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PGEU Comments

Green Paper – On the European Workforce for Health

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1. Introduction

The Pharmaceutical Group of the European Union (PGEU) is the European association representing community pharmacists in 30 European countries including EU Member States, EEA countries and EU applicant countries. Within the enlarged EU, over 400.000 community pharmacists provide services throughout a network of more than 160.000 pharmacies, to an estimated 46 million European citizens daily.

PGEU's objective is to promote the role of 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.

2. General Comments

PGEU welcomes the Commission's Green Paper on the European Workforce for Health.

Pharmacists are the third largest health profession, and many of the issues identified in the Paper – shortages in some areas, feminisation of the profession and capacity issues in Higher Education to name but three, apply to the pharmacy profession both in Europe and globally.[1]

Of course, many of the issues identified in the paper cannot be considered in isolation from problems facing the skilled labour force in Europe more generally, and some potential solutions to workforce shortfalls – economic incentives for example – need to be considered in the wider context of the funding of health systems in an era of constrained public finances. Nonetheless, the unique place of health care in the European social model, and the acknowledged contribution of high levels of public health to overall productivity, mean that an EU level consideration of the challenges we face in ensuring we have a sustainable health workforce in Europe is both warranted and necessary.

3. Spreading the Workload

The Health workforce is characterised by specialisation and sub-specialisation, co-ordinated to provide a comprehensive health service. The sheer range of knowledge and skills required across the health system limits the contribution of the generalist. There are however areas where a redefinition of roles and a redistribution of tasks can make a useful contribution to overall efficiency and effectiveness.

Moreover, given the key role of prevention and early diagnosis in promoting better health outcomes (and thus reducing the burden on the health system), the deployment of easily accessible diagnostic and preventative health services to ensure there optimal effectiveness is highly desirable.

All over Europe, Community Pharmacists provide a range of services which go beyond the core role of dispensing and providing advice on medicines. While the extent of service provision varies from country to country, blood pressure measurement, cholesterol measurement, glucose measurement, weight measurement, smoking cessation counselling, vaccination, therapeutic education and follow up, hypertension management, diabetes management and asthma management are all widely available.

[1] For an excellent survey of the Global issues, see Global Pharmacy Workforce and Migration Report – a Call for Action by FIP (International Pharmaceutical Federation) http://www.fip.org/files/fip/HR/FIP%20Global%20Pharmacy%20and%20Migration%20report%2007042006.PDF

In some countries, prescribing or renewing prescriptions by health professionals - including of course pharmacists - other than doctors is a reality, as is a pro-active policy of encouraging patient self-care through the pharmacy[2]. The efficiency gain in terms of reducing pressure on medical doctors is obvious.

Spreading some of the workload in the health system does not mean giving people tasks for which they are unqualified. It does not mean for example that a pharmacist who takes blood pressure is assuming the role of a specialised cardio vascular physician. What it does allow is the pharmacist to 'signpost' that patient to more specialised help. Given the frequency and convenience of pharmacy visits (46 million daily in Europe), the result of signposting through health screening and basic diagnostics at pharmacy level is that more patients see specialists earlier than they would otherwise. The overall effect is to reduce burdens on the health system, because problems addressed early are often easier and less costly to treat.

A recent study undertaken by Price Waterhouse Coopers suggests that in just one relatively small EU country, Ireland, such pharmacy interventions saved an estimated 3.9 million GP visits and 500,000 Accident and Emergency hospital attendances.[3] In the light of this, and the range of services provided by pharmacists in the EU, the diagram on page 4 of the Green Paper suggesting that pharmacists are outside the core health workforce is simply wrong.

4. Professional Mobility and Migration

Pharmacists have benefited from the facilitation of professional recognition made possible by EU action[4]. In the UK and Ireland in particular, a significant proportion of the pharmacy workforce comprises registrations from other EU states.[5] As the Green Paper correctly notes, professional mobility in Europe is an established right. It could not be limited without a huge upheaval of the European legal order, even if such a limitation were desirable.

But we should not blind ourselves to the fact that it creates problems. Clearly, there is a large incentive for health professionals to move to countries with better professional opportunities and higher salary levels. While these problems may in some instances be short term and transitional, it seems clear that in some instances health professional workforce shortages caused by emigration of professionals is a problem. While it might be argued that the net effect is neutral – because migration helps address shortages in receiving countries – the fact that the movement is normally from poorer to richer EU states carries with it an inherent inequity. In such cases professional mobility is in effect a form of subsidy from the taxpayers of poorer states to those of richer ones.

PGEU supports the idea of compensatory mechanisms such as bilateral agreements on training and staff exchanges suggested in the Green Paper. The scope for coordinating such mechanisms at EU level should be explored. This would perhaps go some way to addressing the irony that, while DG Sanco is rightly concerned about health workforce imbalance, DG Markt actively promotes and facilitates health professional mobility.

As the Green Paper acknowledges, immigration from outside the EU is another area where EU action offers encouragement to mobile workers. While the loss of skilled workers of any specialisation can create difficulties for developing countries, the importation of health professionals presents particular moral challenges. By any measure, the needs of health systems in such countries far exceed those of the EU, and the additional benefits they can bring to domestic

[2] For example, the Minor Ailments Scheme adopted in Scotland.
[3] Review of Community Pharmacy in Ireland 2007, January 2009.
[4] Directive 2005/36
[5] For example, in the UK 1,822 between 2005 and 2008. In France 208 pharmacists from other EU states are registered.

patients is far greater than any marginal benefit to rich countries. Again, the EU should promote the use of ethical recruitment policies and compensatory bilateral agreements in this area.

Finally, the acquisition of professional recognition rights by third party nationals needs to be monitored carefully to ensure that inappropriately qualified professionals are not exploiting 'weak links' in the recognition system as a means to subsequent free movement.

5. The Need to Plan

The Green Paper encourages the adoption of policies aimed at promoting 'health entrepreneurship', (although the relevance of this to the issue of workforce shortages seems obscure). What does seem clear is that state intervention in health markets is necessary if adequate provision is to be assured.

One example of this is the fact that numbers of health professionals *per capita,* as a raw statistic, may obscure the fact that the distribution of health professionals leaves large segments of the population under provided for. The Green Paper does not address this issue. The current debate in France regarding so called 'desertification' of areas of the country in terms of medical doctors is a good example. With due respect to free marketeers, who argue that the market will evolve to meet all unfulfilled demand[6], entrepreneurship alone will not solve this problem. Planned pharmacy establishment in countries with the potential for 'desertification' given the nature of the territory has been very successful.[7]

6. Awareness , Prevention and Self Care

One obvious way to deal with workforce issues is to limit demand for healthcare services. The market solution to demand management, the price mechanism, is however inconsistent with the solidarity principles underlying health systems. The better way would be to keep people healthier for longer. Greater health literacy, healthier lifestyles, early detection, and responsible self-care are means to help achieve this. We describe above how the use of Community pharmacies, with their 'frontline' role in the Community, easy access and regular patient traffic, are an obvious vehicle for health campaigns, health checks and basic diagnostics.

The core role of pharmacists in medicines counselling is of equal relevance. Poor adherence to medicines is for example a major source of worse health outcomes and wasted resources, and the potential of pharmacists' role in improving adherence is well established. [8]

Equally, responsible self-care can help ensure that limited resources are channelled toward more serious cases. Self care does not mean however that health professionals have no role to play – self care is not 'no-care' – but it does apply the use of frontline resources such as pharmacists to ensure that self carers make informed decisions and are prepared to self-manage their health.

7. Education and Skills

The Green Paper correctly identifies the need to ensure that health professionals maintain and develop skills throughout their careers. Added to this is the need to ensure that the curriculum remains flexible and responsive to deal with the needs of health systems. In pharmacy this

[6] In the context of pharmacies, see 'Benefits and Costs of Regulations in the Community Pharmacy Sector' Schulenburg/ Hodek University of Heidelberg Feb 2008

[7] 94% of Spanish communities have easy access to a pharmacy, for example. In France pharmacy desertification has so far been avoided.

[8] Targeting Adherene: improving patient outcomes in Europe through Community Pharmacists' intervention, PGEU, May 2008
http://www.pgeu.eu/Portals/6/documents/2008/Publications/08.05.13E%20Targeting%20adherence.pdf

consideration has lead in some countries to an increased emphasis on the practical aspects of pharmacy to complement scientific knowledge. One possibility that may prove fruitful in the future is increased closer cooperation and co-learning between health professional students.

As set out above, we believe that there is some scope for diversifying the workload among the health professional workforce. As we stress, this does not mean that professionals should be given tasks that they are not qualified to perform. While of course specialist training may be necessary, this process is one of skill matching, not 'de-skilling'.

There will always be a temptation to increase the involvement in health systems of those with lower skills, and who demand lower remuneration. In some instances this may be justified. What we must guard against in Europe is, however, the wholesale de-skilling of some professions.

From time to time, some EU governments consider relaxing the degree of engagement fully qualified pharmacists must have in the operation of the pharmacy.[9] Occasionally, a far greater role is seen in the dispensing of medicines for staff who are not fully qualified pharmacists. Some extremists question whether the monopoly on the dispensing of prescription medicines should continue.[10]

But this is at precisely the time that the need for highly skilled pharmaceutical care is growing. To take one example, as the Green Paper states, the proportion of elderly people in our population is on the increase. Elderly people are highly dependent on pharmacological therapy, often taking several different medicines concurrently, with greater exposure to adverse effects and with more problems of adherence. Healthy ageing will become a major preoccupation of health systems in the coming years, and pharmacy's frontline role as a locus of health campaigns and accessible advice clearly has a significant role to play. Coupled with the need to promote health literacy and to encourage early detection of problems, as described above, there has never been a worse time to contemplate the de-skilling of the pharmacy profession. The same no doubt applies to the other health professions. What we need is highly developed, flexible skills, not a lowering of qualifications to boost numbers or reduce costs.

8. Technology and Productivity

Finally, the issue of health sector productivity is not discussed in the paper, but nonetheless does merit consideration, for the obvious reason that higher productivity reduces demand for workforce.

Productivity is a complex concept in health care. The standard economic definition – output divided by input – is of limited usefulness, because in health care it does not follow that productivity growth – increasing output per input – necessarily translates into improved care. It is clear for example that there is an emotional engagement between health professional and patient – 'care' – that does not submit to economic analysis. It is equally clear, to take an example from pharmacy, that maximising dispensing of medicines while minimising the number of pharmacists is in no-one's interest at all, although this appears to have been the recommendation of a study recently commissioned by the European Commission.[11]

We cannot ignore productivity growth as an important element in addressing workforce shortfalls. But we must take care to ensure that the key values underlying patient care are not compromised. A more promising approach might be to develop common systems of performance evaluation across the health professions so that areas of potential additional added value can be identified.

Health is a high tech industry. The potential of technology – including pharmaceutical technology – to improve health outcomes seems limitless. In the field where pharmacists operate, primary care,

[9] In the recent past the Netherlands and currently Sweden.
[10] Philipsen/Faure Journal of Consumer Policy 2002 25
[11] The Ecorys study commission by DG Markt

innovations such as e-prescription and electronic health records promise to improve health outcomes by for example facilitating co-operation between professionals at primary care level. PGEU endorses and encourages their development, with one reservation - there is a danger that technology becomes producer led – in other words that the emphasis is on systems innovation for its own sake without regard to the needs of patients (including in respect of data protection and confidentiality) and health professionals. The net result is great expense for limited gain.

Finally, while technology can make a significant added value to healthcare, we should not forget that ultimately healthcare is people-centred. Technology can de-personalise. The development of telemedicine shows promise, but there is no substitute for face to face contact, and it we doubt it is desirable that there should be.

Conclusion

PGEU warmly welcomes the Green Paper, and recommends that:

- **EU Governments are encouraged to consider a wider range of self-care and health screening services at pharmacy level;**
- **Professional Mobility is an important right in the EU, but compensatory measures in states where migration creates difficulties should be considered, and ideally co-ordinated at EU level;**
- **We need to consider the distribution of health professionals as well as their number. 'Desertification' will not always be solved by the free market alone;**
- **We must avoid the temptation to lower standards of education and training in order to boost workforce numbers;**
- **Narrow definitions of productivity are not always in the interests of patients;**
- **Technological Innovation needs to take account the needs of health professionals and patients;**
- **All stakeholders are widely involved in the design of future solutions, both at EU and national levels.**

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