CPME Report
21 November 2020

CPME report on COVID-19 in Europe

The Standing Committee of European Doctors (CPME) represents national medical associations across Europe. We are committed to contributing the medical profession's point of view to EU and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues[1].

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 during the first wave from March to July 2020 capturing doctors' experiences of the pandemic.[2] These reports include information on the availability of human and technical resources, testing and treatment protocols, and the impact on doctors' health and professional practice. Currently, CPME is coordinating a survey covering the second wave.

2. Supplies

The COVID-19 outbreak has had a severe impact on the availability of supplies. At the beginning, most national medical associations reported 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. For example, the Austrian Medical Chamber provided doctors' offices with masks and gowns. The Czech Medical Chamber also assisted doctors with getting the proper equipment and played a key role in the national distribution of PPE among doctors. The Croatian Medical Chamber raised funds for additional PPE supplies 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

[1] CPME is registered in the Transparency Register with the ID number 9276943405-41.
More information about CPME's activities can be found under www.cpme.eu

[2] The surveyed countries include Austria, Albania, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kosovo*, Latvia, Lithuania, Malta, Montenegro, The Netherlands, Norway, Poland, Portugal, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, the United Kingdom and Ukraine, from 25 March until 3 July 2020.
*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.

requesting that healthcare workers be provided with proper protection. The Cyprus Medical Association ordered PPE with its own money to support its members.

A number of national medical associations reported that their country does not produce PPE. Therefore, many countries needed regular additional equipment deliveries from abroad. Agreements on both purchases and donations of equipment were made, 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. lost in transit countries). In some countries, private companies altered their production to producing PPE in order to increase the production capacity, for example Lego in Denmark and also some fashion textiles industries in Italy. Moreover, Finland decided to open its national stockpile of PPE to guarantee availability.

By 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 begun, as in Finland's case. Denmark also reported that cooperation between state authorities, regions and communities in buying PPE contributed to the stabilisation of supplies. The production of home-made masks also improved the overall situation. However, the Medical Chamber of Slovenia reported that a lack of PPE is still prevalent among private doctors, and the Israeli Medical Association reported problems with procuring PPE, for which a black market has developed.

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

Some countries described a lack of clarity relating 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 EU Member States, and requiring early reporting by the pharmaceutical and medical device industries 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 supplies of PPE across Europe, working closely with Member States to assess the available stocks 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 through providing a stronger sense of security.

Ventilators

The outbreak of the COVID-19 pandemic also caused severe shortages of 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 technology for treating COVID-19 patients. The majority of

CPME members confirmed they had initial difficulties with the quick replenishment of supplies (e.g. Belgium reported that an order of 10,000 ventilators could not be completed). Even countries with domestic production of ventilators were not exempt from shortages – Ireland, which is responsible for 25% of worldwide production, still envisaged potential unavailability of ventilators for Irish citizens.

While all countries experienced difficulties with securing sufficient stocks of ventilators to meet (potential) national demand, the actual consequences of their unavailability in the given timeframe 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 in enabling ventilators to remain available. Hungary, Cyprus, the Czech Republic, Latvia, Ireland, and Poland, among others, repeatedly reported possible future shortages but never experienced actual shortages. The Czech Republic, for example, has not used more than a few hundred ventilators (out of 3000 in stock) at any time during the pandemic. However, at the same time, inadequate supplies in countries hit first and most severely by the pandemic resulted in healthcare personnel being forced to triage patients and deny some of them access to life-saving devices. In fact, over the first few months, only Italy and Spain reported 100% usage of their stockpiles.

In early April, CPME members started to report on the replenishment of their stocks, even though the global supply chain was still experiencing backlogs, and by early summer only two countries, Kosovo* and Ukraine, indicated that shortages remained.

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

CPME members also reported on 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 importing new ones on time. For example, in France, the equipment distributors and pharmacists responsible for their dispensation were allowed to replace an unavailable medical device with another one, as long as certain criteria (e.g. an identical use, equivalent technical specification, particular registration procedure) were met and after the prescriber agreed and the patient was informed about it.

At the time of the final CPME surveys on 3 July 2020, almost all countries were sufficiently prepared to treat COVID-19 patients. Notwithstanding this, 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 networks for medical equipment and increasing medical collaboration with neighbouring countries. Moreover, while the situation in hospitals was improving, CPME members were pointing out the need to increase availability of essential equipment in care homes.

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Medicines

Reports of a lack of availability of medical devices coincided with reports of shortages of medicines to treat COVID-19 patients. According to the surveys, several EU countries were running low on sedatives, painkillers, muscle relaxants and antivirals. The outbreak has aggravated already existing problems of medicine shortages in the EU by causing additional disruption of supply chains 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 acquiring medicines potentially effective against the novel coronavirus based on preliminary data, such as Remdesivir or Hydroxychloroquine.

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

CPME members also frequently described supplementary measures introduced by governments when immediate replenishment was not possible. These included imposing restrictions on the quantities that could be prescribed to or purchased by citizens or limiting the renewal of prescriptions. For example, Sweden introduced a limit of 3-months on stocks of medicines purchased by individual patients.

In addition, 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 in short supply could be prescribed, prepared, dispensed, and administered in hospitals. In Sweden, the stocks of propofol were replenished this way.

EU countries also underlined the importance of communication and coordination at national and regional level. In this context, Austria reported on the setting up of a system that envisaged the nomination 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.

3. Data

COVID-19 prevalence among doctors and other health professionals

In April/May, the countries reporting the highest COVID-19 prevalence among health professionals were Ireland (28%) and Cyprus (26%), followed by Spain and Portugal (20%), then the UK (around 15%), with the UK reporting a disproportionately high impact on black, Asian and minority ethnic (BAME) professionals, Italy (10.6%) and Czech Republic (10%). However, many countries did not yet have data in April/May (Austria, Belgium, Finland, France, Georgia, Germany, Hungary, Montenegro, Norway, Slovakia).
In April/May, the countries reporting the lowest COVID-19 prevalence among health professionals were Denmark and the Netherlands with 4%.
The country hit hardest by deaths among health professionals was Italy.

Some countries reported that COVID-19 prevalence among health professionals was high due to the lack of PPE (e.g. Cyprus, Czech Republic), while for others it was related to being tested more often than the general population (Denmark).

Death recording protocol

The recording of deaths varied significantly from country to country making it difficult to compare data. The criteria for recording the cause of death was different. From the few countries reporting on this issue in April, it seems Latvia was the only one following the international WHO guidelines. Some considered only confirmed COVID-19 as cause of death, while others included potential deaths related to COVID-19. While in some countries this was managed by local health authorities or national health authorities, in others it was left to the clinical judgment of physicians.

Testing protocol

The clear majority of countries did not prioritise health professionals in testing. Doctors were tested when symptomatic or when they had had contact with infected persons. In May only seven countries prioritised health professionals in testing, with some prioritising rules for nursing homes in place. In an experiment at an Israeli hospital, 13 asymptomatic health professionals were tested positive, thus proving the risk of spreading the disease unintentionally.

4. Workforce

Working conditions and other workforce measures

Changes to the working hours and conditions of doctors were already reported within the early weeks of the pandemic. Some countries, such as Slovakia, reported that the medical workforce already faced excessive hours, even when not in the midst of 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 working hours accordingly did not affect the entire workforce uniformly. In March and April, several countries reported a more gradual increase in working hours, with the 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 hours locally, rather than nationwide.

Those medical specialties most relevant to treating patients with COVID-19, in particular intensive care medicine, saw a rapid increase in workload; Ukraine and Latvia being among the first countries to report this. 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 hours became an even more valuable resource during the pandemic. Emergency laws drafted for pandemic management made some provision for doctors' working hours, 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 reporting 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 had experienced so far. 47% of doctors surveyed by the British Medical Association reported suffering from mental ill health, of which 32% indicated 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 feared the spread of infection. In Poland, the National Medical Association remarked on 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 reported 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. From the Ukraine it was reported that hospitals compensated doctors' travel expenses and provided accommodation, in addition to an extra payment to those most directly involved 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 there was an additional payment of 200% of their salary for those working in the regions worst affected by the pandemic. In Sweden, doctors working in the most affected region of Stockholm were given a compensation of 230% of their salary during the emergency measures. Doctors in France who were in quarantine were given guarantees regarding social protection. However, in not all countries has the compensation promised been paid so far. In the Czech Republic, for example, the government tried to reverse promised policy changes once the initial emergency phase had passed to avoid a beneficial change to working conditions and an increase in salaries.

It was only in June that there were reports of some of the arrangements on working conditions and time, which were put in place at the peak of the pandemic, being rolled back. While this included a return to more normal schedules for most, Iceland reported that the nursing profession planned to go ahead with strike action due to a stalled salary negotiation. 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.

One additional issue was raised: In Poland and France, as well as in Italy, there are reports of an increase in complaints against doctors and threats of malpractice suits. In Italy in particular, patients were encouraged to launch claims.

Violence against the workforce

Despite the support, solidarity and gratitude demonstrated to healthcare professionals since the beginning of the COVID-19 pandemic, there have been violent incidents and attacks in some European countries and beyond. Considered as "disease spreaders", health professionals have faced discrimination, violence and acts of intimidation on the basis of their profession. Such traumatising experiences have led healthcare professionals, in some cases, to move out of their own homes, as reported by the Belgian media RTBF, having been discriminated against, physically attacked and verbally threatened and abused. Such incidences have been reported, for instance, by the Polish Chamber of Physicians and Dentists. During the first stages of the COVID-19 outbreak, Polish doctors encountered signs of great social sympathy, manifested, for instance, in gifts of 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, such as cars being vandalised with paint or a refusal to admit the children of doctors to kindergartens. Cases of verbal abuse have been reported in the 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'. Reports of such cases are not widespread in every country, but are very concerning nonetheless, especially as it is assumed that some victims did not disclose their experiences to the appropriate authorities due to being focussed on the fight against the virus.

The World Medical Association (WMA) and the European Medical Organisations have condemned these attacks on healthcare professionals, which are 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 often increase fears and panic in the population. Therefore, authorities were requested to communicate clearly on the risks and the latest developments related to the outbreak.

Availability of the workforce

Healthcare professionals are crucial to any healthcare system. During the COVID-19 outbreak, it became even more clear that only an adequate level of staffing could maintain and ensure patient care. From the early stage of the pandemic, a large majority of countries had to face a lack of medical workforce large enough to deal with the unknown extent of a pandemic. In fact, many countries came into the pandemic with a pre-existing shortage of doctors that consequently worsened. In other countries, it was only the relatively low numbers of infections that prevented a problematic situation.

Italy was the first European country to experience health workforce shortages. In March 2020, when the situation became difficult and the healthcare system was close to collapse, almost 8000 doctors of different ages and from each part of the country responded to the Italian government's call for help to create a special task force to face the pandemic. The task force was distributed among the most affected hospitals where a worrying health workforce shortage was registered. In Hungary, doctors and nurses above the age of 65 were excluded from frontline practice to protect them from any exposure to COVID-19 cases. This decision applied to a third of the Hungarian workforce.

To counterbalance these shortages, there have been various emergency remedies. 23 European countries have accelerated medical students' access to medical practice, be it on a voluntary basis as in Greece or by changing laws as reported in Belgium and Germany. In other countries, such as Italy, Ireland and the Netherlands, retired and emigrated doctors were asked to re-join the workforce. In France, the French Medical Council requested nonpracticing doctors to join the health reserve to increase the intervention capacity and ensure the necessary means to deal with the pandemic, especially in nursing homes. Another solution was adopted in Sweden, where the distribution of health staff has been revised, reallocating health professionals from across the healthcare system to the treatment of COVID-19 patients. This solution, however, created new shortages, as all nonurgent surgeries were suspended.

The Irish Medical Organisation reported that Ireland established Community Assessment Hubs around the country to maximise the availability of the healthcare workforce and allow a safe environment for COVID-19 patients. The hubs are staffed by GPs, nurses, other healthcare professionals and administrators. The hubs allow for GP assessment of the patients' condition to determine if they are well enough to be managed at home or if they need referral into a hospital setting. The use of these hubs increases the ability of GPs to manage COVID-19 patients in the community outside of the GP surgery, thus allowing the surgeries to manage non COVID-19 patients more effectively.

In other countries it was decided to support and incentivise the retention of the frontline health workforce with better working conditions, benefits and wage increase.