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On 18 April 2012, the Executive Committee adopted the 'CPME Response to the EU Reflection on Chronic Diseases'.

CPME RESPONSE TO THE EU REFLECTION ON CHRONIC DISEASE

This document has been prepared to request an initial input from stakeholders to the EU Reflection Process on Chronic Disease which is being carried out by EU Member States and the European Commission.

The intention is to launch a further, targeted discussion with key stakeholders involved in European work with the European Commission in the areas of chronic disease and related issues in due course.

European Commission Directorate General for Health and Consumers.
March 2012

Discussion paper – EU Reflection Process on Chronic Disease

This paper has been prepared to guide stakeholders in preparing an initial position as part of a reflection process on chronic disease being led by the European Commission and EU Member State governments. The aim is to identify issues, gaps and suggestions for action to improve current policies and activities on chronic diseases, both at National and EU levels.

What is chronic disease?

Chronic diseases are diseases of long duration and generally slow progression. Although there are a huge number of different chronic diseases there are a number of issues which many chronic diseases share. These include the type and organisation of health services, risk factors such as smoking, diet or alcohol related harm, socio-economic or environmental factors, as well as information and research.
The focus of the reflection process is on these common factors rather than on particular diseases.

What is the current situation on chronic diseases in the European Union. ?

Chronic diseases are the main reason for poor health and restrictions on activity. Effective prevention and treatment of chronic disease is essential to enable people to spend a greater proportion of their lives in good health. Chronic diseases are the greatest challenge to the goal that the EU has set itself of contributing to the achievement of an increase of 2 years in the number of years spent in good health by the EU population, by 2020.

Average EU death rates from many chronic diseases, including cardiovascular and respiratory diseases, have fallen over the last decade. However the number of people actually suffering from chronic diseases such as diabetes, depression, musculoskeletal disorders and some cancers is rising. This is contributing to increases in long term disability and reductions in the average number of years spent in good health in many parts of the EU.

Between 2007 and 2009 the estimated numbers of years spent in good health across the EU declined for men from 61.5 years to 60.9 years and also reduced slightly for women from 62.3 years to 62.0 years. These average figures mask huge differences both within countries and between countries.

Consultation questions:
What further information and evidence should be taken into account by National Governments and the EU regarding the chronic disease situation?

CPME supports the current EU reflection process on chronic diseases and also welcomes a future engagement towards a more targeted discussion to tackle the burden of chronic diseases and add two extra healthy life years to citizens by 2020.
In order to achieve the main objectives of health in all policies, both the EU and National Governments need to further extend and structure dialogue across different sectors and with multiple stakeholders[1] .

[1] CPME response to the European Commission Consultation on the Future "EU 2020" Strategy'

Collaborative approaches such as the European Innovation Partnership on Active and Healthy Ageing need to be further expanded to tackle demographic challenges from multiple approaches, within the immediate environment of the individual: workplace, social and care settings.

Tools that have proven to bring an effective outcome need to be further expanded and implemented by member states. Regulation has proven to be effective both to reduce tobacco consumption and with regard to health claims in food products, increasing consumer protection[2] .Soft law mechanisms, such as voluntary agreements, are arguments often used to further delay effective intervention with immediate effect through hard law mechanisms, going against the public health interest.

In addition, the evidence regarding effects of passive smoking on unborn babies and children constitutes a known risk factor for low birth weight, sudden infant death syndrome, asthma, cardiovascular diseases and cancer, and increases the likelihood for the children to become smokers themselves. There is an urgent need to promote these facts to become common knowledge and underline the right of each child to live and grow up in a smoke-free environment[3].

Complementary to tackling risk factors such as tobacco, obesity and alcohol related risks, tackling Vitamin D deficiency represents another area that requires further attention.

Beyond the proven complications of severe Vitamin D deficiencies that cause osteomalacia and rickets, mild or moderate Vitamin D deficiency represents a risk factor for fractures and falls. Numerous epidemiological surveys confirmed by randomized intervention trials[4] with Vitamin D with or without Calcium proved to reduce fractures and falls[5].

It is now also known that the vitamin D endocrine system is not only important for bone and muscle health but also influences many other tissues such as the immune system, the cardiovascular/ metabolic system, cell proliferation and cancer. This is based on well documented biochemical, cellular and animal data generated in many research laboratories around the world. The human data is principally based on cross-sectional and/or observational data linking many and in fact nearly all major human diseases and preventable conditions to the body's vitamin D status. Overall the highest risk of cancer (especially colon cancer), infections, several major autoimmune diseases such as multiple sclerosis, type 1 diabetes and inflammatory diseases, cardiovascular risk factors and the metabolic syndrome (including hypertension and type 2 diabetes) are more prevalent or more severe in subjects with the poorest Vitamin D status (25OHD levels < 20 ng/ml or 50 nmol/L)[6] .

HEALTH PROMOTION AND DISEASE PREVENTION: WHAT MORE SHOULD BE DONE?

Together tobacco use, poor diet, low physical activity and harmful alcohol consumption are the major risk factors for chronic diseases. In addition, there are many other risk factors including environmental pollution; certain infections; hazards in the home, leisure and work environment, and psychological stress. Socio-economic factors and the quality of living and working conditions are health determinants that also play an important role

[2] CPME Commitments to the EU Platform on Diet and Physical Activity, CPME Policy on Labelling, CPME statement on tobacco control, CPME response to the European Commission consultation on the Possible Revision of the Tobacco Products Directive 2001/37/EC, CPME calls for higher taxes on tobacco in the EU, CPME Position on the Legal Control of Tobacco Products

[3] CPME Policy on Smoking in the Presence of Children

[4] The studies involved more than 50,000 (mostly elderly) subjects.

[5] CPME Vitamin D Nutritional Policy in Europe

[6] Ibid 3

Much of the chronic disease burden in Europe, particularly at younger ages is preventable. In some parts of Europe, this is already happening to a great extent as a large proportion of people live into old age without experiencing chronic disease. In addition large numbers of people are able to cope with their health problems without significant interference with their daily activities. In fact if the number of healthy life years experienced by people in the regions of Europe with the healthiest populations were experienced everywhere, this would result in an increase in healthy life years by over 9 years for the average EU citizen.

So what more needs to be done than to enable more people to live longer without chronic disease and to enable more people with chronic disease to live better? One answer is better prevention to reduce exposure to key risk factors. The experience of tobacco has shown that effective action to reduce these factors requires a range of measures, including regulation, addressing the availability and marketing of products as well as public information and individualised support.

However, there is a well known tension regarding the degree to which government regulation and other actions to influence these factors should compromise the individual's freedom to choose for themselves. Similar tensions exist regarding regulation and role of business.

EU Member States have highlighted a number of actions that are important in this area including:

- To facilitate healthy choices in life for all citizens,
- To establish health promotion communication messages and interventions for all chronic diseases,
- To integrate health into education programmes;
- To further develop quantitative analysis of the cost effectiveness and health gains of health promotion and prevention;
- To explore, based on scientific evidence, the scope for early detection of relevant risk factors for chronic diseases;
- To strengthen prevention by applying the principles of health in all policies;

Consultation questions:
What additional actions and developments are needed to address key risk factors to prevent chronic diseases?

CPME welcomes a health in all policy approach to address chronic disease and comorbidity risk factors that extend from behavioral risk factors to socio-economic and environmental related factors.
While CPME agrees that government action should not compromise the individual's freedom to choose, it considers that health promotion is a common responsibility; however, this should not preclude for example the individual's right to adequately formulated, correct and easy to understand nutritional information on food and beverages. Complementary to health promotion campaigns, regulations proved to be most effective both in tackling tobacco consumption and ensuring the provision of correct and adequate nutritional information on products.

As mentioned above, Vitamin D deficiency represents another risk factor that needs to be further addressed. Correcting such deficiencies is a simple, economic and effective measure in the prevention of falls, fractures as well as several other associated conditions such as major autoimmune diseases and inflammatory diseases[7].
CPME recommends Vitamin D supplementation (600-800 IU D3) plus calcium to be considered for elderly people (older than 75 years) with an increased fracture and/or fall risk, in particular people living in nursing homes[8].

How can existing actions on primary prevention be better focused and become more effective?

Adopting a life-course approach to health promotion requires first better coordination between various policies to address health. Employment, agriculture and food policy, social policy, education, environment, research and transport need to address within their remits ways to contribute towards better health outcomes for the population.

Regarding employment, health at the workplace is key to diminish disease related unemployment and achieve better productivity. Active, labour market policies need to be aimed at protecting the mental well-being of those unemployed, whilst also improving the efficiency of the labour market.

Regarding social policy, the interface between medical institutions and society and/or work organisations needs to be improved. Collaborative approaches between health and social sectors can reduce risk factors and increase protective factors in mental health, to reduce risk of mental ill health in the population and increase the social support of people experiencing mental health problems [9].

Clean water and appropriate housing have a positive effect on health. Polluted water causes serious health problems and homeless usually receive less health care than the rest of the population. They are usually not in an economic situation where they are able to pay for their health care.

Regarding the environmental impact on health, the availability of green areas and fresh air are well-known to contribute to the overall health of the population.
However, beyond such essential needs, global warming brings about an increase in deaths, injury and disability especially in the elderly and those with chronic disease, from extremes of heat (mostly) and cold[10].

Types of vaccinations with a strong evidence basis should also be further utilised as one of the best

[7] CPME Vitamin D Nutritional Policy in Europe
[8] Ibid 2
[9] CPME Statement on Mental Health, Combating Stigma and Social Exclusion, 2011
[10] CPME Statement on Global Warming and Health

means of prevention, strengthening the effectiveness of prevention policies in healthcare.
CPME also recommends that beyond the environmental factors influencing health, special attention needs to be given to address health inequities and promote equal access to healthcare[11], focusing especially on vulnerable groups.
Among the vulnerable groups mentioned, CPME would like to highlight an additional consideration for the discussion on healthcare for irregular migrants. In many countries, legislation attempts to restrict healthcare professionals in their provision of treatment to irregular migrants. Initiatives such as the 'European Declaration of Health Professionals' by Médecins du Monde, co-signed by many organisations including CPME, which calls for the abolition of legislation which tries to prevent healthcare professionals from treating patients, including irregular migrants, according to each patient's individual needs, should therefore be further supported and implemented.

In order to make existing prevention measures more focused and efficient, it is advisable to consult professional organisations like the CPME which can provide the view of physicians with concrete proposals and hands-on advice from practical professional experience.

What potential is there for broad based early detection action?

Actions for early detection need to be targeted and communicated to the population at risk. The potential for broad based early detection action needs to be justified first by its effectiveness and needs to respond to an adequate mapping of populations at risk.

In what areas is there a particular need for additional action at EU level?

Better indicators and exchange of best practice on health inequalities can support and add value to respective national policies.
Structural funds need to be oriented within countries and regions to improve housing and distribution of potable water.

In what areas is there a particular need for action at national level?

In the area of prescription and adherence, there is scope for action at regional level, as well as for remote monitoring of chronic diseases, please see the following question.

What will you/your organisation contribute to address this challenge?

At EU level, CPME is committed to tackle lifestyle related chronic disease risk factors.
CPME is engaged within the EU Alcohol and Health Forum as well as the EU Platform on Diet, Physical Activity and Health and is fully committed to the active participation of its membership to combat alcohol-related harm as well as promote diet and physical activity by informing its members, adopting a health at the workplace approach[12] .

At EU level, CPME participated within the European Innovation Partnership on Active and Healthy Ageing (EIPAHA) committed towards reducing the burden of chronic diseases through functional capacity evaluation and awareness on Vitamin D deficiency and appropriate solutions[13]. ().
Within the Steering Group, Sherpa Group and preparatory workshops of the EIPAHA, CPME supported

[11] CPME Policy on Health inequalities
[12] CPME Commitments to the EU Platform on Diet, Physical Activity and Health 2011-2013, CPME Commitments to the EU Alcohol and Health Forum 2011-2013
[13] CPME Response to the Commission consultation on Active and Healthy Ageing, CPME Statement on Mental Health and the Elderly – Healthy Ageing, CPME adopts the Strategic Implementation Plan on Active and Healthy Ageing

evidence-based and measurable solutions. Furthermore, CPME participated to the drafting and adoption of the Strategic Implementation Plan on Active and Healthy Ageing which identifies six main priority actions:

1. Prescription and adherence action at regional level
2. Personal health management, starting with a falls prevention initiative
3. Action for prevention of functional decline and frailty
4. Replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional level
5. Development of interoperable independent living solutions, including guidelines for business models
6. Thematic Marketplace: Innovation for age friendly buildings, cities and environments

At national level:
Regarding health inequalities, CPME recommended to National Medical Associations to contribute to the reduction of social gradients by:

- informing health authorities concerning health inequalities and identify areas where changes are most needed.
- By working with other parts of civil society to make a significant contribution to the reduction of health inequalities, by developing partnerships with central and local governments, NGOs and other stakeholders.
- By informing and educating their members to raise their awareness of the influence of social determinants on health disparities. Draw the attention of governments to international conventions or charters that secure the right to health
- By ratifying international human rights treaties that affirm the right to health, a state agrees to be accountable to the international community, as well as to the citizens, for the fulfillment of its obligations. A role of the NMAs could be to follow up their governments and hold them accountable for fulfilling their obligations. Lobbying their health authorities for better health care particularly for disadvantaged groups[14].

HEALTHCARE

The healthcare system is central to chronic disease prevention, treatment and care. Prevention includes screening and early detection and treatment of biological markers of risk for chronic disease such as hypertension, high blood lipids and raised blood sugar.

The extent to which the health care system proactively seeks out individuals, who may benefit from preventive treatment and follows patients actively to ensure that preventive care is maintained over long periods varies enormously between EU countries. In addition to the differences between countries in the occurrence of certain diseases and the level of risk factors, these differences may partly result from differences in the view of the balance of responsibility between individuals and the health care system and in perceived benefit of certain prevention policies.

Wide differences also exist in thresholds for treatment and treatment protocols for active chronic disease and to some extent these differences are reflected in differences in survival rates.

[14] CPME Statement on Health Inequalities

In nearly all EU Member States the cost of health care continues to rise driven by a combination of increasing chronic disease levels, rising expectations from patients and professionals and improved availability of treatments. Attempts to reduce costs by improving efficiency in health care have met with limited success. It has been suggested that with better prevention to prevent chronic diseases or delay their onset, that this could reduce health care costs. Others point out that the possibilities for treatment of chronic disease already far exceeds the amount that is currently delivered, implying that any reduction in demand from prevention will be made up from increased treatment of those with disease.

The role of the health care system as a supporter of patients to manage their own illness is one which is becoming increasingly important. In many parts of Europe this role has expanded rapidly with specialised health professionals carrying out this role and the possibility of providing patients with training, information and technology for their conditions.

Innovation in healthcare can be important to almost every aspect of prevention and treatment of chronic diseases. E-Health is a huge area for innovation. Applications include communication, screening systems, predictions of risk, follow up of prevention and treatment in primary care, the organisation and delivery of health care in hospitals, remote monitoring etc.
These aspects are linked to a broader debate on the future of health care in Europe. The Commission and the Member States have launched a specific reflection process on this.

EU Member States have highlighted the following issues in relation to identifying and sharing good practices in relation to health care:

- ways to enable patients with chronic diseases to maximize their autonomy and quality of life; effective, proactive early interventions;
- secondary prevention of chronic diseases by the health care sector;
- affordability and access of care for chronic diseases;
- implementation of innovative chronic care models, especially in primary and community health care,
- ways to reduce health inequalities in this field.

A specific reflection process on sustainable health systems is being undertaken in parallel to the Chronic disease process.

Consultation questions:
What changes could be made to enable health care systems to respond better to the challenges of prevention, treatment and care of chronic diseases?

A better coordinated and stronger monitoring framework represents a necessary support for prevention, treatment and care of chronic diseases. More and better cross-border coordination of health information systems are key to the planning and oversight of chronic diseases. Alongside, supporting centers of excellence to treat rare diseases should be further promoted. Such information systems should be

accompanied by effective health in all policies (fiscal, employment, research, education, social, environment, transport), healthy settings and primary and secondary prevention.

Patient-centered integrated care plans are needed to address patients with multiple chronic diseases and the comorbidity and these should include guidelines for good practices, wide deployment of innovative and effective telemonitoring tools to enable chronic disease self-management.

Communication between healthcare professionals should be encouraged to include better cooperation between key levels and sharing of knowledge on chronic diseases.

What changes could be important to better address the chronic disease challenge in areas such as: financing and planning; training of the health workforce; nature and location of health infrastructure; better management of the care across chronic diseases?

Financing and planning should support comprehensive integrated care models and the health system should support the participation of healthcare professionals both in promoting a healthy lifestyle as well as to provide continued care.

The professional autonomy of physicians is paramount for the provision of adequate care and needs to be ensured. Decisions regarding treatment need to be within the best medical interests of the patient and should be free from conflicts of interest of any type and of administrative/financial pressure.

How much emphasis should be given to further developments of innovations, including eHealth and Telemedicine in prevention and treatment of chronic disease such as remote monitoring, clinical decision support systems, e-health platforms and electronic health records?

The use of eHealth solutions and research and innovation should be promoted in the health sciences as well as in the ongoing professional development of health carers. It should be advocated more actively to include eHealth related courses within the curricula of the EU medical universities. Likewise, more funding could be allocated to encourage scientific networking between medical associations and medical faculties within the EU. Furthermore, research and innovation in eHealth should also focus on eHealth solutions that improve patient safety and cross-border interoperability, and on measures that improve the physicians' daily work and medical care.

eHealth and Telemedicine are valuable tools as long as they contribute to a higher quality of health care provision. They should be evaluated in this capacity only.

Benefits could be broadly structured in four main groups:

• Access: easier access to health services in remote or under serviced areas, reduction in wait-times for diagnostic, therapeutic and rehabilitative procedures, improved access to data for audit and research, subject to appropriate consent.

• Quality: improved patient and population health outcome, better treatment of patients with chronic or rare conditions, reduction in preventable adverse events, patient empowerment, improved patient satisfaction, improved privacy and security.

• Working conditions: facilitation of the physicians' work, increase of mobility possibilities, supporting cross borders mobility of physicians.

• Productivity: increased efficiency, reduced duplication of tests and procedures, cost reduction/avoidance[15].

In what areas is there a particular need for additional action at EU level?

In the area of interoperability, electronic identity and data protection:

CPME calls upon the development of European guidelines that help strengthening the legal certainty of eHealth, including issues such as: responsibility and data protection, legality and financing of on-line medical acts, and on-line pharmaceutical information and product supply.
In particular, data protection principles need to be based on patients' consent and safeguard.

Also, international standards in nomenclatures should be promoted. Europe has adopted several WHO standards and other clinical schemes in many EU Member States. ICD-10 for diagnoses and ATC code in drug coding are good examples and good basis for further developments in this field.

Furthermore, CPME believes that eHealth solutions remain widely unknown by the European public opinion. The European Commission is therefore right in focusing potential awareness actions towards citizens, patients, and health carers. For example, the European Commission should help publicise those eHealth solutions, such as telemedicine support for chronic heart failure, which have demonstrated significant reductions in acute healthcare costs.

In what areas is there a particular need for additional action at national level ?

Interoperability would need to be achieved at local and regional as well at European level.
A better "joining up" of what will be needed locally (often at very local level because there is where most people are getting care), linking primary, secondary and social care records, with the different needs regarding cross-border transfer.
Noting that issues relating to health fall under the principle of subsidiarity, CPME is of the opinion that the EU national governments should also be involved in any efforts aimed at increasing the awareness of eHealth solutions.

What will you/your organisation contribute to address this challenge?

The CPME participates in several EU funded projects, for example, InterQuality, the eHealth Governance Initiative, the Chain of Trust project, Momentum etc. It furthermore informs and raises awareness for eHealth solutions among doctors, thus aiming to provide the medical profession's timely and expert advice on telemedicine.

[15] CPME Response to the European Commission Public Consultation on the eHealth Action Plan (eHAP) 2012-2020

RESEARCH

Bio medical and public health research contributing directly or indirectly to chronic disease prevention and treatment are some of the most important research areas.

One important issue is how to ensure that the best research knowledge is actually used in practice.

Another is to identify existing gaps in research

There is also a need to enhance research cooperation in order to ensure that the research supported by the EU level and by national governments complements each other.

Some research could benefit from better use of existing initiatives, such as the Innovative Medicine Initiative (IMI) and the European Strategy Forum on Research Infrastructures (ESFRI), which includes research infrastructures for clinical trials and biomedical research which could pave the way for a more harmonised European framework.

Reflection questions:

How should research priorities change to better meet the challenges of chronic disease?
In what areas is there a particular need for additional action at EU level?
In what areas is there a particular need for additional action at national level? What will you/your organisation contribute to address this challenge?

Research priorities should further encourage and support the discovery of better preventive measures and treatments as well as organizational solutions, especially as we face higher rates of patients suffering from multiple chronic diseases.
Further support training for healthcare professionals, including training on health promotion should be another area of focus together with innovation for integrated chronic disease care.
Better medical treatments, especially addressed to patients with multiple chronic diseases need to be further researched and made available.

INFORMATION, AND INFORMATION TECHNOLOGY

Information systems on chronic diseases are important first of all to support individual patient care. Accurate information is also needed to plan and manage services and to develop and modernise policies for prevention.

There may be scope for additional action on comparable information at national and European levels on the incidence, the prevalence, the risk factors and the outcomes concerning chronic diseases. Such action needs to take into account the different health care systems in Member States as well as EU activities such as the European Health Interview Survey, the European Health Examination Survey, the development of morbidity statistics by Eurostat and other bodies, as well as registries and other sources, to enable benchmarking and evidence-based policy. EU actions in areas such as cross-border mobility, e-health and active ageing are also

relevant in this context.

There may be also scope for improving information systems by identifying obstacles in the collection of data and indicators, including the accessibility of data and legislative obstacles.

Reflection questions:

What more needs to be done on the development of information and data on chronic disease? In what areas is there a particular need for additional action at EU level? *In what areas is there a particular need for additional action at national level?* *What will you/your organisation contribute to address this challenge?*

An appropriate mapping of Vitamin D deficiencies as well as overall of populations that are exposed to a higher risk of developing a chronic disease needs to be further considered. The WHO Europe region committed in 2010 to adequately map such deficiencies and such efforts would need to be further continued[16].

[16] WHO to Map Vitamin D Deficiency in Europe

ROLES OF MEMBER STATES, THE EU AND STAKEHOLDERS

EU Member States are responsible for the definition of their own health policy and for the organisation and delivery of health services and medical care. Although each Member State has different approaches because of their own unique situation, key aspects of the challenges of chronic disease, risk factors, treatments and policy options, are very similar. This provides good opportunities for working together to identify solutions.

EU level activities are particularly relevant for primary prevention of chronic disease in areas such as aspects of action on tobacco, alcohol, nutrition and physical activity as well as addressing underlying socio-economic and environmental factors. EU policies such as cohesion, agriculture and rural development, research and innovation are also highly relevant. In addition the EU has a role in supporting Member States through example exchange of information and good practice, the development of information systems and guidelines.

EU support can include the possibility of specific funding being made available for projects or joint actions supporting activities and actions in the area of chronic diseases. It can also provide support to stakeholders working on specific chronic disease areas/issues. EU support also includes independent, non-food Scientific Committees, managed by the Health and Consumers Directorate General, which provide scientific rationale for evidence-based policy making.

Stakeholders include patients and health professionals but also employers and businesses involved in activities which are directly or indirectly related to chronic disease. As chronic disease affects virtually every part of society this means that every part of society needs to be involved in the solutions. Doing this effectively is possibly the single biggest challenge.

Reflection questions:

What additional activities on chronic disease beyond the four areas described above should be considered at EU level?
How can the EU engage stakeholders more effectively in addressing chronic diseases?
How can EU Member States engage stakeholders more effectively in addressing chronic diseases?

The European Innovation Partnership model seems to be an effective way to tackle health challenges in cooperation and to identify specific and targeted actions that may have a measurable effect. Such wide partnerships could be usefully replicated in the future and steered towards achieving public health benefits. Since several commercial interests were involved, steering the partnership towards patient-effective outcomes needs to be made more clear.

Other areas

This paper has identified a few of the areas that are important when considering chronic disease. Many other issues are also relevant.

Reflection questions:

> *What additional areas for action should be considered? Which of these should be addressed by activities within EU Member States? Which should be addressed through activities involving cooperation at EU level?*

The professional autonomy of doctors, good working conditions (including reduction in the red-tape obligations set on doctors) and proper remuneration are essential elements that affect positively the quality of healthcare services and should support recommendations for a more equitable distribution of human resources for health.

An area of further investigation concerns the wider impact of task shifting on appropriate, safe and high quality delivery of health services, ensuring that patients receive care from the most appropriate health professional, without compromising on education and training standards for doctors in training[17] .

[17] CPME Statement: Impact of Task-Shifting on Junior Doctors