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CPME Final Report COVID-19

1. Introduction

The COVID-19 pandemic has moved health policy to the top of political agendas. At CPME , a discussion around the lessons learnt has been launched. This process draws on the extensive collection of status reports from national medical associations CPME coordinated which capture doctors' experiences of the pandemic. These include information on the availability of human and technical resources, testing and treatment protocols, and the impact on doctors' health and professional practice.

2. Supplies

The COVID-19 outbreak has caused a severe impact on the availability of supplies. In the beginning, most national medical associations reported about shortages due to high demand.

Personal Protective Equipment (PPE)

The biggest problem was the supply of FFP 2 and FFP 3 masks, both in hospitals and doctors' offices. National medical associations tried to tackle the problem in different ways. As an example, the Austrian Medical Chamber provided doctors' offices with masks and gowns. Also, the Czech Medical Chamber was assisting doctors to get the proper equipment. The Croatian Medical Chamber was raising funds for additional PPE supply for its members. The Latvian Medical Association initiated the production of PPE by a joint effort between different institutions and the industry. The British Medical Association wrote to the Prime Minister requesting that healthcare workers have the proper protection. The Cyprus Medical Association ordered PPE with their own money to support their members. The Czech Medical Chamber had a key role in the national distribution of PPE among doctors.

A number of national medical associations reported that their country does not produce PPE on their own. Therefore, many countries needed regular additional equipment deliveries from abroad. Agreements of both purchase and donations were set especially between China and many European countries such as Austria, Croatia, Cyprus, the Czech Republic, Denmark, Greece and Poland. Some countries, for example Malta and Denmark, reported that shipments of PPE were blocked and delayed in other countries (e.g. being lost in transit countries). In some countries, private companies altered their production to producing PPE to increase the capacity, as an example Lego in Denmark and some fashion textile industries in Italy. Moreover, Finland decided to open their national stockpile of PPE to guarantee the availability.

In May 2020, the availability of PPE had improved in many countries. Some countries such as Austria and Denmark reported that their own production of PPE had increased, or started, like in Finland. Denmark also reported that cooperation between state-authorities, regions and communities in buying PPE contributed to the stabilisation. Also self-made masks of citizens improved the overall

situation. However, the Slovenian Medical Association reported that the lack of PPE is still prevalent among private doctors, and the Israeli Medical Association reported about problems with procuring PPE, for which a black market has developed.

In the beginning of July 2020, more countries reported about better availability of PPE. The German Medical Association reported that the shortage problem was resolved but there were still issues getting the PPE to the right place. The idea of a national emergency reserve was also being explored in Germany. The Czech Medical Chamber informed that they had created guidelines for producers and retailers of PPE. The Polish Medical Association reported about the problem of some PPE supplies being below standards. Also the Swedish and Turkish associations reported about some quality issues with masks.

Some countries described obscurities related to the procurement of PPE. Therefore, the response to the potential second wave should be better coordinated at EU level. It includes monitoring of PPE shortages, facilitating information sharing among the EU member states, and requiring early reporting from pharmaceutical and medical device industry about any supply problems. The Danish Medical Association reported that Denmark has already put the PPE issue on the EU agenda. The European Commission has started to help ensure adequate supply of PPE across Europe, working closely with the member states to assess the available stock of PPE in the EU, the production capacity and anticipated needs. Sufficient availability of PPE is essential to help avoid stress and related burnout. Ensuring availability and use of proper PPE is important for physical but also mental wellbeing by giving a stronger sense of security.

Ventilators and Medicines

The outbreak of the COVID-19 pandemic caused also severe shortages of medicines and ventilators. The CPME survey reveals that most EU Member States were caught unprepared to respond to the health crisis and unable to secure early access to essential therapeutics and technology for treating COVID-19 patients. The majority of CPME members confirmed their initial difficulties with its quick replenishment (e.g. Belgium reported about an order of 10,000 ventilators that could not be completed). Even countries with domestic production of ventilators were not exempted from shortages – Ireland that is responsible for 25% of their worldwide production still envisaged the potential of their unavailability for Irish citizens.

According to the surveys, several EU countries were running low on sedatives, painkillers, muscle relaxants or antivirals. The outbreak has aggravated already existing problem of medicine shortages in the EU by causing additional disruptions of the supply chain and by resulting in increased demand for some medicines in clinical trials for COVID-19 and off-label use. Understandably, some countries also reported difficulties with acquiring medicines potentially effective against the novel coronavirus based on preliminary data like Remdesivir or Hydroxychloroquine.

As all countries experienced difficulties with securing sufficient stocks of ventilators and medicines to meet (potential) national demand, the actual consequences of their unavailability in given time

differed significantly between EU Member States. In most cases, early decisions about the introduction of non-pharmaceutical measures to slow down the spread of the virus were effective for enabling ICU beds, ventilators, and therapeutics to remain available. Hungary, Cyprus, Czech Republic, Latvia, Ireland, and Poland, among others were repeatedly reporting possible future shortages but never experienced actual ones. For example, Czech Republic has not used more than a few hundred (out of 3000 in stock) ventilators at any time during the pandemic. However, at the same time, inadequate supply in countries hit first and the most severely by the pandemic resulted in healthcare personnel being forced to triage patients and deny some of them access to life-saving devices and medicines. In fact, over the months, only Italy and Spain reported the 100% usage of their stockpiles.

Whereas a rapid increase in the number of people requiring treatment was the main reason of shortages in most countries, some of them (e.g. Ukraine, Serbia, or Kosovo[*]) underlined long-existing, national, systemic problems that made it additionally difficult to procure necessary therapeutics. For example, Ukraine experienced a critical number of antiviral drugs and had only 180 mechanical ventilators in Lviv, a region of more than two million inhabitants.

In early April, CPME members started to report on replenishing their stocks, even though the global supply chain still experienced backlogs, and in the early summer months, only two CPME members (Kosovo[*] and Ukraine for the above-discussed reasons) signaled continuous shortages.

One explanation of this improvement can be enhanced cooperation among EU Member States and between EU and third countries. For example, Cyprus highlighted its successful collaboration with Israel from which it received fifty ventilators in exchange for Chloroquine that is produced in the former in big quantities. Moreover, Serbia and Ireland reported about effective procurement of ICU's machineries from China.

Besides, CPME members reported about successful bottom-up initiatives and contributions from individuals. Poland highlighted public fundraising that allowed underfunded hospitals to acquire additional ventilators and Greece shared examples of contributions from wealthy donors to buy the devices.

European governments were also taking different measures to safeguard accessibility to the limited number of essential medical devices in case of difficulties in timely importing new ones. For examples, in France, the equipment distributors and the pharmacists responsible for their dispensation were allowed to replace an unavailable medical device with another one given certain criteria (e.g. an identical use, equivalent technical specification, particular registration procedure) were met and after the prescriber agreed on and the patient was informed about that.

In regard to medicines, CPME members also often reported about supplementary measures introduced by governments when immediate replenishment was not possible. They included imposing restrictions on the quantities that could be prescribed to or purchased by citizens or limiting the

[*]References to Kosovo are without prejudice to positions on status. They are in line with United Nations Security Council Resolution 1244/1999 and the opinion by the International Court of Justice on the Kosovo declaration of independence.

prescriptions' renewal. For example, Sweden introduced a limit of 3-month stock of medicines purchased by individual patients.

Unstable supply of medicines led policymakers to also tighten the obligations of marketing authorization holders. Austria obliged them to report any problems with a steady supply of prescription medicines (reporting on non-prescription medicines was voluntary).

Besides, CPME members shared their practices of repurposing veterinary medicinal products with the same therapeutic aim as unavailable human ones. In France, a given veterinary medicine that had the same active substance, the same dosage, and the same route of administration as a human one being in shortage could be prescribed, prepared, dispensed, and administered in hospitals. In Sweden, the stocks of propofol were replenished that way.

EU countries also underlined the importance of communication and coordination at national and regional level. In that context, Austria reported about setting up a system that envisaged the definition of a central COVID-19 pharmacy in all nine states that functioned as a single point of communication. These pharmacies were in charge of keeping an overview of COVID-19 medicines and their distribution to the hospitals in their state.

At the time of finalizing the CPME surveys on 3 July 2020, almost all countries were sufficiently prepared to treat COVID-19 patients (although e.g. the UK signaled that still 33% of their hospitals reported medicines shortages at that time). Notwithstanding, many of them were still in the process of acquiring additional medical devices and identified different challenges on the way forward, such as enhancing local distribution network for medical equipment and increasing medical collaboration with neighboring countries. Moreover, while the situation in hospitals was improving, CPME members were pointing out at the need to increase availability of essential equipment in care homes.

3. **Data** (to follow)

4. Workforce

Changes to the working time and conditions of doctors were reported already within the early weeks of the pandemic. Some countries, such as Slovakia, reported that the medical workforce faced excessive hours even outside a pandemic. In others, the working conditions of doctors were affected within weeks, with Portugal and Romania for example soon reporting that doctors were overloaded. Often however, this excessive workload and accordingly working time did not affect the entire workforce uniformly. In March and April, several countries report a more gradual increase of working time, with Netherlands and Ireland reporting case-by-case approaches to overtime. Sweden and France reported regional hotspots where the medical workforce was affected by changes in working time locally, rather than nationwide.

Those medical specialties most relevant to treating patients with COVID-19, in particular intensive care medicine, saw a quick increase in workload; Ukraine and Latvia being among the first countries to report such. Several countries, including Spain and later also Sweden and Cyprus, adapted shift schedules to 12-hour or even 24-hour rotations, often with fixed teams allocated to shifts. Such adjustments to working schedules or other policy measures to govern working time during the pandemic were a frequently used tool. From general monitoring of working time, like in Malta, to employee-based solutions in Austria, or collective bargaining as was used in Israel, doctors' working time became an even more valuable resource during the pandemic. Emergency laws drafted for pandemic management made some provision for doctors' working time, such as prohibiting holidays to be taken as was decreed in Serbia.

In parallel, there were efforts to pro-actively reduce the demand for healthcare, most frequently by postponing elective interventions, with almost all countries report the adoption of this measure. A further measure to support the medical workforce was the rapid and extensive use of online consultations, in particularly in primary care. Designated 'COVID-19 hospitals' in Austria and Spain organised the workforce providing specialised care. In general, doctors were prohibited from moving between different hospitals in many countries, including Cyprus, Serbia, the Netherlands, and Georgia.

The pandemic exposed doctors and other health professionals in many countries to a workload and psychological burden few have experienced so far. 47% of doctors surveyed by the British Medical Association report to be suffering from mental ill health, of which 32% indicate that this has been aggravated by the pandemic. From Romania, there were reports of doctors resigning from positions due to the lack of adequate PPE and of doctors being harassed by neighbours who fear the spread of infection. In Poland, the National Medical Association marked incidences of legal advisers encouraging patients to bring malpractice suits against doctors.

Several National Medical Associations, including those in Greece and Latvia created helplines for their members to provide advice and support, both for questions relating to patient care and doctors' own well-being. In the Netherlands and France, public websites recruited volunteers to help with non-medical tasks in hospitals, thereby lightening doctors' workload. The National Medical Associations in Finland and Slovenia report on their activities in providing information to their members on the applicable protocols and employment rights during the pandemic; in addition Slovenian doctors were surveyed on a weekly basis. Doctors also reported on active engagement in policy decisions, for example in Portugal where a multidisciplinary panel of doctors monitoring ministerial decisions. For the Ukraine, it is reported that hospitals compensated doctors' travel expenses and provided accommodation, in addition to an extra payment to those involved most directly in the care of COVID-19 patients amounting to 200% of their salary.

The question of monetary compensation for the care delivered during the pandemic was also addressed in several countries. In many countries, the overtime incurred by doctors was paid, as was granted in Latvia. Lithuanian doctors were given a pay rise, while for those working in the regions worst affected by the pandemic, there was an additional payment of 200% of their salary. In Sweden, doctors working in most affected region Stockholm were given a compensation of 230% of their salary during

the emergency measures. Doctors in France who were in quarantine were given guarantees as regards social protection. However, not in all countries has the compensation promised has been paid so far.

It was only in June that there were reports of some of the arrangements on working conditions and time which were put in place for the peak of the pandemic were rolled back. While this included a return to more normal schedules for most, Iceland reported that the nursing profession even planned to go ahead with strike action due to a stalled salary negotiation. But a commonly shared focus is tackling the unmet care needs of treatments or diagnosis postponed during the first months of the pandemic. In Croatia, doctors are working extra shifts in the evenings and weekends to deal with this backlog.

Violence against workforce

Despite the support, solidarity and gratitude demonstrated to the healthcare professionals since the beginning of the COVID-19 pandemic, attacks against them have been perpetrated across Europe and beyond. Often considered as carriers of the virus, they have faced discrimination, violence and acts of intimidation on the basis of their profession. Such traumatising experiences lead healthcare professionals to be ostracised and, in some cases, pressured to move out of their own homes, as reported by the Belgian media RTBF, as well as discriminated against, physically attacked and verbally threatened and abused.

This situation has been reported for instance by the Polish Chamber of Physicians and Dentists. During the first stage of the COVID-19 outbreak, Polish doctors encountered signs of great social sympathy, manifested, for instance, with food and PPE offered by numerous individual donors. Unfortunately, with the first appearance of COVID-19 cases in medical facilities, verbal abuse, aggressive gestures and hate speech have been reported by healthcare professionals. In particular, many of them denounced events such as nurses' cars vandalised with paint or the refusal to admit the children of doctors to kindergartens. Similar cases of verbal abuse have been reported in UK, where, according to England's chief nurse and the Royal College of Nursing, nurses caring for patients in the community have been spat at and called 'disease spreaders' by members of the public.

However, these examples appear to be the tip of the iceberg, as in most of the cases victims did not disclose their experiences to the appropriate authorities as they kept focusing on the fight against the virus and therefore no legal action has been taken.

The World Medical Association (WMA) and the European Medical Organisations have condemned those attacks on healthcare professionals happening almost on a daily basis, both inside and outside the workplace, and asked for campaigns to stop misinformation related to COVID-19 contamination. Misinformation and disinformation in fact often increase fears and panic in the population. Therefore, it was asked that authorities communicate clearly on the risks and the latest developments related to the outbreak.

Availability of workforce

(to be continued)