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PGEU SUBMISSON

Commission's Green Paper
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"Promoting healthy diets and physical activity:
a European dimension
for the prevention of overweight, obesity and chronic diseases."

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The Pharmaceutical Group of the European Union (PGEU) represents the community pharmacists of 29 European Countries. The Members of the PGEU are the professional bodies and pharmacists' associations in EU Members States, EU candidate countries and EEA Member States.

PGEU objective is to promote the role of the pharmacists as key players in healthcare systems throughout Europe and to ensure that the views of the pharmacy profession are taken into account in the EU decision making process. In addition PGEU provides its' members with an ideal platform to facilitate exchange of information, collecting and disseminating best practices. PGEU also encourages its members to further develop new projects aiming at anticipating and responding to society's needs, in the brooder context of Public Health.

Thus, PGEU has a leading and motivational role in awareness raising and actions' coordination within its members.

PGEU welcomes the opportunity to respond to the Commission's Green Paper on this important Public Health topic.

Introduction

Over 10 million people visit the community pharmacies in EU Member States every working day. Those who visit pharmacies most often include mothers of young children and patients with long term medical conditions. Others seek advice on general health issues. All are clear target groups for messages designed to encourage healthy diets and to highlight the importance of undertaking appropriate physical activity.

Community pharmacies are recognised by members of the public as a vital, integral part of the health services in their country. They are also known to be conveniently accessible places where sound, objective advice on health issues can be obtained[1], from a knowledgeable health professional, in an informal environment in which they feel relaxed, without the need to make an appointment. In brief, pharmacies are obvious centres in every community for the effective transmission of messages designed to encourage healthy lifestyles. This has already been recognised by the health departments of governments in many Member States which have ensured that pharmacies are included in a structured way, in Public Health initiatives. Community pharmacists are, therefore, ideally located to make a valuable contribution, in some cases in collaboration with colleagues in other health professions, in the implementation of national strategies both to prevent and to tackle obesity. It is probably true to say that the full potential of the involvement of community pharmacists, and their well trained support staff, through the pharmacies network, has yet to be tapped in some Member States. The Commission may have a key role in support the exchange of information between Members States on successful initiatives run by community pharmacists Associations' to contribute to a positive public health agenda. The PGEU in cooperation

[1] Several European wide and national surveys show that pharmacists are highly trusted for their professional services (i.e. Reader Digest "Most trusted Professional services, 2005"). Moreover, the Council of Europe Resolution ResAP(2001)2 concerning the pharmacist's role in the framework of health security recognizes that pharmacists provide added value to the healthcare system both through their scientific and pharmaceutical expertise and in term of ethics.

with other international pharmacists Associations would be glad and willing to provide all necessary information to make this possible.

Pharmacies are already directly involved in health promotion, for example in encouraging smoking cessation, promoting the value of immunisation against infectious diseases and in helping those with long term medical conditions to maintain as high a quality of life as possible. Similarly, involvement in initiatives to prevent unwanted weight gain as a first goal and to tackle obesity when that occurs is therefore natural.

Strategies for tackling obesity must, of course, be country specific, recognising cultures, normal dietary habits and other relevant factors. However the European Union and the Commission, in particular, has important responsibilities in relation to regulatory aspects that can contribute to fight obesity and can support healthy diets. In addition, the supporting role of the Commission in promoting a high level of public health is an important element that can greatly contribute to promote a positive public health agenda in particular in the area of healthy lifestyles and obesity.

It must be recognised that Public Health is an area in which resources are generally scarce. Despite established evidences showing the benefits of a positive Public Health agenda to the society and in particular to the economy, national Governments tend to focus their investments in health, in providing healthcare services rather than in implementing Public Health strategies. This has been explained by the long term return in investment in Public Health. The Commission, if adequately resourced would be well placed to support Members States activities in implementing public health policies to fight challenges like obesity. For this purpose the newly proposed Public Health and Consumer Programme could be instrumental.

The Commission, also through the Programme, could act as a catalyst, by enabling the relevant stakeholders and NGOs to develop and implement a framework for action that can be then adapted in individual Member States, in the light of country-specific factors.

It must also be recognised that while messages should be as simple as possible, it is necessary to be specific on the action to be taken and ensure clarity. While it is true that the answer to avoiding becoming overweight or obese is simply to ensure that energy consumption is matched by energy output, people need guidance and advice on how this can be achieved. Therefore it is important that non-verbal and verbal written communication is reinforced with verbal oral communication and pharmacists are well trained and accessible to provide additional advice, thus adding value to interventions in Public Health.

The need for specificity was illustrated by the conclusions from three studies carried out as part of the Women's Health Initiative in the USA published on 7 February of this year, in the *Journal of the American Medical Association*. After tracking 50,000 post-menopausal women for 8 years, the results of the studies showed that eating a diet high in fruit and vegetables and low in fat, did not significantly reduce the risk of heart attacks, strokes or breast or bowel cancers. The researchers pointed out, however, that the importance of different types of fat had not been appreciated at the start of the studies and the women had just been advised to reduce total fat intake. Better outcomes were expected from following more specific advice on diet and for a longer period.

This example shows how important it is to target public health messages.

To illustrate pharmacists' involvement in developing Public Health campaigns and specific messages associated with healthy diets and physical activity, we take this opportunity to include, as annexes to this submission, some informative brochures and posters received from our members.

Moreover, and although it has not been addressed it this Green Paper, we would like to draw the Commission's attention to **other nutritional disorders** affecting more and more a larger number of the population, specially adolescents, which will also need to be dealt with if we are to consider healthy diets in a brooder context. In concrete, we refer to **bulimia and anorexia**. In this area, pharmacists play a key role in promoting the rational use of medicines, acting as Public Health gatekeepers when dispensing certain types of medicines that in several cases are available without a prescription and that are misused and abused by people suffering from the above disorders (concrete examples are laxants and diuretics).. PGEU would be keen in further elaborating in this area and contributing in developing any actions considered relevant to tackle this other important Public Health problem.

Finally, PGEU is determined to contribute in health promotion and heath education strategies for the prevention of obesity and other nutritional disorders to curb the pandemic. Nevertheless, we also strongly advocate for the need of controlling the existing cases and providing the necessary treatment and professional advice. At this level, community pharmacists have been involved in disease management programmes and pharmaceutical care and in particular in the rational use of medicines. These activities are essential in order to ensure that people derive maximum therapeutic benefit from prescribed medication dispensed in pharmacies as well as providing high quality advice to ensure safe and responsible self-care including, where appropriate, self-medication. Such action has proven to be not only important to overcome a Public Health problem but also to cost contain medicines expenditure. Community pharmacists are therefore a useful and highly accessible resource that should be used to its full potential in regards to treatment strategies.

PGEU's Comments

In this submission the PGEU will focus only on the questions which are more relevant to the community pharmacy sector and to the activities of the PGEU. We feel in these we can provide a more constructive input.

IV.3. Health across EU policies

> Questions on which the Commission invites contributions include:
>
> – What are the concrete contributions which Community policies, if any, should make towards the promotion of healthy diets and physical activity, and towards creating environments which make healthy choices easy choices?
>
> – Which kind of Community or national measures could contribute towards improving the attractiveness, availability, accessibility and affordability of fruits and vegetables?
>
> – On which areas related to nutrition, physical activity, the development of tools for the analysis of related disorders, and consumer behaviour is more research needed?

Healthy choices and healthy living are the results of a number of factors affecting citizen's life. These are not limited to nutrition policies and public health but also to a number of horizontal policies which affects the way of living. Examples include agricultural and industrial policies, school policies, urban planning, and many more.

The European Union (EU) has different levels of responsibilities in many of the areas mentioned above, however in the context of this submission we will focus on these specific responsibilities' that the EU has in relation to **Public Health**.

The Community has the objective of ensuring a high level of Public Health protection in all Community policies; in addition, article 152 of the current Treaty (confirmed in article 274 of the proposed Constitutional Treaty) entrusts to the Community a supporting role in promoting a high level of Public Health protection. One of the key instruments that the Commission has to pursue this objective is the **Public Health Programme**. The Programme is a key financial instrument which allows the Commission to support campaigns and activities which have as final objective the promotion of Public Health. A number of important projects have been carried out by stakeholders and Member States under the auspices of the Programme, also in the specific area of nutrition and healthy living. In light of this, and in our view, such a programme must continue to remain an essential instrument to promote Public Health in Europe. Unfortunately we are aware that in the current debate for the adoption of the new Community Programme for Public Health and Consumer Policy (2008-2013), and as it has been also emphasized by the European Economic and Social Committee.[2], the financial resources made available to the Commission are likely to be much lower than what was

[2] Opinion of the European Economic and Social Committee on the Proposal for a Decision of the European Parliament and of the Council establishing a Programme of Community action in the field of health and consumer protection 2007-2013 COM(2005) 115 final – 2005/0042 (COD) – INT/271 Health and consumer protection, of 14 February 2006, point 3.1.11

asked for, and by far not sufficient to respond to the many Public Health challenges the EU is facing today.

We have already referred to the fact that investment in Public Health is by definition a long term investment. A positive Public Health message passed to citizens today may see its results only in several years, and, in certain cases, generations are needed to change habits. This tends to discourage national Governments in their investments in long term Public Health strategies. As mentioned earlier, the Commission, through the Programme, and in particular by enabling stakeholders in carrying on **targeted campaigns** at national and even local level, could greatly contribute in supporting Members States in the implementation of Public Health policies relevant to promoting healthy living and fighting obesity. And thus could greatly contribute in supporting the implementation of long term objectives that may otherwise be less effectively targeted.

In this context, we wish to highlight the contribution that community pharmacists, through the network of community pharmacies, can make in transmitting targeted messages to citizens. PGEU Members are already active at local and national levels in Public Health campaigns, including fighting obesity.

For example, Spanish community pharmacists, through the network of pharmacies covering the whole country, have been participating since 1992 in a health programme called Plenufar. The objective of this programme is to campaign for correcting the dietary habits of the population, promoting healthy life-styles and a healthy diet. It is managed at national level by Consejo General de Colegios Oficiales (the National Professional Association) and it is implemented with the collaboration of the regional colleges. It has undergone three phases with different targets populations. In the first phase it was targeted to housewives as the person responsible of the dietary habits of the family. During this phase 2,000 pharmacists in the whole of the Spanish territory participated and followed the campaign informing more 100,000 housewives. At that time the campaign had a good impact and there was positive media coverage encouraging the idea of promoting similar activities. The second phase of this programme took place in 2000, and it was addressed to school children as it was recognised that they are in danger of acquiring unhealthy eating habits. His time, 3,000 pharmacists participated in the project providing information to more than 120,000 children. Nowadays many schools still demand the information and speeches that were part of the campaign. After the success of these two phases of the programme, the third one, now under implementation, will be focusing on elderly people. It is estimated that 40% of the elderly population in Spain is undernourished. The objective of the campaign is to detect the percentage of the elderly population affected by the unhealthy dietary habits, to evaluate its nutritional status, inform about healthy eating habits and define the interaction between food and medicines taken by many elderly people.

We feel that this type of activities could benefit from a multiplication effect if repeated in different Member States and coordination at EU level, eventually thought the support of the Public Health Programme, could greatly contribute to the desired objective.

The example mentioned above shows that to enable citizens to make healthy choices it is essential that they are given the necessary information and are supported, when necessary, by an expert's advice. In this context, we believe that it is also important to refer to another important area which could contribute to enable the consumer to make healthy choices about his/her food: the provision of accurate and clear information. Besides promoting the general message through campaigns, the Commission should

ensure that legislation in the area of **labelling of food products** and health **claims** on food products meets this objective. In both areas the Commission has important responsibilities.

In relation to food labelling we wish to highlight the important progresses made in Europe in relation to enhancing information on food products. However, there is still room for improvement as the clarity, accuracy and user friendliness of information on food products remains an essential instrument to enable consumer in making healthy choices (please see section V.1 for more details on PGEU position in relation to these topics).

We have already referred to several policy areas in which the EU has responsibilities and that may have an influence in creating a favourable environment for healthy diets and for promoting physical activity. We also mentioned the key role played by Member States in implementing any Public Health strategies and the importance in any campaign and/or action to target the activities to the national dimension and habits, using all relevant channels including health professionals and in particular community pharmacists. We also referred to the Commission, in particular via the Public Health Programme, as a potential greater resource for implementing these national strategies.

In light of the above, we would like to refer to another important role of the Commission in this are which is its activity as catalyst to promote dialogues and discuss possible solutions by tackling the problem in a cross-sector way. The so called EU Platform on Diet, Physical Activity and Health is, in our analysis, an important example. We consider it is important for stakeholders from different backgrounds and representing different sectors to discuss possible ways forward and solutions to fight this important Public Health challenge. Although the PGEU is not involved in the Platform, we would like to be kept informed on its activities and are ready and willing to contribute with relevant successful examples as the ones mentioned above and throughout this submission.

IV.4 The Public Health Action Programme

Questions on which the Commission invites contributions include:

- How can the availability and comparability of data on obesity be improved, in particular with a view to determining the precise geographical and socio-economic distribution of this condition?
- How can the programme contribute to raising the awareness of the potential which healthy dietary habits and physical activity have for reducing the risk for chronic diseases amongst decision makers, health professionals, the media and the public at large?
- Which are the most appropriate dissemination channels for the existing evidence?

In designing any campaign aimed at raising awareness on a specific issue it is important **to target the message** to the audience the message is addressed to and to use the most appropriate channel to achieve a change in the habits of the recipient.

In relation to the topic referred to in the question above we feel it is important to highlight to a given audience the most relevant factors of the key message. For

example, in relation to decision makers it would be essential to outline the costs to society and to the economy of chronic diseases; through adequately highlighting this aspect of the message it would be easier to outline the potential benefits from healthy dietary habits and physical activity. It is also important to underline the fact that health expenditure must not be curbed at the expense of quality of care, and the old maxim that one can prevent extensively at relatively low cost but can only treat on an individual basis at much higher cost, especially in the secondary care sector, is the appropriate message. **Adequate resourcing** of measures to help people to maintain good health and avoid ill health is essential. As mentioned earlier in this submission, this is always seen as a difficulty because the benefits of successful health promotion campaigns are not seen for some years and, in the meantime, there is no reduction in expenditure on treatment. The "time-bomb" represented by increasing obesity and the widespread development of long term medical conditions that will inevitably result, should be the trigger for acceptance by decision makers of the need to evolve, implement and resource adequately, policies with undoubted long term benefits.

Health professionals are already well aware of the benefits of healthy diets and appropriate physical activity. The key is to utilise this awareness on their part to communicate effectively with those who seek their professional services and to ensure that **the messages they convey are consistent and clear**. To reach health professionals, for instance with campaigns aimed at promoting a cross-professionals cooperation in this area, the most effective means would be the specialised professional press.

On the other hand, individuals can be reached via properly structured and tested initiatives. **Media at large are an important channel to raise awareness**, however, as mentioned earlier, any health related message has to be well targeted. Moreover, it has to be followed up and repeated in order to be effective and to determine a change in habits which is the final objective of such campaigns.

In this context, we wish to underline that community pharmacists naturally provide an ideal source to transmit Public Health messages, including raising awareness messages. It has been demonstrated that their intervention in specific health information campaigns make a significant contribution to determine a **change in the habits** of the recipient of the message. In particular, research[3] in the area of smoking cessation showed that the intervention of community pharmacists in supporting citizens in quitting smoking resulted in higher rates of successful quitting. These findings may be equally relevant to the area of diet and weigh loss as, like in smoking cessation, people have to be personally motivated to achieve the change in habits and, more importantly, maintain it over time.

Last but not least, to ensure an effective awareness campaign it would be important to **coordinate any activities of different parties** involved. Through this course of action, it would be possible to ensure consistency of the message transmitted as well as a wider reach of citizens by using complementary sources. To ensure effectiveness it would be also important to involve food industry and advertisers.

[3] Pharmacists against Smoking - Research Report 2001, EuroPharm Forum - Forum of European Pharmaceutical Associations and the World Health Organization Regional Office for Europe

As an example of this coordination at national level, we would like to point out the case of Portugal where in order to implement the Public Health National Strategy, several national coordination committees have been established, according to specific action areas, such as obesity. These committees gather different stakeholders, and pharmacists are also represented through their professional regulatory body. We believe this is a good practice that should be encouraged by the Commission to Member States.

V.1. Consumer information, advertising and marketing

Questions on which the Commission invites contributions include:

- When providing nutrition information to the consumer, what are the major nutrients, and categories of products, to be considered and why?
- Which kind of education is required in order to enable consumers to fully understand the information given on food labels, and who should provide it?
- Are voluntary codes ("self-regulation") an adequate tool for limiting the advertising and marketing of energy-dense and micronutrient-poor foods? What would be the alternatives to be considered if self-regulation fails?
- How can effectiveness in self-regulation be defined, implemented and monitored? Which measures should be taken towards ensuring that the credulity and lacking media literacy of vulnerable consumers are not exploited by advertising, marketing and promotion activities?

and

V. 2. Consumer education

Questions on which the Commission, in view of identifying best practices, invites contributions include:

- How can consumers best be enabled to make informed choices and take effective action?
- What contributions can public-private partnerships make toward consumer education?
- In the field of nutrition and physical activity, which should be the key messages to give to consumers, how and by whom should they be delivered?

The aim should obviously be to ensure that the information given on food labels is **easily understood** and this will only be achieved by the standardisation of the format in which the information is given. The information must, of course, also be accurate. A report in 2004 by the UK consumer organisation now named Which? found that of 70 product labels, only 7 per cent of the "facts" given were accurate. Consumers want information that genuinely helps them to make sensible choices. This information should be prominent and possibly in a colour coded format, not in small print on the rear of the package.

Statements such as "90 per cent fat free" or "reduced fat" can be misleading because, although in themselves accurate, they may refer to products that still contain a relatively

high level of fat. In this context, we would like to refer to the debate on the proposed legislation on claims for food. The PGEU is convinced that **any health claims for food must be justifiable scientifically;** in addition with a number of other health NGOs, PGEU supported the inclusion of a **nutrition profile** on food products. We regret that this was not adopted by the EP however we are confident that the EU Institutions will address this issue. We are convinced that it is essential that claims made on food have to be understandable for consumers and in our analysis the inclusion of nutritional profile on products would have provided an important instrument to enable citizens to make healthy choices in relation to the food they decide to eat.

The active involvement of the food Industry, in particular of producers of high-fat or high-salt and energy-dense products, in the debate on obesity and healthy eating is important to ensure that such enormous Public Health challenge can be addressed. **The EU Platform on Diet, Physical Activity and Health** is trying to achieve this. Producers should be made aware that the costs to society of this "new pandemic" will in the long run hit the Industry too. Therefore, and ideally, self-regulation, for instance, to the maximum content of salt or fat in given products for children and aggressive and misleading advertising, could be a way forward. However, considering the dimension of the phenomenon and the Public Health consequences that it has on society, the implementation of any relevant self-regulatory mechanism has to be carefully monitored and any breach severely punished. The PGEU is not aware on whether existing self-regulation measures in this area have proven to be successful. However in the pharmaceutical sector, which is the area of major expertise for the PGEU and its Members, the non compulsory nature and the difficulties in monitoring the effective implementation of Industry's **self-regulation has already showed its weaknesses.** We obviously cannot assume that all self-regulation may or would fail, but we believe it would be essential to promote, in parallel, raising awareness campaigns and, via legislation, to enhance further the provision of clear, accurate and understandable information on food. Ultimately, a legal framework in regard to the nutrional profile of certain processed food should be considered.

We are of the opinion that a balance between self-regulation measures and a legal framework for food advertisement should also be further developed. At this level, we believe that the experience gained in the area of tobacco control initiative should be taken into consideration for future steps.

The role of Public-Private partnerships (PPP) in providing information and in particular in raising awareness is extremely relevant in this context, as long as the **PPP is well defined** in its objectives and there are no competing messages transmitted.

Again, it is interesting to notice that **pharmacists are well trained to provide information and to be active in health education**. As an example of this, we can mention the "train de la vie" (healthcare train) French initiative. Between 17th March 2005 and 14 April 2005, a train went to 25 different cities in France in order to put forward health education. Different health professionals were involved in this initiative. Pharmacists, with the National Council of French Pharmacists, were particularly active at each stop of this train. The train was composed of five coaches according to different subjects: breathe well; eating and health; use your head; move your body. In 11 of the 25 cities visited by the train, conferences were organised by pharmacists on health education. The main objective was to exchange experience and propose new ideas on how to deal with patient education and prevention.

V.3. A focus on children and young people

Questions on which the Commission, in view of identifying best practices, invites contributions include:

- What are good examples for improving the nutritional value of school meals, and how can parents be informed on how to improve the nutritional value of home meals?
- What is good practice for the provision of physical activity in schools on a regular basis?
- What is good practice for fostering healthy dietary choices at schools, especially as regards the excessive intake of energy-dense snacks and sugar-sweetened soft drinks?
- How can the media, health services, civil society and relevant sectors of industry support health education efforts made by schools? What role can public-private partnerships play in this regard?

Undoubtedly, the school environment is ideal for conveying messages about healthy lifestyles, good diet and adequate physical activity. This must, of course, be supported in the home. Children who become overweight early in life have higher propensity to be much less enthusiastic to participate in sports and the vicious circle then begins to form. Governments have it in their power to ensure that energy dense snacks, or products with a high salt content, are not readily available in state schools, for example via vending machines[4].

In some Member States, pharmacists, with support from their professional organisations and teacher organisations, **visit schools to convey to children health messages**. However, this tends to depend on local initiatives. The practice should be co-ordinated at national level, through a code of best practice and these possibly disseminated at European level. Pharmacists could, as part of their presentations, reinforce the healthy eating and adequate physical exercise messages that are being promoted by others. This is something that can be easily done and with very low costs associated as pharmacists are already trained to convey this kind of messages. Instead, training teachers to do so would be a more costly solution.

V.5. Building overweight and obesity prevention and treatment into health services

Questions on which the Commission invites contributions include:

- Which measures, and at what level, are needed to ensure a stronger integration aiming at promoting healthy diets and physical activity into health services?

From what has been said earlier in this submission, the PGEU clearly agrees that "health professionals have a strong potential for improving patients' understanding of the relations between diet, physical activity and health and for inducing necessary lifestyle changes", particularly if they all convey complementary messages and work

[4] It is relevant to underline the recommendations made in this area by the Council of Europe in its Resolution ResAP(2005)3 on healthy eating in schools.

under a same national strategy. Our only quarrel would be with the use of the word "patients". Pharmacists would wish this potential to be utilised fully before people become patients, and therefore contribute for the main goal of primary prevention. And as we have said, the community pharmacy is an ideal location for this activity.

Community pharmacists operate at three distinct levels in helping people in the area of weight and health.

At the first level, all pharmacies participate in campaigns to convey messages designed to encourage healthy lifestyles and many are involved in screening programmes for early detection of conditions such as cardiovascular disease and diabetes. As we have indicated, we believe that the full potential of the involvement of community pharmacies, in a structured, co-ordinated and adequately resourced manner, is not being utilised in Member States.

At the second level community pharmacists in some Member States are directly involved in weight management programmes for people who are overweight and are personally motivated and committed to reduce their weight, through diet and appropriate physical activity.

The success of such programmes was demonstrated by the results of a study in Denmark, in which "slimming courses" were held at 19 community pharmacies, involving 269 obese clients. Average weight loss, measured in the pharmacies, was 5.3kg for women and 6.2kg for men. At follow up after one year, 20 per cent of those who had completed the courses had maintained a weight loss of 5kg or more.

In the UK, some of the bodies responsible for managing the National Health Service (NHS) at local level have commissioned Weight Reduction Clinics through community pharmacies with appropriate facilities. The aims of these programmes are to

- identify, prevent and modify health risks;
- set realistic and achievable goals for weight loss;
- improve nutrition;
- increase levels of exercise;
- maintain weight loss by encouraging change of lifestyle.

The availability of the service is promoted by leaflets and posters in the practice premises of general medical practitioners. Criteria are set for those who will be able to receive the service, which is free of charge to the individual.

The programme consists of six sessions at monthly intervals and the target is for those involved to achieve a 10 per cent reduction in weight over that period. There are twelve elements within the programme, including, for example, calculation of BMI, measurement of blood pressure, blood glucose and total cholesterol and advice to individuals of the implications of their BMI and on exercise, healthy eating and other lifestyle issues. With the consent of the individual concerned, relevant information is fed back to the general medical practitioner.

Again in the UK, there is a third level of activity. A service of the kind described at the second level is provided but, in addition, the community pharmacist concerned may supply appropriate medicinal products from a locally agreed formulary, to assist individuals with weight loss.

One pharmacy group in the UK has launched a private weight loss programme, which includes the supply of appropriate medication if necessary, for people who meet specified criteria. A pilot in three pharmacies, prior to wider availability, involved 400 people and the drop out rate was only 3 percent. The average weight loss over a six month period was 10.6 per cent. In addition more than half of those eligible for participation in the scheme were found to have high blood pressure or raised glucose levels and were referred to their general medical practitioner.

Quite apart from these programmes, community pharmacists play an important role in helping those being treated for obesity with management of their medication. Because adherence to treatment is vital if it is to be successful, it is important to provide necessary support to enable people to comply with the medication regime. Providing advice and support if they encounter side effects, is a simple but highly effective way to enhance adherence to therapy. The best place for this advice to be available is the community pharmacy where patients have a focus on medication if they are undergoing treatment.

As an example, a pharmacy-based US research study aimed at promoting patient persistence and compliance with prescribed dyslipidemic therapy that enables patients to achieve their National Cholesterol Education Program (NCEP) goals, and building upon collaborative work with patients and physicians, showed that in a population of 397 patients over an average period of 24.6 months, observed rates for persistence and compliance with medication therapy were 93.6% and 90.1%, respectively, and 62.5% of patients had reached and were maintained at their NCEP lipid goal at the end of the project[5]

5 Pharmaceutical Care Services and Results in Project ImPACT: Hyperlipidemia
J Am Pharm Assoc. 2000;40:157–65.

Conclusion

Obesity has many possible causes which can be genetic, environmental, behavioural or cultural. Obesity is said to reduce life expectancy by nine years and is very costly to treat.

The first goal must therefore be prevent obesity starting with appropriate programmes for parents and children and continuing throughout life. This will require commitment to annual expenditure by governments over a lengthy period, rather than for intermittent campaigns. The supporting role that the Commission could provide via the Public Health and Consumer programme could be instrumental to fight this important public health challenge. The eventual benefits in reduced treatment costs for conditions such as diabetes, cancers and cardiovascular disease will be immense and therefore should be included in the design of any initiative aimed at addressing the overall challenge of obesity. In addition raising awareness to citizens and policy makers using the most appropriate message and the most relevant source of information should be considered as an important priority.

Before the goal of prevention is achieved, there will be a need to motivate people who are overweight or obese to reduce their weight and to help them achieve that aim.

As indicated in this submission, the PGEU considers that community pharmacies have an important role to play both in prevention and treatment. The expertise of pharmacists and the existing network of pharmacies throughout national territories is long available and should therefore be fully utilised.

END

Annexes

In this section we include a small example of what PGEU members are doing at a national level in order to illustrate what has been addressed in this submission. PGEU is working on a more comprehensive document which will include further information from its members. We will be pleased to forward it as soon as it is finalised.

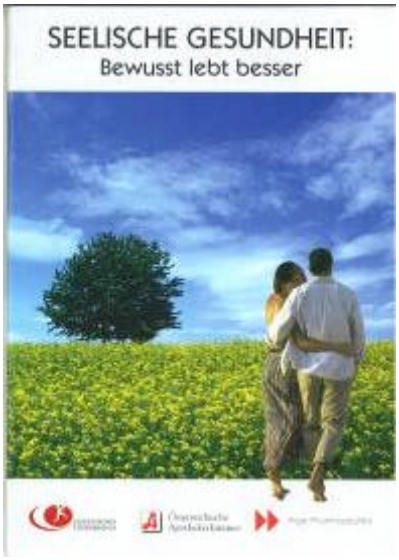
Examples from Austria

In September 2005 a large campaign was started and 3x300.000 brochures were printed in a first edition to be distributed via community pharmacies. The brochures are designed by the so-called "Healthy Austria Fund" in cooperation with pharmacists. They are distributed free of charge via pharmacies and complemented by media campaigns and posters for display in pharmacies. Its content and quality currently is probably the best available for the large public.

The first brochure is called "Nutrition - living consciously is living better" and stresses on the right variety of food, the nutritional pyramid, a lot of tips around healthy and balanced nutrition and some nutrition facts and risks (fat, salt, sugar, wholemeal, proteins, drinks, etc). It contains as well information on the BMI and how to measure it and many references for further reading and counselling.

The second is called "Physical activity - living consciously is living better". It is dedicated to the risks of no and the bonuses of regular activity and a couple of tips how to organise and execute sports as well as some practical examples for exercises and a "fitness ABC". Again, more sources of information and useful addresses are found on the last pages.

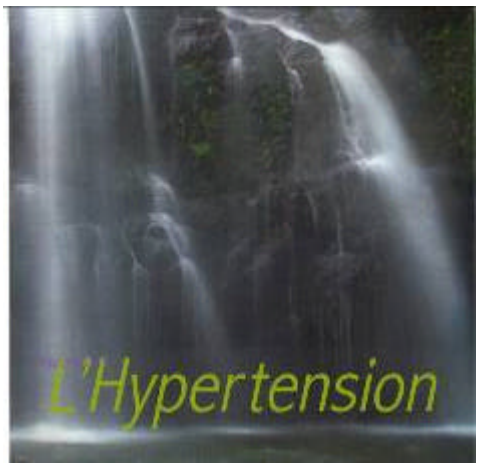
The last brochure is "Mental Health - living consciously is living better" which focuses on the importance of "training" of the spirit. It gives advice on how to cope with difficult situations, stress and how to understand first signs of mental problems or physical conditions that might result from. It has sections on the job, partnership and family, children and youth and the elderly. Finally, there are tips on mental well-being, a check-list to seek professional advice and once more, a series of other information channels and advice.



We would also like to point out another big initiative on screening that will take place from 20 March to 20 May and which also has implications with the above subject. This campaign is called "10 minutes for my health" and is offered in pharmacies in Vienna and Lower Austria (together some 500 pharmacies and more than 3 million inhabitants). The screening includes measurements of BMI, cholesterol, blood pressure, weight and blood sugar, offered free of charge to customers. The aim is to make people with one or more of the cardio-vascular risk factors aware of their data and to refer them to a thorough health check if necessary. The counselling interview includes advice on healthy diets and the importance of physical exercise.

Examples from Belgium

In Belgium, an in regard to patient information and prevention of Public Health, several elements have been prepared to assist pharmacists in their daily advice to patients. Bellow we include the most relevant to the scope of this submission, but there are many others, like the ones on migraine, digestive pathologies, allergic rhinitis, rational use of antibiotics, etc.



Examples from France

In France, around 14 million people are overweight and 5 million are obese. All the health professionals and especially the pharmacists play a main role in the spread of the nutritional recommendations towards the public.

â For 3 years, the CESPHARM[6] has relayed to the French pharmacists the recommendations of the Nutrition and Health National Program (PNNS).
Launched by the French Minister for Health in 2001, the Program laid down 9 top priorities:

- to increase the consumption of fruits and vegetables
- to increase the calcium consumption
- to reduce contribution of lipids
- to increase the consumption of carbohydrates
- to reduce the alcohol consumption
- to reduce the average cholesterol level
- to reduce the blood pressure
- to reduce by 20% the prevalence of the overweight and obesity
- to increase the daily physical activity

The pharmacists are regularly informed about this Program through articles in the Journal of the French Council of Pharmacists.

Since 2002, the CESPHARM has distributed to the French pharmacists several guides published by the National Institute for Health Education (INPES).

Guides intended for the public

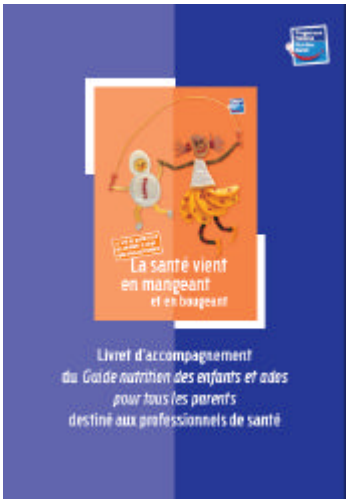
- "Manger c'est la santé" (*Be healthy by eating*): This guide presents dietary guidelines and nutritional advice adapted to each way of life and various food behaviours.
- "Bouger c'est la santé" (*Be healthy by moving*): This guide promotes the physical activity and recommends for all the population at least 30 minutes of fast walk per day.
- "Manger et bouger c'est la santé" (*Be healthy by eating and moving*): This guide is intended for the parents and answers their questions about the nutritional needs of their infant, their child or their teenager.

[6] The Health and Social Education Committee for French Pharmacy (CESPHARM) is a special unit of the French Council of Pharmacists. The purpose of the Committee is to develop the role of pharmacists in disease prevention and health education and to provide them with the needed tools.

Guides intended for the health professionals

These documents aim to provide the health professionals scientific information according to the PNNS recommendations. So, the pharmacists have been helped in their educational role on nutrition.

- "Manger c'est la santé" (*Be healthy by eating*)
- "Manger et bouger c'est la santé" (*Be healthy by eating and moving*)
- "Produits sucrés, féculents et santé : que conseiller ? » (*Sweetened products, starchy foods and health: what to advise?*)



â A poster with the PNNS dietary guidelines has been systematically distributed to the one thousand members of the CESPHARM "Windows poster program" on March 2005. The poster stays available for all the French pharmacists free on request from the CESPHARM.

â The CESPHARM also distributed to the French pharmacists a leaflet to inform the parents on the problem of paediatric obesity "L'obésité de l'enfant".

â During a public trade fair "Forme & Santé", in October 2005, the Cespharm took part in the tracking of the overweight by measuring the body mass index of the visitors. Pharmacists provided the PNNS guides with advices to public.

The Nutrition and Health National Program will continue until year 2008. New guides on nutrition and elderly people will be available on September 2006. The Cespharm will carry on with the distribution of PNNS documents to help the French pharmacists in the prevention of obesity and nutritional education.

Examples from Portugal

Although in Portugal there is not yet a program exclusively directed to obese patients, community pharmacists develop 2 different levels of interventions worth mentioning:

1. Essential level – In November 2005 pharmacies launched a 2 week nationwide campaign for screening patients at high cardiovascular risk as a platform to improve point-of-care monitoring in pharmacies. The point of care measures included both weight and height – BMI. Pharmacists' intervention on CheckSaúde (the name of the pharmaceutical service) comprises three different levels: prevention of modifiable risk factors, screening and follow-up of patients at risk. Pharmacists promote an healthy nutrition, weight loss (when needed) and a sufficient level of exercise as primary modifications for patients at risk, in order to achieve the lowest possible risk – action on modifiable risk factors, pharmacy measurable.

2. Advanced level – Since 2001 Portuguese pharmacies have Disease state management (DSM) programs on diabetes, hypertension and asthma, and one of the main objectives of the first two is to promote non pharmacologic therapy, meaning to promote lifestyle changes such as improving nutrition and exercise with the ultimate goal to control both diseases and subsequent health problems. We have a patient leaflet comprising this specific topic – healthy nutrition - as a tool for these programs. A similar cross-sectional program could be launched, as well, in order to follow obese patients, being obesity the primary disease.

In the following pages we include some posters with the results of DSM programs. In a very short term results from the cardiovascular campaign will also be available.

Programas de Cuidados Farmacêuticos

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Pharmacy-Based Disease Management Programs: An Overview After 17 Months of Operation

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1. BACKGROUND

Political vision

In 1999, the Board of the National Association of Pharmacies (ANF) - a private organization that comprises 98% of Portuguese community pharmacies - defined a political strategy for the implementation of pharmacy-based services associated with the delivery of medicines in daily practice focused on achieving positive patient outcomes and practical sustainability on a long term basis, as well as on securing both the professional and economic future of pharmacies.

A project team was created to develop methods and tools that would best achieve this purpose.

Mission

- To develop pharmacy-based programs along the lines of Disease State Management (DSM) and Pharmaceutical Care;
- To support Portuguese community pharmacists in providing these services;
- To assess its impact on a regular basis.

2. OBJECTIVE

To outline the strategy, methods and tools developed to assist Portuguese community pharmacists in providing pharmaceutical care and to present the main achievements after 17 months of operation following the pilot intervention.

3. IMPLEMENTATION STRATEGY

The implementation strategy considered two stages with the following objectives:

- To assess the feasibility of this practice-based model in the real environment and to obtain key process and outcome indicators through a pilot intervention (2001-2002);
- To adjust the model, expand it and, at the same time, retrieve and assess data on a permanent basis (2003 onwards).

4. DESIGN AND SETTING

Descriptive analysis from a prospective intervention targeted to 427 community pharmacies (16% of total no. of Portuguese pharmacies) / 1874 chronic disease patients (asthma/COPD, diabetes and hypertension).

5. RESULTS

Main achievements after 17 months of operation following the pilot intervention:

Practice tools

- 2nd version of Program Manuals
- Optimized pharmacists' intervention protocols

- Problem-oriented SOAP approach for delivering care
- New Drug Related Problem (DRP) classification system adopted (3)
- DRP and Pharmacists' Intervention coding systems
- Standard reporting notes to the prescriber
- Optimized patient records to document each visit
- Pharmacy Patient File and computer web application

Drug Use Profile from web application

Training / Coaching

Initial training of pharmacists (28 hrs.) on:

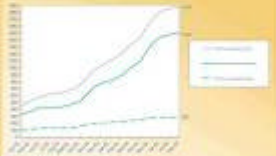
- Disease + Pharmacotherapy
- DSM / Pharmaceutical Care concepts and Patient Care Process
- Communication skills (patient oriented)

Follow-up training on:

- Communication skills (prescriber oriented) 1 month after patient enrolment (7 hrs.)
- Specific disease topic + discussion of real patient cases every 6 months (4 to 7 hrs.)

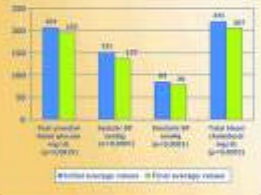
Coaching provided by each ANF Program Supervisor.

No. active pharmacies / no.patients

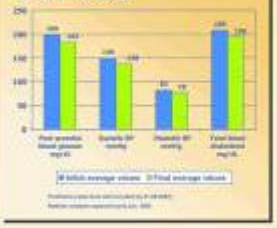


Drug-Related Problems (DRPs)

Clinical outcomes (first visit / last visit) Pilot intervention (31-12-2002)



Clinical outcomes (first visit / last visit) As of 31-08-2004



Political achievements

Due to the positive outcomes (statistically significant) in the pilot intervention of the Diabetes Management Program, an agreement was signed, in September 2003, between ANF, the Portuguese Pharmaceutical Society and the Ministry of Health, in which the latter remunerates pharmacists for the care provided to diabetic patients who are followed, according to the methodology and tools of this program.

6. CONCLUSIONS

These findings suggest a more structured pharmacist's performance in managing patients, improvements in clinical outcomes and important political achievements for pharmacy practice.

They also reflect the influence of a combined mix that includes a clear political vision and strategy for the Profession, a defined methodology, tools and evaluation techniques designed for practice purposes.

7. FUTURE PERSPECTIVES

As the number of patients increases, cluster sample evaluation techniques, involving comparison to equivalent reference populations, are likely to be performed on a regular basis.

However, this type of enhanced service has limitations in terms of universal implementation in the vast majority of pharmacies and does not reach and/or is not suitable for all patients within a specific disease state.

Thus, future plans aim at expanding and consolidating these comprehensive programs but encompass less complex approaches, as well, focusing on key quality outcomes that can ensure the professional and economic sustainability in community pharmacies.

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EuroPharm Forum PCNE 2004

Programas de Cuidados Farmacêuticos

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Pharmacy-based hypertension management programme in Portugal: results of a pilot intervention

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1. BACKGROUND

Since 1999, the National Association of Pharmacies (ANF) has developed a strategy, methods and tools (documentation forms, software application, pharmacist's intervention protocols, etc) for pharmacy-based disease management programs in Portugal, following the concepts of Disease State Management and Pharmaceutical Care, with the support of medical and pharmacy experts and based on the work of US clinical pharmacists operating in a large HMO in Colorado and in two chains of pharmacies..

In 2001, a pilot intervention began in selected pharmacies/patients.

2. AIMS

To test the implementation and evaluation methodology of a pharmacy-based hypertension management program, following the concepts of Disease Management and Pharmaceutical Care in Portuguese pharmacies and to assess the impact of the program.

3. METHODS

Prospective intervention in 29 community pharmacies, selected according to pre-defined criteria in 2 geographical areas, targeted to at least 110 hypertensive patients.

Patients selected by pharmacists according to inclusion criteria and followed for at least 6 months.

Pharmacists received specific training to follow hypertensive patients and to document patient data and care provided, according to the methods and tools designed by ANF. This training addressed disease-specific topics, pharmacotherapy and the process to provide pharmaceutical care (27 hrs. / person).

Local meetings were held with family doctors prior to the intervention aiming at improving the communication between professionals throughout the process.

Pharmacists reviewed drug therapy and measured blood pressure (BP), capillary blood glucose (BG), total cholesterol (COL) and body mass index (BMI) for each patient at scheduled appointments in the pharmacy.

A direct contact (information/recommendation) to the prescriber or a referral was made whenever drug related problems (DRPs) were identified or when patients were not reaching therapeutic goals.

4. PRELIMINARY RESULTS

Results pertaining to data extracted on 31-12-2002

4.1. Patient demographics and medical care profile

- 143 patients initially enrolled, out of which 130 on follow up in 29 pharmacies
- Average patient is female (58,8%), mean age of 65,7 years, 4 or less years of education (67,9%)
- Usual medical care setting: health centre (64,3%)
- Usual doctor: general practitioner (67,9%)

4.2. Use of healthcare resources

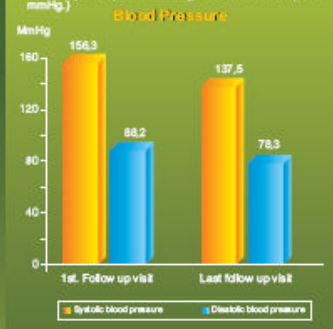
- 2257 visits to the pharmacy (average 78 / pharmacy, 17/ patient)
- 246 medical appointments
- 23 urgency room visits
- 237 sick leave days
- 32 in-patient hospital days

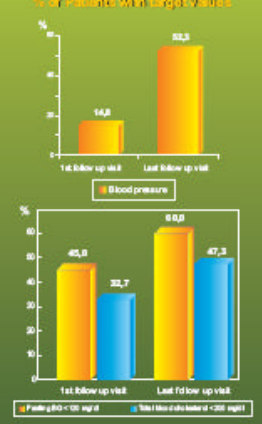
4.3. Clinical parameters

Pharmacists performed 4063 measurements (average 140 /pharmacy, 31 /patient), out of which:

- 2255 BP
- 590 capillary BG
- 276 total COL
- 778 BMI

It was observed a significant statistic decrease ($p<0,0001$) in both systolic (of 18,8 mmHg) and diastolic BP (of 9,9 mmHg.)

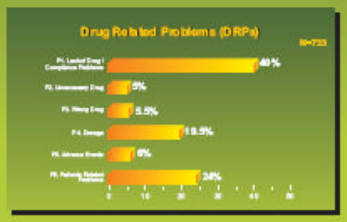




The % of patients with BP <140/90 mmHg, fasting capillary BG <120 mg/dL and total COL <200 mg/dl increased from 14,8% to 32,3% ($p<0,0001$), 45,0% to 60,0% ($p=0,0339$) and 32,7% to 47,3% ($p=0,0736$, close to significance) respectively.

4.4. Drug Related Problems (DRPs) identified

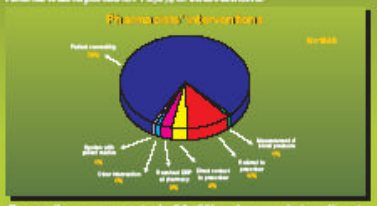
Pharmacists documented 733 DRPs (Pharmaceutical Care Network Europe DRP classification ver. 1.2, 2001). The most common DRP category was lack of drug/compliance problems (40%):



4.5. Pharmacists' interventions and feedback from prescribers

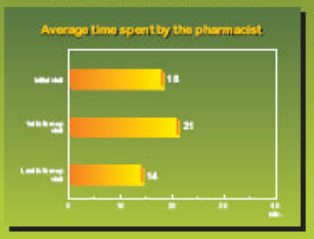
Pharmacists documented 1648 interventions.

Counselling represented 68% of pharmacists' interventions. A direct contact (information/recommendation) to the prescriber or a referral was reported for 13,3% of interventions:



Prescribers accepted 29,5% pharmacists direct information/recommendations and modified drug therapy in 14% of either pharmacists direct contacts or referrals.

4.6. Average time spent by the pharmacist



5. CONCLUSIONS

These findings seem to suggest a more structured pharmacist's performance and improvements in patient clinical outcomes through collaboration with prescribers. Refined statistic analysis and further clinical, economic and humanistic indicators are expected to be completed during 2004.

These results have been used to adjust the model for expanding the program in Portuguese pharmacies - a process which has already began.

6. ACKNOWLEDGEMENTS

We gratefully acknowledge the following individuals / entities for their collaboration:

- all pharmacists and patients who participated in the pilot intervention.
- Our Pharmacoepidemiology and Pharmacoeconomics Department (CEFAR) who performed the statistic analysis.

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20th Scientific Meeting of the International Society of Hypertension

Programas de Cuidados Farmacêuticos

Associação Nacional das Farmácias

Pharmacy-based disease management in Portugal: preliminary results of a pilot intervention

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1. BACKGROUND

Since 1999, the National Association of Pharmacies (ANF) has developed a strategy, methods and tools (documentation forms, software application, pharmacist's intervention protocols, etc) for pharmacy-based disease management programs in Portugal, following the concepts of Disease State Management and Pharmaceutical Care, with the support of experts and based on the work of US clinical pharmacists operating in a large HMO in Colorado and in two chains of pharmacies.

In 2001, a pilot intervention began in selected pharmacies / patients.

2. AIMS

To assess the impact of 3 programs (Asthma, Diabetes and Hypertension) following the concepts of Disease State Management (DSM) and Pharmaceutical Care in Portuguese pharmacies.

3. METHODS

Prospective intervention for at least 6 months targeted to at least 90 pharmacies / 330 patients.

Pharmacists received specific training (27 hrs.) to follow patients and to document patient data and care provided, according to the methods and tools designed by ANF.

4. PRELIMINARY RESULTS

Results pertaining to data extracted from all 3 Programs on 31-12-2002

4.1. Patient demographics and medical care profile

- 396 patients initially enrolled, out of which 366 on follow up in 88 pharmacies.
- Average patient is female (56%), mean age of 61 years, 4 or less years of education (62%)
- Usual medical care setting: health centre (54%)
- Usual doctor: general practitioner (61%)

4.2. Use of healthcare resources

- 4226 visits to the pharmacy (average 50 / pharmacy, 12 / patient)
- 743 medical appointments
- 78 urgency room visits
- 498 sick leave days
- 68 in-patient hospital days

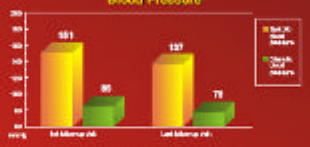
4.3. Clinical parameters

Pharmacists performed 9025 measurements (average 106 / pharmacy, 26 / patient), out of which:

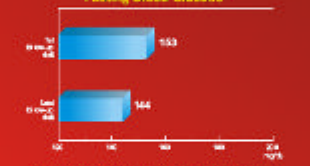
- 3811 blood pressure (BP)
- 2290 capillary blood glucose (BG)
- 387 total cholesterol
- 141 triglycerides
- 272 peak flow expiratory rate (PFER)

It was observed a decrease in both systolic BP (of 14 mmHg) and diastolic BP (of 7 mmHg), in fasting BG (of 9 mg/dL), in total cholesterol (of 14 mg/dL) and in triglycerides (of 47 mg/dL):

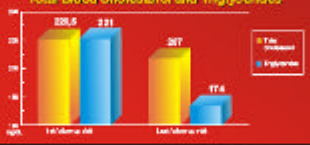
Blood Pressure



Fasting Blood Glucose



Total Blood Cholesterol and Triglycerides



% of Patients with Target Values

Diabetes Program (n=130)

% of Patients with Target Values

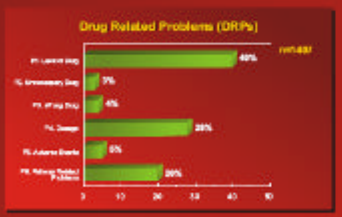
Hypertension Program (n=128)

Statistic significance still being assessed (not completed as of 05-05-2003)

4.4. Drug Related Problems (DRPs) identified

Pharmacists documented 1407 DRPs (PCNE DRP classification ver. 1.2, 2001). The most common DRP categories were lack of drug (40%) and dosage (28%).

Drug Related Problems (DRPs)

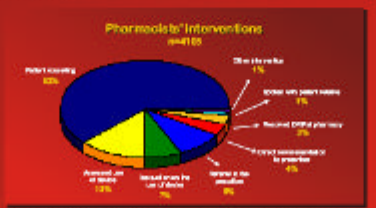


4.5. Pharmacists' interventions and feedback from prescribers

Pharmacists documented 4105 interventions.

Counseling represented 62% of pharmacists' interventions. A direct contact to the prescriber or a referral was reported for 13% of intervention.

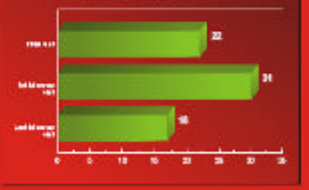
Pharmacists' Interventions



Prescribers accepted 31% pharmacists' direct recommendations and modified drug therapy in 9% of either pharmacists' direct recommendations or referrals.

4.6. Average time spent by the pharmacist

Average time spent per patient per visit



5. CONCLUSIONS

Although these findings are still preliminary, they seem to suggest a more structured pharmacist's performance and improvements in clinical outcomes. Refined statistic analysis and further clinical, economic and humanistic indicators are expected to be completed in mid 2003.

These results have been used to adjust the model for expanding DSM programs in Portuguese pharmacies - a process which has already began and is targeted to 200 more pharmacies during 2003.

6. ACKNOWLEDGEMENTS

We gratefully acknowledge the following individuals / entities for their collaboration:

- all pharmacists and patients who participated in the pilot intervention
- managers and clinical pharmacists from Kaiser Permanente Colorado Region, CVS Health Connection and Eckerd Patient Care Network (USA)

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** Kaiser Permanente Colorado Region Pharmacy and Therapeutics Operations Director (USA)

ISCP Spring Conference 2003