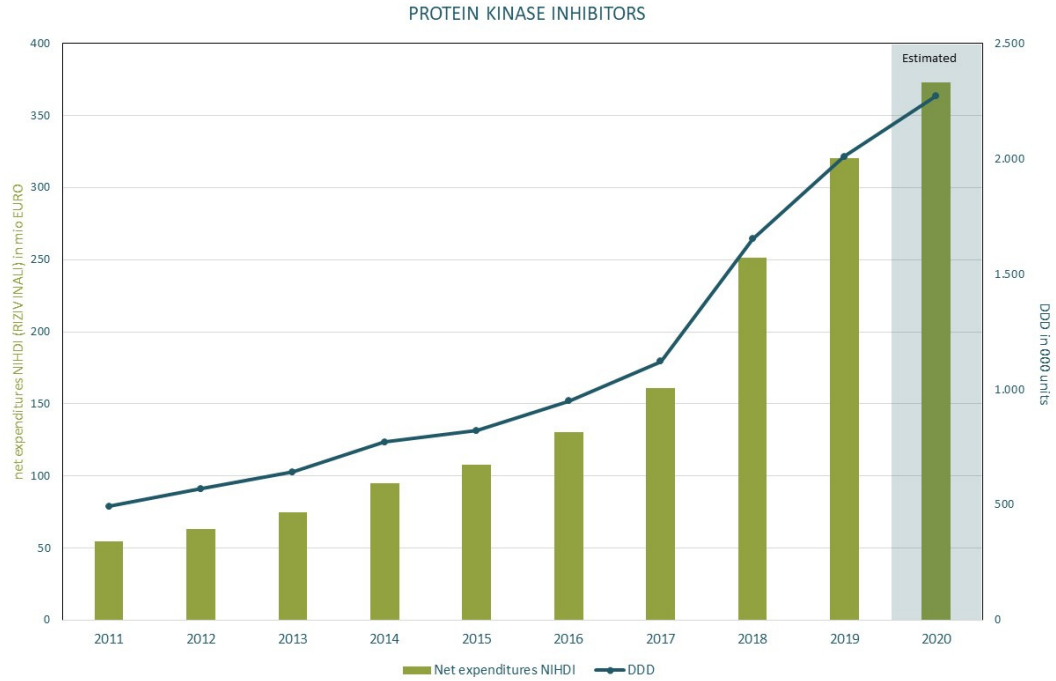


Figure 88: Evolution of NIHDI net quarterly expenditure (hospitals (all patients) 2016-2020) for ATC class L01E protein kinase inhibitors

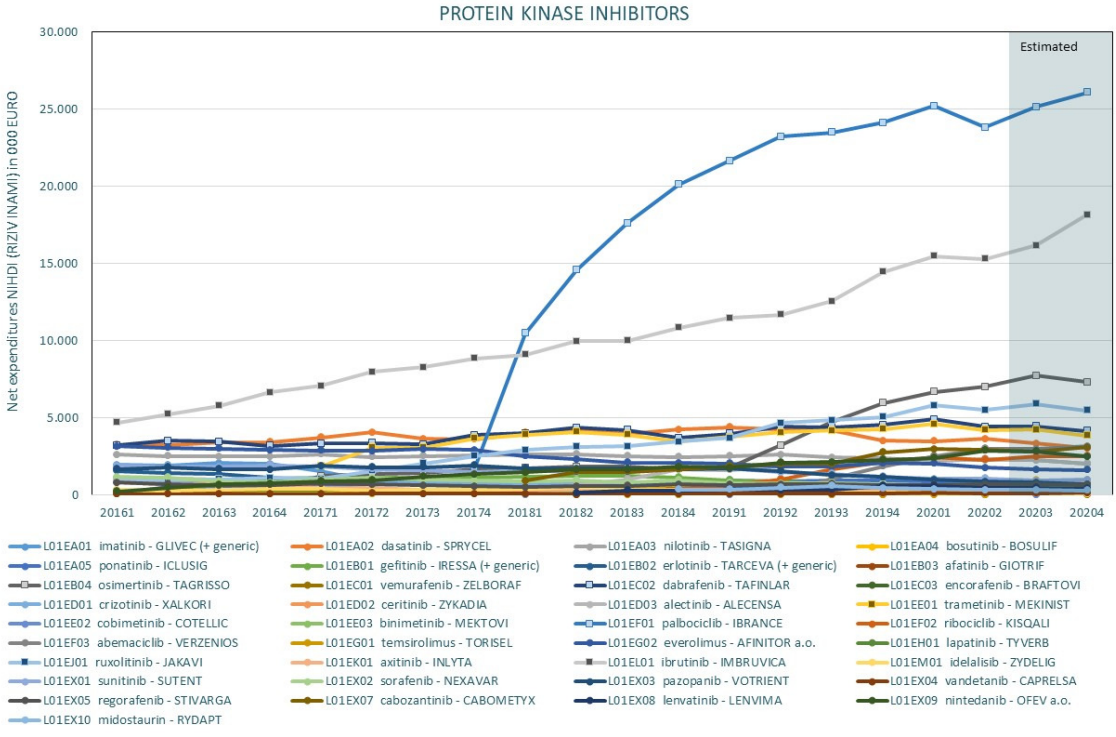


Figure 89: Evolution of number of DDDs per quarter (hospitals (all patients) 2016-2020) for ATC class L01E protein kinase inhibitors

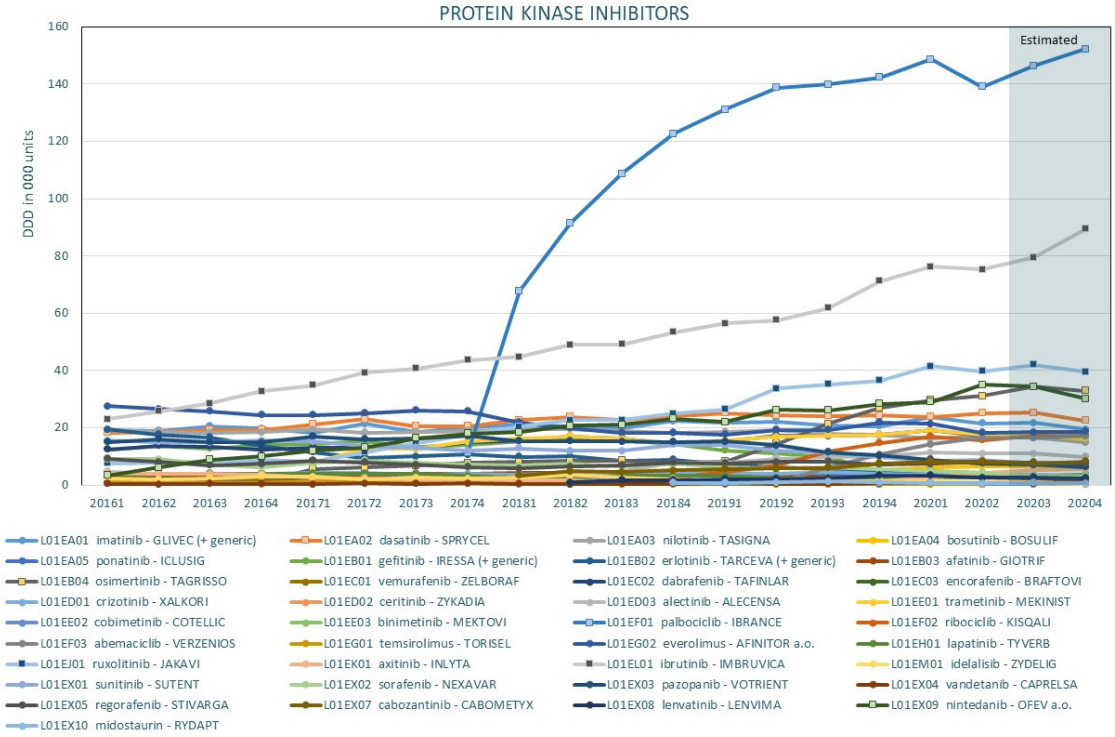


Figure 90: Evolution of NIHDI net annual expenditure and number of DDDs (hospitals (all patients) 2011-2020) for ATC class S01L ocular vascular disorder agents

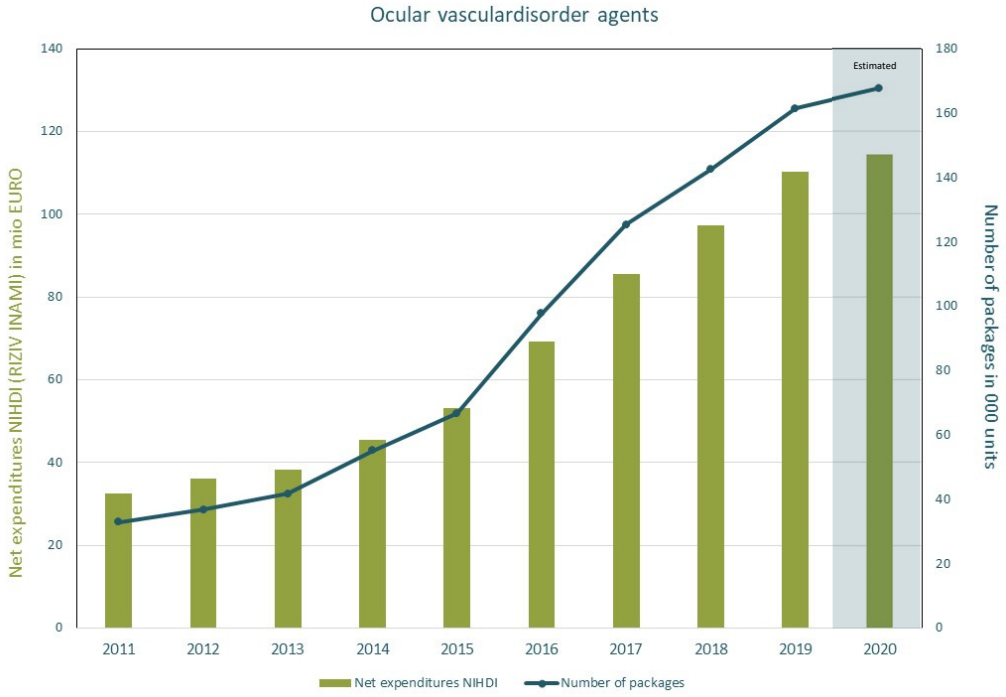


Figure 91: Evolution of NIHDI net quarterly expenditure (hospitals (all patients) 2016-2020) for ATC class S01L ocular vascular disorder agents

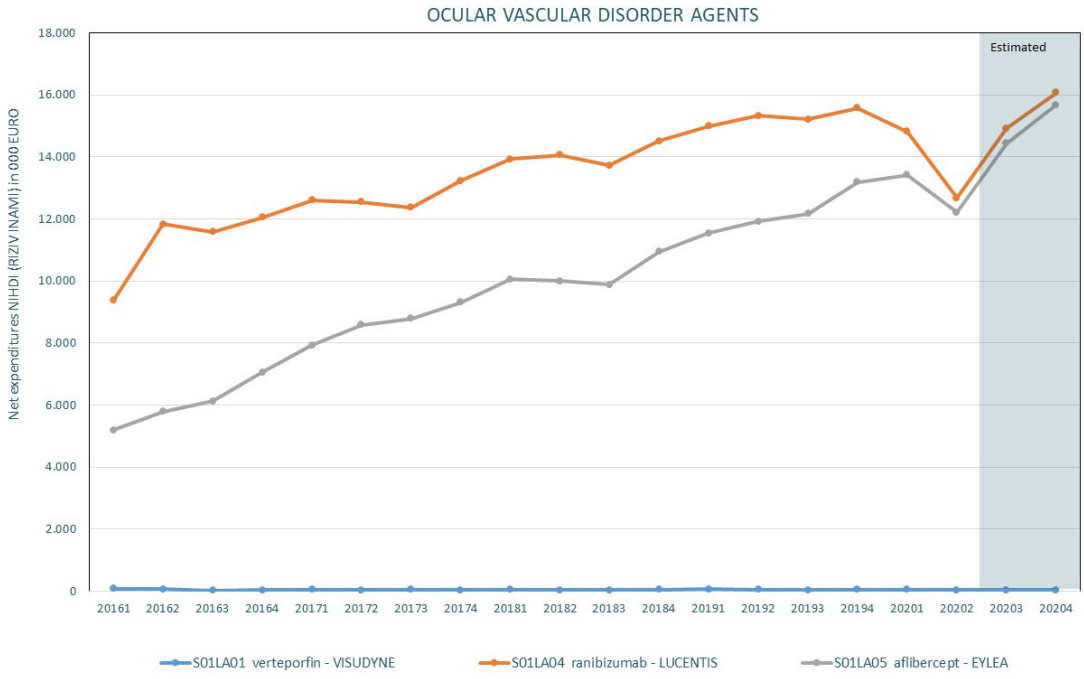


Figure 92: Evolution of number of DDDs per quarter (hospitals (all patients) 2016-2020) for ATC class S01L ocular vascular disorder agents

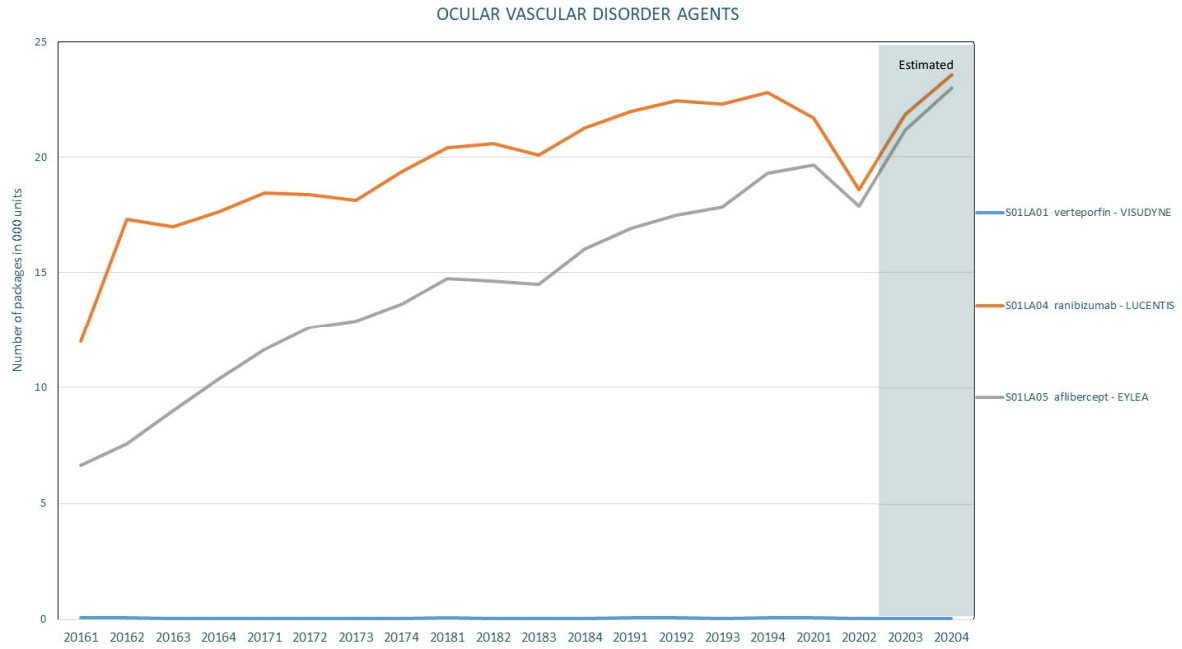


Figure 93: Evolution of NIHDI net annual expenditure and number of DDDs (hospitals (all patients) 2011-2020) for ATC class L02B hormone antagonists and related agents

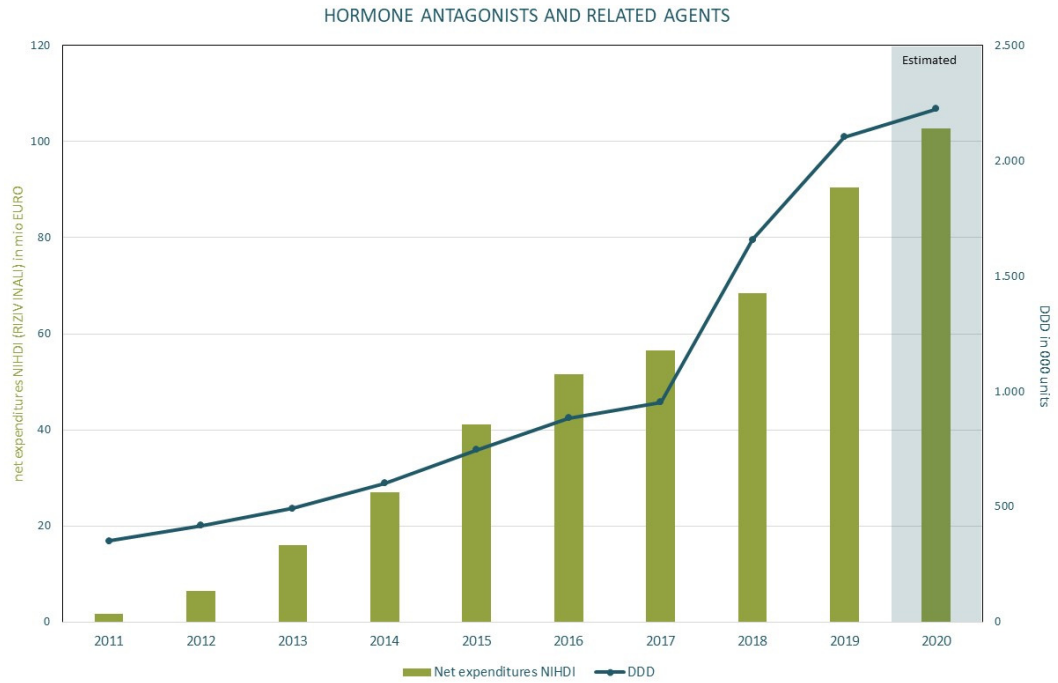


Figure 94: Evolution of NIHDI net quarterly expenditure (hospitals (all patients) 2016-2020) for ATC class L02B hormone antagonists and related agents

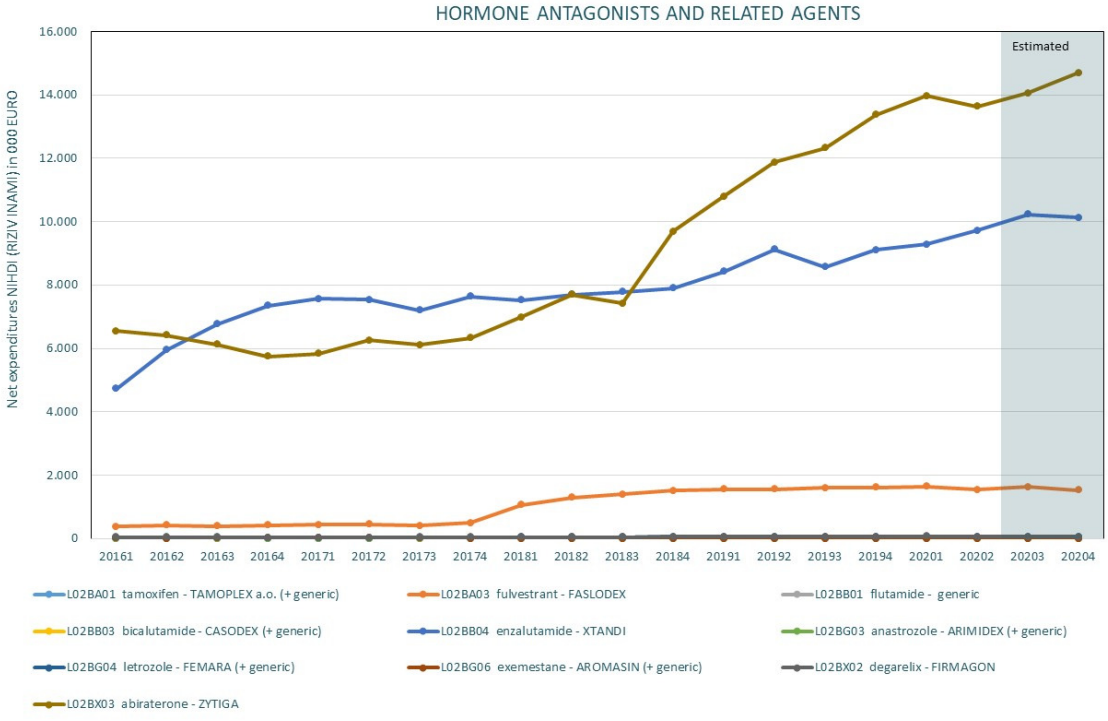


Figure 95: Evolution of number of DDDs per quarter (hospitals (all patients) 2016-2020) for ATC class L02B - hormone antagonists and related agents

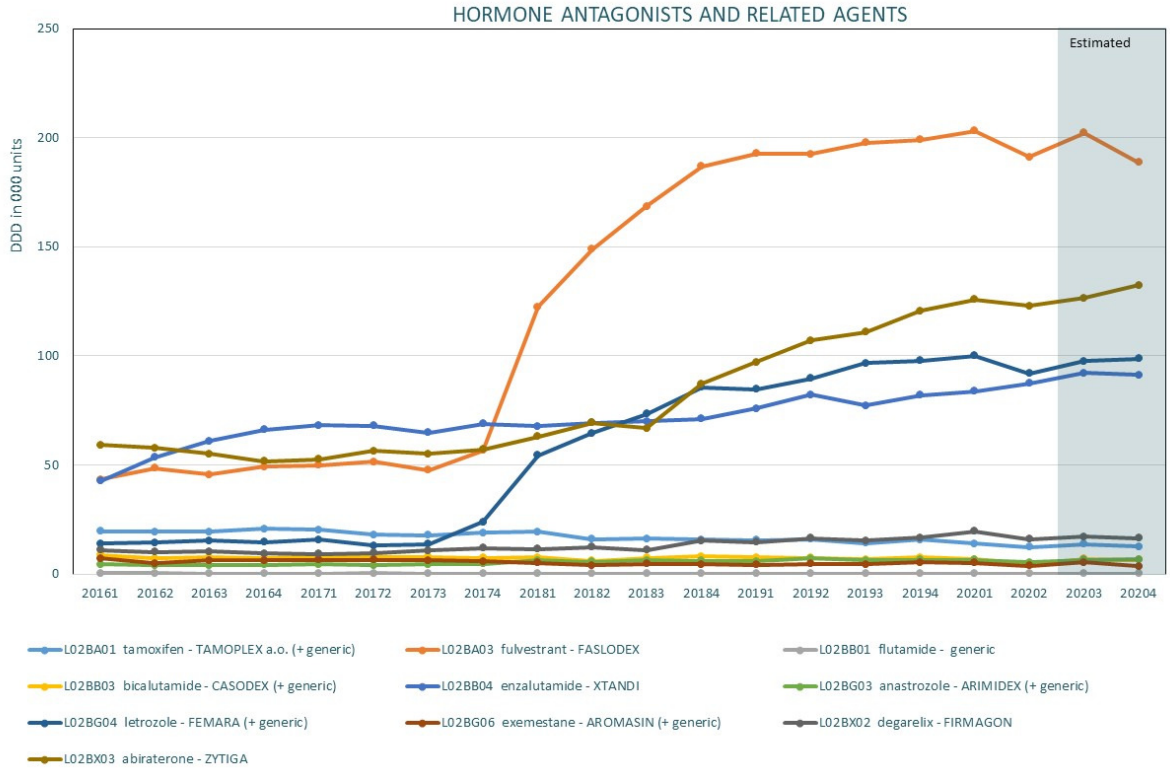


Figure 96: Evolution of NIHDI net annual expenditure and number of DDDs (hospitals (all patients) 2011-2020) for ATC class B02B vitamin K and other hemostatics

Figure 97: Evolution of NIHDI net quarterly expenditure (hospitals (all patients) 2016-2020) for ATC class B02B vitamin K and other hemostatics

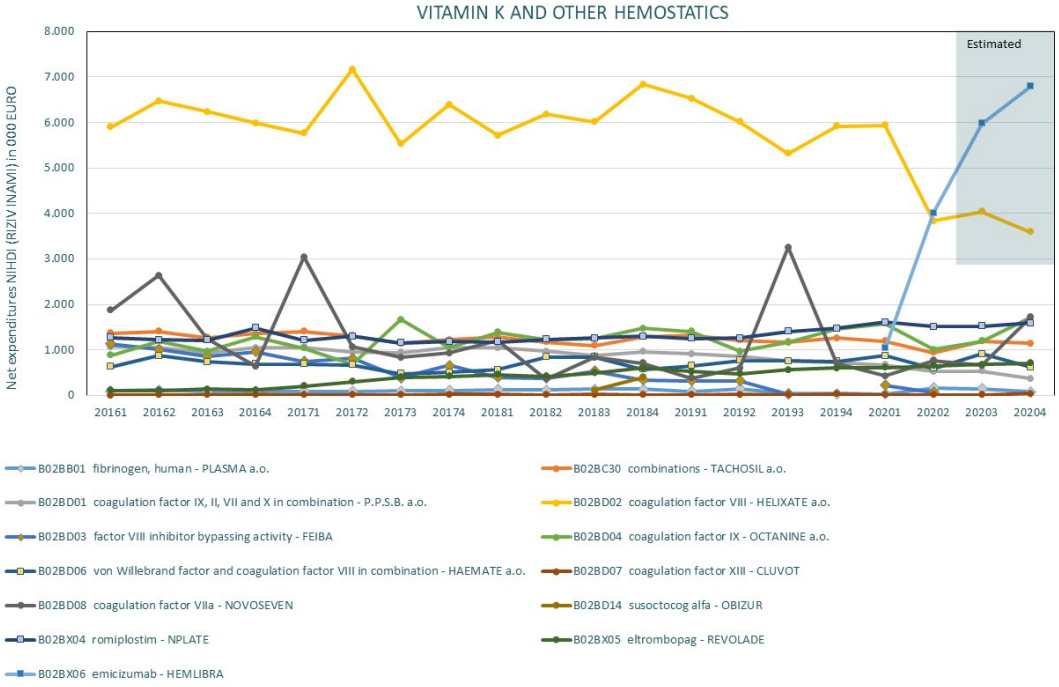


Figure 98: Evolution of number of DDDs per quarter (hospitals (all patients) 2016-2020) for ATC class B02B vitamin K and other hemostatics

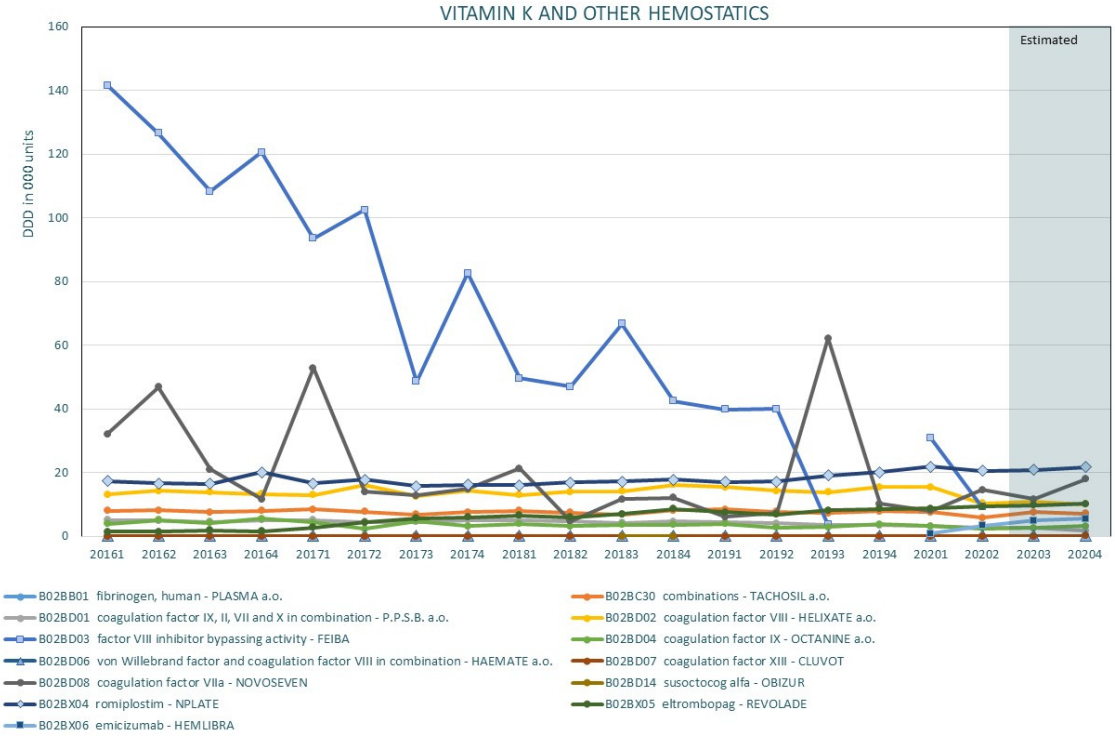


Figure 99: Evolution of NIHDI net annual expenditure and number of DDDs (hospitals (all patients) 2011-2020) for ATC class J05A direct acting antivirals

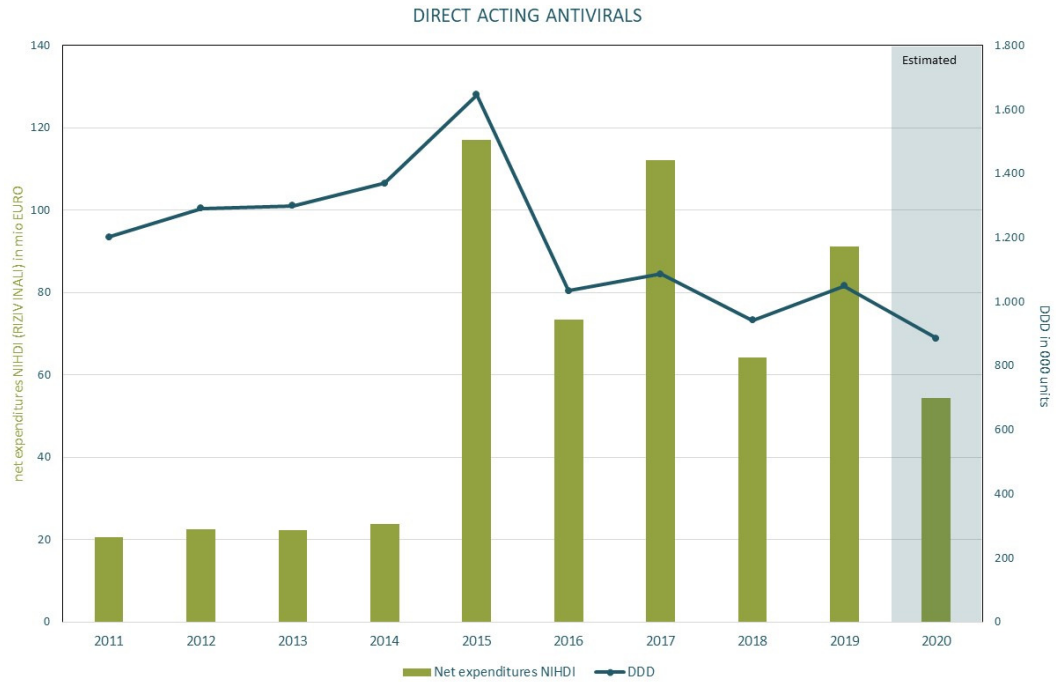


Figure 100: Evolution of NIHDI net quarterly expenditure (hospitals (all patients) 2016-2020) for ATC class J05A direct acting antivirals

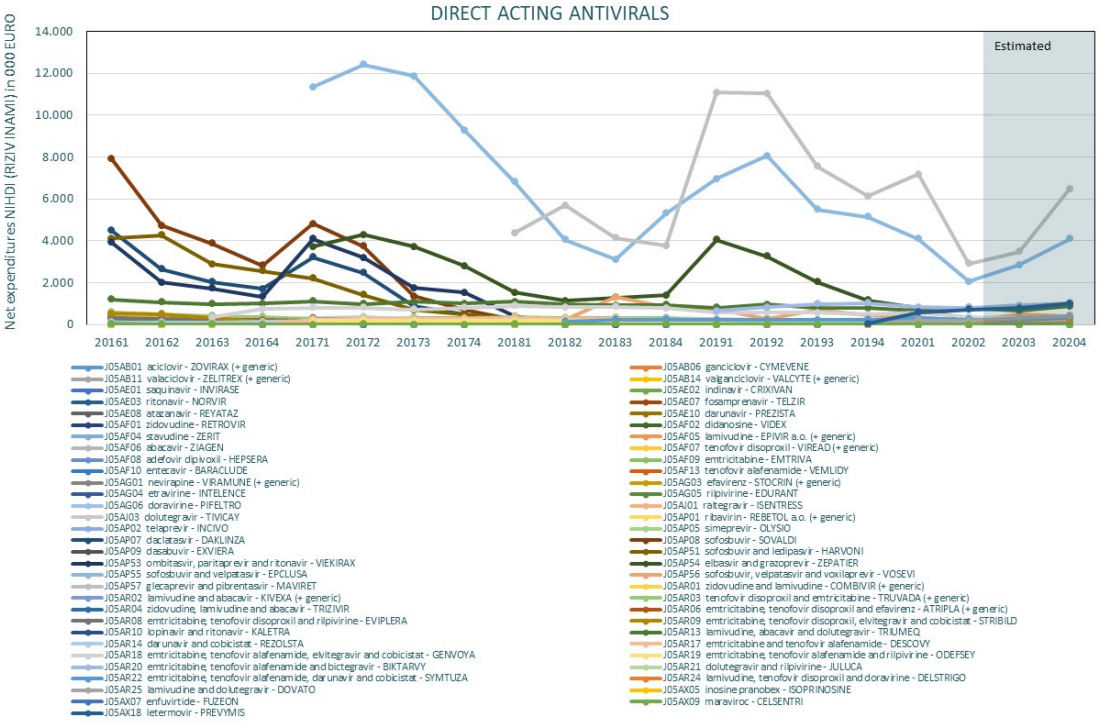
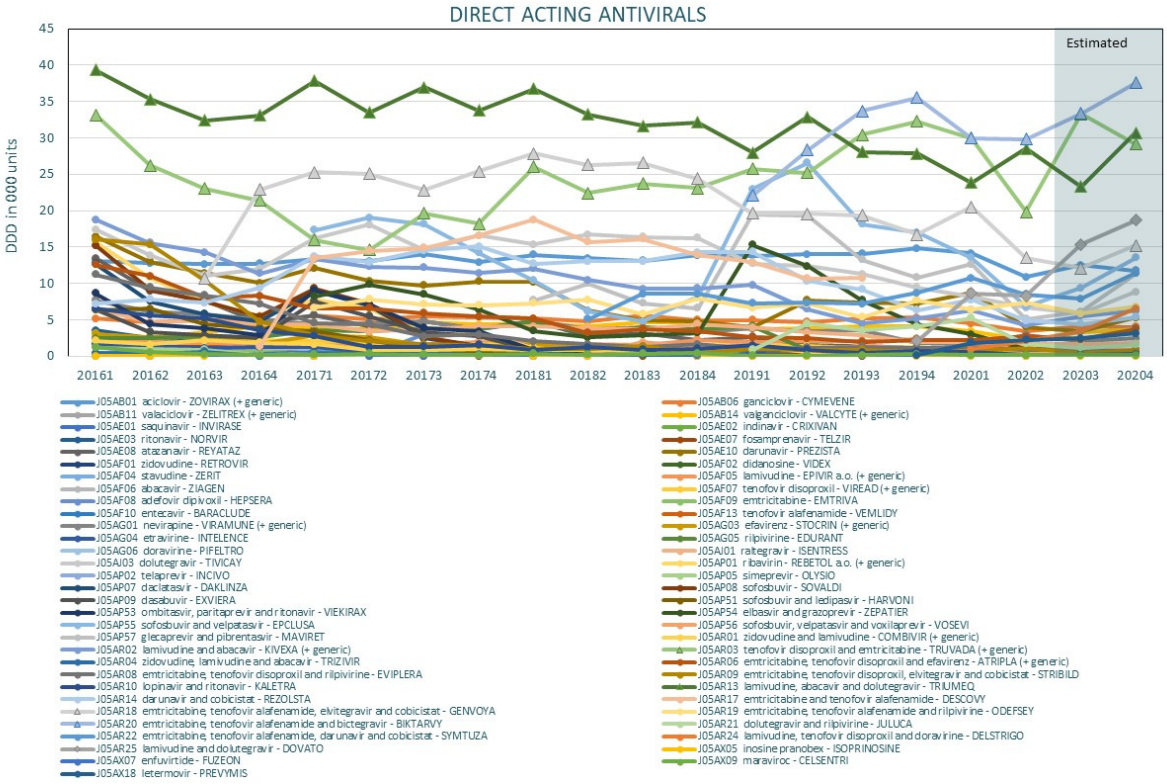


Figure 101: Evolution of number of DDDs per quarter (hospitals (all patients) 2016-2020) for ATC class J05A direct acting antivirals



ANNEX 5

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