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## SAVE THE DATE! - CPME Meetings 2017



7- 8 April  
2017, Vilnius

24 - 25 November  
2017, Brussels

## MESSAGE FROM THE CPME PRESIDENT

Dear Friends and Colleagues,

Welcome to this 21st edition of our CPME newsletter, which reports on the outcomes of the CPME Board and General Assembly meetings held in Tel Aviv on the 19 of November 2016, and on new developments at EU level.

Let me first use this opportunity to thank all CPME members for their active contribution to our very fruitful last CPME meetings. They have been an occasion to make important decisions, both political and internal, confirming our strong commitment to the best possible medicine and healthcare in Europe.

In this newsletter, we also report on a bilateral discussion held with Dr Vytenis Andriukaitis, EU Commissioner for Health. This meeting was an excellent opportunity to exchange ideas on the main issues in European health politics. We agreed once again on the need to collaborate in achieving the highest quality of health care for all patients in Europe and on the importance of physicians' autonomy.

Furthermore, this CPME newsletter will give you recent news from two CPME members, featuring articles from the Panhellenic Medical Association and the Israeli Medical Association.

Last but not least, you will find two guest articles, from the Smoke Free Partnership (SFP) and from the European Centre for Disease Prevention and Control (ECDC).

I hope that you will enjoy reading this edition, and I wish you a wonderful holiday season, a merry Christmas, and an excellent, peaceful new year.

*Dr Jacques de Haller, President of CPME*



# FRUITFUL MEETING WITH DR VYTENIS ANDRIUKAITIS, EU COMMISSIONER FOR HEALTH

On 8 November 2016, the President of the CPME, Dr Jacques de Haller, CPME Vice-President Dr Patrick Romestaing and CPME Secretary General, RA Annabel Seebohm met with Dr Vytenis Andriukaitis, EU Commissioner for Health.

The topics discussed were manifold. CPME and Commissioner Dr Andriukaitis agreed on the need to put patient safety high on the health agenda. President Dr de Haller recalled that a longstanding cooperation between Member States and stakeholders was in place at EU level through the Expert Group on Patient Safety and Quality of Care ([PSQC Expert Group](#)) until September 2015. CPME and Commissioner agreed on the importance to reboot and continue this co-operation in order to preserve the Member States' and stakeholders' support and commitment.



(from the left) CPME Secretary General RA Annabel Seebohm, CPME President Dr Jacques de Haller, EU Commissioner for Health, CPME Vice-President Dr Patrick Romestaing

The discussion moved on to antimicrobial resistance. "We all know how fast this issue is becoming a global emergency," argued Commissioner Dr Andriukaitis. "The health costs are rising in parallel to the spread of antimicrobial resistance. It is our responsibility to tackle this emergency and keep the topic high on the EU health agenda, working together on different sides, such as medicines, food and animals fields." The Commission underlined the importance of support to Member States for the establishment, implementation and monitoring of national plans. At the same time, it is important to advance and continue research and innovation, also to make EU a 'best practice-region' on AMR. On this regard, Commissioner Dr Andriukaitis underlined the urgency to set a global agenda on AMR in co-operation with international organisations. For this reason, talks are already in place to draft potential memorandum of understandings to enable countries to speak the same language and share the same priorities. CPME highlighted the central role played by doctors in containing AMR, also in the context of healthcare associated infections, by promoting good practices on the prudent use of antibiotics and providing input to the European and national policies.

***"We strongly believe that the definition of medical ethics should not be left to mixed consortia, but to the medical profession itself."***

***CPME President, Dr Jacques de Haller***

CPME President Dr de Haller discussed the relevance of medical ethics at EU level. "CPME noted the recent interest of the European Commission (DG Research) in engaging in the definition of medical ethics, including medical ethics, by releasing calls within the H2020 programme (e.g. ['The Ethics of informed consent in novel treatment including a gender perspective'](#))," he said. "We strongly believe that the definition of ethics should not be left to mixed consortia, but to the medical profession itself." The Commissioner fully agreed and took note of the activities led by DG Research.

CPME also had the chance to confirm strong support to DG SANTE in underlining its leading role in all the EU legislative or other initiatives which have an impact on patients, doctors, healthcare and the health system. Today, some important topics, such as the European Semester process, are coordinated by other DGs than DG SANTE, even if DG SANTE has an important stake in them.

Commissioner Dr Andriukaitis welcomed CPME's support and appealed to CPME and other stakeholders to engage with other DGs in charge, to create an environment of understanding and ensure policy coherence and 'health in all policies'.

"The meeting represented an excellent opportunity to discuss ideas and share concerns on key issues of common interest," concluded Dr Jacques de Haller. "We are pleased to see that the Commission is working hard on different relevant topics, such as antimicrobial resistance and the importance to put patient safety high on the health agenda. Commissioner Dr Andriukaitis can always count on CPME's proactive co-operation to achieve the highest quality of healthcare for all patients across Europe." Commissioner Andriukaitis and CPME agreed on the need to continue to work together to ensure best possible quality of health and access to healthcare for everyone.

Further information on CPME policies:

- [Patient Safety and Quality of Care](#)
- [Ethics](#)
- [Antimicrobial resistance \(AMR\)](#)
- [EU Semester](#)

For further information, please contact:

[Miriam D'Ambrosio](#), Communication and Project Officer

**"Commissioner Dr Andriukaitis can always count on CPME's proactive co-operation to achieve the highest quality of healthcare for all patients across Europe."**

**CPME President, Dr Jacques de Haller**

## OUTCOMES OF THE CPME BOARD AND GENERAL ASSEMBLY:



On 19 November 2016, the CPME Board and General Assembly met in Tel Aviv (Israel). The outcome of these meetings includes the following decisions:

- The CPME Board adopted the CPME policy on access to medicines and pharmaceutical pricing ([CPME 2016/063 FINAL](#))
- The CPME Board adopted the CPME policy on medication - interprofessional collaboration between doctors and pharmacists ([CPME 2016/034 FINAL](#))
- The CPME Board adopted the 'CPME Statement on the Medical Treatment of Refugees' ([CPME 2016/097 FINAL](#)).
- CPME members had a fruitful discussion on professional practice, eHealth, diet and nutrition and pharmaceuticals.

## ACCESS TO MEDICINES AND PHARMACEUTICAL PRICING

Equal access to medicines should be a reality for everyone in society. At a time when European countries are confronted with severe cuts to their healthcare budgets, soaring drug prices have put this paradigm at risk, notably by leading governments to take restrictive measures to contain pharmaceutical expenditures. In CPME's policy on access to medicines, European doctors emphasise the negative impact of excessive drug prices on clinical practice and ultimately on health inequalities. In this respect, restricted access to available treatments for certain groups of patients raises severe ethical questions in terms of nonmaleficence and equity.

Welcoming the Council Conclusions on strengthening the balance in the pharmaceutical systems in the EU and its Member States from 17 June 2016, CPME underscores the need for a comprehensive overview and revision of the regulatory framework to improve affordability of medicinal products. The orphan drug regulation has created unintended side-effects which require a thorough revision to impose stricter rules for orphan drug designation procedures. While current initiatives to provide early access to drugs raise concerns about patient safety, CPME considers that a high level of clinical evidence, based on extensive clinical trial data, should remain the rule. Finally, transparency on R&D and manufacturing costs but also on various incentives should help governments to take informed decisions on drug prices. In this context, CPME considers voluntary cooperation on drug pricing among Member States a valuable approach and supports a multidimensional approach based on Health Technology Assessment (HTA). The CPME policy on access to medicines and pharmaceutical pricing was adopted by the CPME Board on 19 November 2016 and can be found here: [CPME 2016/063 FINAL](#)



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[Jonas van Riet](#), EU Policy Intern

## INTERPROFESSIONAL COLLABORATION BETWEEN DOCTORS AND PHARMACISTS

With the adopted policy on medication, European doctors acknowledge and reaffirm the need for an enhanced cooperation between doctors and pharmacists in the context of increasingly complex pharmacological treatments. This cooperation should however take place in a legally secure environment with a clear distinction of respective roles and competences.

The CPME policy also points out that patient safety, quality and continuity of care should remain at the heart of healthcare system reforms. An evidence based approach, which includes an evaluation of the impact on continuity of care and on conflict of interests, should be adopted. The CPME policy on medical-interprofessional collaboration between doctors and pharmacists was adopted by the CPME Board on 19 November 2016. It is available here: [CPME 2016/034 FINAL](#).

*For further information, please contact:*

[Carole Rouaud](#), EU Policy Adviser

# CPME SETS OUT RECOMMENDATIONS ON MEDICAL TREATMENT OF REFUGEES

Against the background of the different national experiences of providing medical treatment to refugees, in particular during the migration waves in 2015, the CPME Board has adopted a [statement](#) which puts fundamental rights and medical ethics at the heart of the debate. To ensure effective access to healthcare for every refugee, CPME proposes to integrate them into the existing healthcare systems. This ensures equal treatment and avoids the administrative burdens a parallel system would entail. The principle of equality is also reaffirmed in relation to the patient-physician relationship and the right to confidentiality. As provided for in codes of medical ethics, doctors have professional obligations to maintain patient confidentiality and to act in the best interest of the patient. They may not be pressured into breaching this and are encouraged to openly speak out against attempts by authorities to challenge these principles. CPME continuously highlights these obligations, also with regard to [healthcare for undocumented migrants](#). In concluding discussions, CPME members confirmed the importance of the topic and the potential for exchange and implementation of good practice. To this end, CPME will create a working group on the health of refugees and undocumented migrants.



Calais (France), Ph. Valerio Nicolisi

*For further information, please contact:*

[Sarada Das](#), Deputy Secretary General

## THE ISRAELI HEALTH SYSTEM



Israel is a small country located on the eastern shores of the Mediterranean Sea. Its territory stretches over 22,072 sqm, with a population of approximately 8.5 million residents. Israel is mostly comprised of urban population, with less than 10% residing in rural settlements. Common health indexes show that Israeli residents enjoy a relatively high level of health. Israel's life expectancy is steadily rising and currently stands at 82 years. Concurrently, the infant mortality rate is gradually decreasing and now stands at 3.1 deaths to one thousand births. The health indicators however show inequalities between different population groups: Jews tend to have a better health status than Arabs, similarly the residents of central district have a better health status than those living in the outlying areas. The inequality is also apparent in the health infrastructure data – the number of physicians and beds in relation to the size of the population in the Southern and Northern districts is lower as compared to the central district.

### Characteristics of the Healthcare System

Israel's healthcare system is comprised of a mix of public and private services provision and finance. The Israeli healthcare system is mainly public. As of 2014, about 61% of the national healthcare expenditure came from public finance (national budget) and designated taxing (healthcare fees). The rest came from private expenses, composed of direct payment from households for healthcare services and private health insurances (both complementary insurance purchased through the health funds and commercial insurance marketed by insurance companies). The national expenditure on healthcare constitutes about 7.5% of the GDP – a rate that is considered low on the international level compared with developed countries. About 80% of Israeli citizens currently have some kind of private insurance – a relatively high rate, considering the fact that the state provides a basic services package to all its citizens. The National Health Insurance Law (1994) sets a healthcare package that is uniform, equal and universal to all of Israel's citizens. Pursuant to the law, citizens are insured with mandatory insurance in one of four health funds that act as non-profit organizations. The health funds' package includes services such as medications, doctors' visits, hospitalisation services, and paramedical treatments.

Concurrently, the state funds a separate services package supplied by the Ministry of Health, which includes mental health services, geriatrics, preventive medicine, and rehabilitation equipment. In recent years, the healthcare system has constructed reforms that would assign the mental health services to the healthcare clinics and covers dental health services for children as part of the health funds' basic package. Israel has 45 general hospitals, 11 of which are government operated, 11 are private and the rest are public institutes or operated by the largest health fund Clalit. The rate of general admission beds in Israel has been regularly decreasing since the 80's, and now stands at about 2 beds per 1000 people.



### **The Medical Profession - Education and training:**

In order to become a physician in Israel, one must undergo 6 years of undergraduate education. There are currently 5 medical schools in Israel. Acceptance to medical school is extremely competitive, and as a result many Israelis choose to study abroad, mostly in European countries such as Italy, Hungary, Lithuania and Romania. Following 6 years of study, of which three are pre-clinical and three are clinical, the student performs a year of internship in a designated hospital. The 12-month internship covers 9 months of mandatory rotations in internal medicine, surgery, pediatrics, emergency medicine and intensive care, 2 months of elective rotations and one month vacation. There is also an option to undergo 'straight internship' in internal medicine, surgery or pediatrics, 6 months of which are then counted towards subsequent residency training in the chosen field. At the end of the internship, physicians educated in Israel will receive a license to practise medicine. The vast majority of Israeli physicians continue on to 4-6 additional years of postgraduate training in one of 30 basic specialties, and often another 2-3 years in one of 28 subspecialties. Upon completion of the residency period, successful completion of 2 residency exams and a letter of recommendation from the department head, the resident may apply to the

Scientific Council of the IMA to be granted specialty certification. After reviewing his or her file, the relevant professional committee of the Scientific Council will recommend to the Ministry of Health that he or she be granted specialty certification. The actual certification is granted by the Ministry. Continuing Medical Education (CME) in Israel is not mandatory. Nonetheless, each physician is encouraged to continue his or her medical education beyond the years of formal education and to remain current in new medical developments. The IMA issues certificates to physicians who complete a set amount of CME.

### **Workforce shortage**

Shortages in the medical workforce is a global issue. The increase in the number of retiring physicians, the sharp decline in the number of doctors immigrating to Israel, and the failure to expand the scope of physician training frameworks in medical schools have all given rise to very real concerns regarding an anticipated physician shortage in Israel. The establishment of the 5<sup>th</sup> medical school is expected to elavate the number of physicians in the future, but meanwhile the number of physicians per population has continued to decrease since the late 1990s. In 2014, the percentage of physicians (medical license holders under 65) was 3.09 physicians per 1,000 persons, with a total of 25,637 physicians. In addition to the overall decrease, Israel contends with a disparity between the scope of healthcare services available in the periphery as compared to that in central Israel. In order to narrow the gap between periphery and centre, as well as between the less attractive medical specialties such as anesthesiology and pathology and the more attractive ones, the physicians' collective agreement signed in August 2011 included financial incentives for medical residents who choose to work in the periphery and in specialties in distress as specified in the agreement. Immediate impact was achieved in the first years after the agreement as medical centers in the south and north of the country experienced an influx of residents. Hospital departments once closed reopened due to the arrival of new medical manpower. Although still far from having achieved complete equality, it is evident that the northern and southern districts experienced an increase in the number of physicians per population as opposed to a decrease in the central districts, thus narrowing the geographical gap during the three years following the agreement. The long-term impact of the agreement remains to be seen, as it is unclear to what extent the government will be able and willing to continue providing financial incentives to medical residents as a solution to healthcare disparities.

*For further information, please contact:*

*[Michelle Glekin](#), International Relations Officer, Israeli Medical Association*

# THE HEALTH CARE SYSTEM IN GREECE UNDER THE SHADOW OF CRISIS



The memorandum<sup>1</sup> policies have led to a dramatic underfunding of the healthcare system. The budget for healthcare funding is currently at 4.5% of GDP for 2016. Considering that the safety limit of a funding is considered to be 6% of GDP, and the European average is 6.9% of GDP, it is possible to understand a humanitarian crisis gripping Greece. Today, in a population of 11 million citizens, 3 millions of them are uninsured and the average pharmaceutical expenditure per capita is 179 euros, while European average is 320 euros. Patients are required to pay themselves for a contribution of approximately 30% and 1,300 pharmaceuticals approximately, are not reimbursed by the state.

Hospital budgets for operational costs for 2016 were scarcely able to offer basic services, transferring into the patients' pockets an increasingly larger part of the examination and hospitalisation costs. This tends to be the procedure for reducing deficits in hospitals. The dismantling of the public character of the operation of hospital structures, dramatic shortages in medications, materials, machinery, the large reduction in salaries of the healthcare staff which amounts up to 45-50%, and vacancies of doctors' positions in hospitals, have weakened hospital healthcare and junior doctors are led to unemployment and migration.

During the last three years approximately 18,000 doctors have migrated to Great Britain, Germany, France, Saudi Arabia, United Arab Emirates, etc. There is a lack of 6,500 doctors and 16,000 nurses in the public health system, because the memorandum does not permit to fill vacant positions. Thus, doctors work more than 48 hours per week (usually, more than 90 hours per week)! Consequently, Greece is penalised by a large fine because of contravention of the European Working Time Directive (EWTD) Limit of 48 weekly working hours.

Primary healthcare in Greece is very much weakened. There are few public structures in healthcare and the National Organisation of Health Services (EOPYY), which began operating in 2012 in order to purchase health services for insured citizens, does not cover the needs for primary healthcare. It reimburses a total of only 8 million visits to the physician, while 30 million visits are required. Doctors with a contract arrangement with this organisation, are compensated for each patient's visit at a very low fee, that is, 10 Euros, therefore only 5,000 doctors, of 30,000 self-employed doctors approximately across the country, have contracts with the organisation.

There are no health centres in urban centers with on-call service in order to provide health services to patients in primary healthcare structures. Health centres in semi-urban and rural areas have minimum medical staff and inadequate health care is provided to the population. As a result, the number of patients visiting hospitals for primary care, even for mild illnesses, has increased in recent years, by 70%. The migration problem has further encumbered the healthcare structures, while diseases, such tuberculosis, malaria and even poliomyelitis have started to reappear. The pathogenesis of the system with a mixed health insurance system, limited funding from the state budget and uncollected contributions from the EOPYY, the deficits of the electronic system with the exclusion of therapeutic and diagnostic protocols in the prescribing practice of doctors, the lack of real time monitoring of the total system, the pathogenesis of supplies, the inability of public and private health structures to communicate with the central government, but also between them, as well as the non-regulated operation of the system in line with European and international standards, create conditions not promising for the immediate future.

1) Memorandum refers to all agreements concluded between the Greek Government, the Greek central bank and the EU following the financial and economic crisis on Greece's economic adjustment.

*For further information:*

*Dr Marily Passakiotou*

*Member of the Greek Delegation to the CPME*





# TOBACCO CONTROL IN THE EU: MISSION ACCOMPLISHED?



With the entry into force of the Tobacco Products Directive (TPD) in May 2016, the European Union's tobacco control policy has reached an important milestone. Almost all the EU Member States have transposed and implemented the TPD into national law, whose provisions notably require mandatory pictorial warnings covering 65% of the front and back of cigarette and roll-your-own tobacco packets and

ban flavoured tobacco products (except menthol, which will be banned as of May 2020). The TPD also allows Member States to introduce further measures such as plain packaging, already in force in the UK and France, and soon in other EU Member States.

With the TPD now in force, has the EU reached the limits of its mandate for tobacco control policies? By all means, we must not believe so. Tobacco products regulation is one side of a multi-faceted strategy. Some policies, including plain packaging or restrictions of tobacco advertising at the point of sale can best be enacted at the national level. However other important policies such as tobacco taxation and the fight against illicit trade in tobacco products fall under the mandate of the EU.

The EU Commission has recently launched a public consultation on the possible review of the Tobacco Tax Directive. At stake here is the recognition that tobacco prices are the single most effective measure to reduce tobacco use sustainably, while preserving or increasing government revenues. It is important that the wider public health community engages in this process to ensure that a future review of tobacco excise duties legislation reflects the impact of tobacco prices on consumption.

The EU Commission is also in the process of defining an EU system of tracking and tracing tobacco products, which is a major part of the fight against illicit trade. Illicit tobacco trade impacts all EU Member States and erodes public health by making cheaper (untaxed) tobacco available, particularly to already vulnerable groups such as young people and low-income citizens, while depriving governments of billions in excise tax revenues each year. Identifying an appropriate system to ensure that products do not escape the legal supply chain and that this system is independent of tobacco industry interference are key objectives enshrined in the Tobacco Products Directive. The EU's tracking and tracing system will also have a global impact: what the EU does to reduce illicit trade will be followed in many other parts of the world.

Taxation and illicit trade are not natural topics for the public health community, who have to speak to a different audience of finance or customs officials. However, these policies will have a major impact on public health and as such, we have a key role in ensuring that public health objectives are upheld in the on-going legislative discussions. SFP encourages all public health organisations to become involved in the consultations and are available for information and support to that end.

***With the TPD now in force, has the EU reached the limits of its mandate for tobacco control policies? By all means, we must not believe so.***

***Smoke Free Partnership***

*For further information:*

[Anca Toma Friedlaender](#), SFP Senior Policy Advisor



# WHY DOES FLU VACCINATION MATTER?



Influenza vaccination matters because the annually observed burden on individual's health, healthcare systems and the socioeconomic consequences of influenza can be mitigated by this safe intervention. We all know the mantra so why does the question still need to be asked? And why does vaccination coverage in Europe remain below the targets that have been set?

Seasonal influenza causes 40-50 million symptomatic cases in the EU/EEA each year. Each one of these cases then has a consequent economic impact in terms of absence from work, and pressure on the healthcare system. That burden is substantial. Even though severe outcomes of influenza are relatively rare, every year 15 000/70 000 Europeans die due to causes associated with influenza, due to the large number of infected people. Further, in the eight EU countries reporting hospital data, more than 8 500 hospitalised cases of influenza were reported last influenza season; almost two-thirds of those patients were reported from intensive care units.

These issues were central to the Council of the European Union (the health ministers of all the EU countries) issuing a recommendation for countries to do more to increase vaccination coverage for risk groups and healthcare workers – Council Recommendation 1019/2009. But despite this explicit political prioritisation, there has been a collective failure over the past six years to even get close to the targets of 75% vaccination coverage for the elderly and other risk groups and increasing coverage of healthcare workers.

The reasons for this are well-researched and understood. Many of the barriers are perennial problems: low perception of risk; fear of possible side effects from vaccination and questions about the effectiveness of the influenza vaccine. As with so many things in public health, successfully applying the responses is easier said than done.

Familiarity with influenza as it comes around every winter, and perhaps its inappropriately perceived similarity to the relatively innocuous common cold, has led to a complacency towards influenza vaccination. Annual vaccination against influenza is the most important element of our toolbox against influenza. The role of healthcare professionals is known to be critically important in convincing people to be vaccinated. However low influenza vaccine coverage is as much of an issue among healthcare workers as it is among the general public. So before you can convince others, you need to be convinced yourself.

Recognising that convincing healthcare workers is an exercise that needs much skill and effort, ECDC has developed an e-learning course about influenza disease and vaccination campaigns for healthcare workers. During the interactive course, information about influenza disease, protection against influenza, how to plan, implement and evaluate influenza vaccination campaigns and barriers to vaccination are presented. The course is open for a limited period only.

***The role of healthcare professionals is known to be critically important in convincing people to be vaccinated.***

**ECDC**

*For further information:*

*Pasi Penttinen, Head of influenza and respiratory viruses disease programme*

*Romit Jain, Communication lead for influenza, European Centre for Disease Prevention and Control*

<http://ecdc.europa.eu/en/healthtopics/influenza>

## CPME NEWS

From 18 to 22 October 2016, CPME President Dr Jacques de Haller and CPME Secretary General Annabel Seebohm attended the World Medical Association's general assembly in Taipei, Taiwan. Please find a link to the general assembly decisions [here](#).

On 28 October 2016, CPME Secretary General Annabel Seebohm attended the Healthcare Professionals Crossing Borders (HPCB) conference entitled "Promoting patient safety across borders" in London. More information on the outcome can be found [here](#).

On 8 November 2016, CPME President Dr Jacques de Haller, CPME Vice-President Dr Patrick Romestaing and CPME Secretary General, RA Annabel Seebohm met with Dr Vytenis Andriukaitis, EU Commissioner for Health. More info on page 3.

On 8-9 November 2016, CPME Vice-President Dr Bernard Maillet spoke at the conference on 'Patient & Family Empowerment for Better Patient Safety' in Brussels (Belgium) organised by the European Patients' Forum. More info available [here](#).

On 12 November 2016, CPME Immediate Past-President Dr Katrín Fjeldsted attended the third UEMS Conference on CME-CPD in Amsterdam (The Netherlands). More info on the Conference available [here](#).

On 21 November 2016, Immediate Past-President Dr Katrín Fjeldsted attended the first advisory board meeting for Joint Action on the market surveillance of medical devices in London.

On 2 December 2016, CPME President Dr Jacques de Haller and CPME Secretary General Annabel Seebohm attended the plenary meeting of the European Council of Medical Orders (CEOM) in Paris.

On 8 December 2016, CPME Vice-President Bernard Maillet will speak at the third annual eHealth Summit in Brussels organised by the European coordination committee of the radiological, electromedical and healthcare IT industry (COCIR). Please find more information [here](#).

## WHO-EUROPE'S REGIONAL COMMITTEE TALKS GOVERNANCE, FINANCE AND POLICY

The WHO-Europe's regional committee met in Copenhagen on 12-15 September. The agenda included intensive discussions on governance and finance: amid on-going reforms, WHO has adopted a Framework for Engagement with Non-State Actors (FENSA), which will apply to all stakeholder relations and include, i.a. a register to facilitate transparency on stakeholders' governance, financing and composition, as well as their cooperation with WHO. The budget discussions reflected the increasing range of activities WHO-Europe has committed to. There was an appeal to maintain investment in key policy areas, such as antimicrobial resistance and social determinants of health. The meeting also featured discussions i.a. on continued action against non-communicable diseases, the management of health emergencies and the health workforce. In its written submission to the meeting, [CPME highlighted](#) the opportunities to implement the 'health in all policies' principle in the current EU-level negotiations towards a revised Audio-Visual Media Services Directive which has the potential to introduce stricter controls on advertising of alcohol and unhealthy food. CPME looks forward to continuing its cooperation with WHO. One recent occasion was the consultation for input to the UN High-Level Commission on Health Employment and Economic Growth. A WHO expert group is supporting the process and is collecting examples of stakeholder activities relating to the policy recommendations adopted. CPME will continue to monitor this process.



*For further information, please contact:*

[Sarada Das](#), Deputy Secretary General

## JA-CHRODIS FINAL CONFERENCE



The final conference of the Joint Action addressing chronic diseases and healthy ageing across the life cycle (JA-CHRODIS) will be held in Brussels on 28 February 2017. The main objective of the joint action is to promote and facilitate a process of exchange and transfer of good practices between European countries and regions, addressing chronic conditions, with a specific focus on health promotion and prevention of chronic conditions, multi-morbidity and diabetes. More info available [here](#). CPME will be represented by Secretary General RA Annabel Seebom.

*For further information, please contact:*

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## PISCE FINAL CONFERENCE



The final conference of PiSCE, the EU Tender on the Promotion of Self-Care Systems in the EU, will be held in Brussels on 17 March 2017. The event will present concrete proposals for policy actions and collaboration at EU level on self-care, giving an added value in supporting the broader implementation of effective self-care. CPME will be presented by President Dr Jacques de Haller and EU Policy Advisor Markus Kujawa.

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[Markus Kujawa](#), EU Policy Adviser

## INSTITUTIONAL NEWS

On 20-21 October, the European Council met in Brussels (Belgium). The European Council conclusions may be found [here](#).

On the occasion of the European Antibiotic Awareness Day celebrated on 18 November 2016, the European Union pledged to continue its fight against antimicrobial resistance (AMR) with the launch of a second action plan in 2017, building on the previous plan that comes to an end in 2016. Please further information [here](#).

On 22 November 2016, the European Committee of the Regions and WHO-Europe have signed a Memorandum of Understanding to combine their efforts in key areas of public health. Please further information [here](#).

On 23 November 2016, the European Commission and OECD presented the new "Health at a Glance: Europe" report, marking the start of a new two-year State of Health in the EU cycle that aims to increase country-specific and EU-wide knowledge on health. More information and the report [here](#).

The next EPSO Council meetings, bringing together ministers responsible for employment, social affairs, health and consumer policy are scheduled for 8-9 December 2016 and 3 March 2017. More information on Health Council configurations and related documents can be found [here](#).

On 1 January 2017, Malta will take over the rotating six-month presidency of the Council of the European Union from Slovakia. More information on the presidency's priorities may be found [here](#).

## Editorial Board

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*Thank you*

### *Guest commentary*

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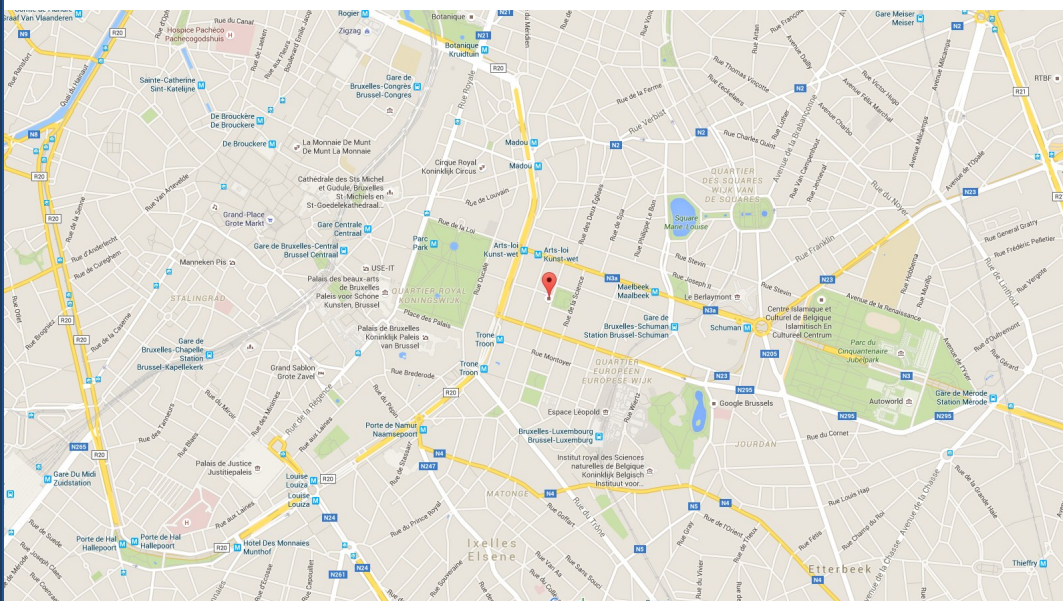
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