COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

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SAVE THE DATE! - CPME Meetings 2020—2021

20-21 November 2020	19-20 March 2021	26-27 November 2021
Virtual meetings	Tallinn (Estonia)	Oslo (Norway)

MESSAGE FROM THE CPME PRESIDENT

Dear Colleagues and friends,

Welcome to the 33rd edition of the CPME Newsletter.

We were deeply concerned when, in late July, EU heads of state and government announced over seven billion euro of cuts to health spending in the EU's recovery fund. These were resources meant for actions such as boosting the resilience of health systems, which is so desperately needed in the face of the COVID-19 pandemic. In that context, we explain more about how the European Parliament can play a role by vetoing the EU's Multiannual Financial Framework in an upcoming vote. The Parliament's Health Committee has come up with a proposal to ensure adequate funding for health from the EU budget.

Unfortunately, as we have seen, COVID-19 is still very much with us. We are currently in the midst of a second wave of the COVID-19 pandemic. One of the positives we look at is the agreement by EU Member States to procure COVID-19 vaccines jointly but also we delve into issues relating to lack of transparency in the governance of Advance Purchase Agreements with vaccine manufacturers. As we see it, building the trust and confidence of European citizens in the allocation of public resources and the procurement of safe and effective vaccines is key.

Staying with the issue of vaccination, we give you an update on the Coalition for Vaccination campaign, which is particularly important given the potential of flu and COVID-19 to disrupt healthcare services. We invite you to join it and make use of the updated communication toolkit available here.

Building on that, we invite you to read about how some European countries are facing the second wave of the COVID-19 pandemic. The Czech Medical Chamber, the Panhellenic Medical Association and the Israeli Medical Association will report about their current experience. Another aspect of COVID-19 we look at is the challenge of health inequalities and what should be done about them.

Looking to the future, data flows are of course a huge issue in lots of policy areas, including health. We update you on the future Joint Action on the EU Health Data Space and what the CPME will be monitoring in particular there as well as the European Commission's moves in relation to data governance.

In relation to Brexit, we stress the need to keep EU-UK medical mobility on the agenda and suggest a solution for the mobility issue.

We also tell you more about two occupational health campaigns that the CPME has joined. One, called 'Lighten the Load', is about preventing work-related musculoskeletal disorders and the other, called 'Stop Cancer at Work', is about workers in the EU being exposed to deadly carcinogenic, mutagenic and reprotoxic substances in their workplaces. Mental health is another big challenge facing healthcare systems in the future. In that context, our newsletter includes an article from the Council of Europe Committee on Bioethics, which is calling for examples of good practices in mental healthcare.

We also have an opinion from the World Health Organisation representative to the European Union that revolves around three core issues: human resources for health, immunisation and inclusive partnerships.

I hope you will find this edition informative.

Kind regards and stay healthy!

Prof. Dr Frank Ulrich Montgomery

CPME President

EU LEADERS MUST PROVE THEY PUT CITIZENS' HEALTH BEFORE INDUSTRIAL AND COMMERCIAL INTERESTS

The COVID-19 outbreak has shifted the EU's and Member States' attention and health policies have become more prominent on political agendas than ever before. At the start of the pandemic, policy-makers all over Europe were emphasising the importance of robust health systems, praising healthcare professionals for their dedication and assuring citizens that their health and wellbeing is their top priority.

However, over the following months, these beliefs were apparently gradually fading as, at the end of July, the heads of state and government spoke with one voice to announce a cut to the recovery fund dedicated to health amounting to €7.7 billion. These resources were meant for strengthening the resilience of health systems, increasing coordination on public health and enhancing crisis management. Even if this cut would not necessarily mean giving up these objectives altogether, it would be doubtful whether they could be achieved with much less money.

This decision demonstrated that it is cheap and easy to applaud those who have risked their lives to combat COVID-19, but when it comes to making decisions, European leaders turn away from their declarations and scale down their health ambitions.

We will not be able to strengthen health security and adequately prepare for future health crises with a reduced health budget. European doctors condemned this decision and turned to the European Parliament, asking MEPs to stand up for health. Even though parliamentarians will not vote on the recovery Next Generation EU fund, they can veto the Multiannual Financial Framework (MFF) if they find the overall budget insufficient or inadequately distributed.

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The Parliament's health committee is already leading the way by calling for the whole €9.4 billion (€1.7 billion as proposed by the European Commission, plus €7.7 billion to compensate for the cut in the recovery fund) to be allocated to the health budget within the MFF. We believe the Parliament's budget negotiating team has a similar stance and, along with the Commission and Council, they will find a compromise that can provide the EU with the resources that correspond to its needs.

The Commission has put forward relevant and ambitious objectives on health for the years to come. Drawing conclusions from the pandemic, the EU should strengthen its health agencies. Both, the European Medicines Agency and the European Centre for Disease Prevention and Control should be equipped with stronger mandates, better infrastructure and greater resources. The EU should improve data collection and sharing related to infectious diseases and increase the use of joint procurement for health supplies. The pandemic also aggravated already pre-existing problems, such as medicine shortages and health inequalities.

In addition, there is a whole range of health issues not related to COVID-19 that need to be addressed by the next budget. Antimicrobial Resistance (AMR) remains one of the greatest challenges. Digital transformation of healthcare is ongoing and it must be closely planned and controlled. Similarly, actions on non-communicable diseases, mental health and healthy living have not become less important during the crisis.

Although the goals may be set correctly, they will remain empty words unless they are supported by an adequate budget. European policy-makers must provide the EU with the means to deliver on its ambitions and prove that they put the health of its citizens before industrial and commercial interests.

Piotr Kolcyński, *Legal Advisor*

UNPRECEDENTED COOPERATION AND STARTLING LACK OF TRANSPARENCY IN THE EFFORT TO SECURE EARLY DOSES OF COVID-19 VACCINES

The European Commission is negotiating Advance Purchase Agreements (APAs) with vaccine manufacturers in order to secure early access to future, potential vaccines. In this historic effort, all EU Member States have agreed to procure the vaccines jointly and refrain from striking separate deals with pharmaceutical companies. This approach improves the Member States' bargaining power and will lead to equal access to future vaccines by all EU citizens. It is a great example of solidarity and cooperation instead of competition and putting internal interests before the common good.

As of 14 October, the Commission has already signed contracts with AstraZeneca, Sanofi-GSK and Janssen Pharmaceutica NV (Johnson & Johnson), and concluded successful exploratory talks with CureVac, BioNTech-Pfizer and Moderna.

However, despite all these positive aspects, the Commission and Member States are facing severe criticism related to the lack of transparency regarding the governance of APAs and on several aspects of the deals, such as how the EU spends public funds, what provisions regarding liability and indemnity are included in the contracts and how vaccines will be priced.

In order to respond to these concerns, EU officials and industry representatives have appeared before the European Parliament on different occasions over the past weeks. Ahead of these meetings, the CPME, together with other organisations, issued a statement calling for greater transparency to build the trust and confidence of European citizens in the allocation of public resources and the procurement of safe and effective vaccines.

The statement also noted that high hopes for the potential benefits of early access to vaccines result in substantial pressure on the European Medicines Agency (EMA) and on the European Commission to approve and procure vaccines against COVID-19 as fast as possible. European doctors stand firmly by the European regulators, who should be allowed to conduct their mission free from any external influence.

A series of public hearings and webinars has already shed some light on the process and the deals themselves. For example, the Commission has explained that liability always remains with the manufacturer, in line with EU product liability rules, but if the company agrees to a low price for its vaccine, the contract will provide for Member States to indemnify it for possible liabilities incurred under specific conditions. Moreover, the EMA declared that all vaccine candidates will have to go through a rigorous approval process and the Agency will publish all clinical trial data once a decision about a marketing authorization application has been completed.

Nevertheless, the public remains under-informed and, regrettably, is more likely to receive news of negotiations from the press than from official channels. The Commission and Member States should provide a breakdown of the billions of euros of public money already committed and outline all forms of public support and flexibilities granted to pharma companies.

At this crucial stage in the COVID-19 vaccine development, trust and accountability need to be upheld in order to safeguard and promote public health, the quality of healthcare systems and patient safety.

Piotr Kolczynski, Legal Advisor

GET VACCINATED FOR INFLUENZA

CPME and other European associations of healthcare professionals which make up the Coalition for Vaccination started an online influenza campaign at the beginning of October. The campaign was launched simultaneously with Flu Awareness Week, organised annually by the WHO/Europe.

This year, the influenza season coincides with the COVID-19 pandemic and both diseases can disrupt healthcare services.

In order to keep these services running, it is particularly important that healthcare professionals, who are exposed to different viruses on a daily basis, get vaccinated against flu.

Therefore, the Coalition for Vaccination's campaign focusses on the importance of flu vaccination among doctors and other healthcare professionals, but also among their patients, especially those who belong to at-risk groups. As influenza viruses change, a new vaccination is needed every year.

CPME and the other co-chairs of the Coalition, the European Federation of Nurses Associations (EFN) and the Pharmaceutical Group of the European Union (PGEU), have developed a user-friendly communication toolkit for European and national organisations, including videos, images, key messages and example posts.

The first 2020-2021 influenza season joint analysis of the European Centre for Disease Prevention and Control (ECDC) and the WHO/Europe showed that influenza activity remains at baseline levels. In the northern hemisphere, the influenza circulation is normally seen from November up to May, so now is the best possible time to receive the vaccination.

ECDC and WHO/Europe highlight the fact that the COVID-19 pandemic has affected healthcare presentations and testing capacities. As long as the pandemic continues, their influenza data needs to be interpreted with caution, notably in terms of seasonal patterns.

The Coalition for Vaccination was convened by the European Commission in 2019.

Markus Kujawa, EU Policy Adviser

CPME JOINTS TWO OCCUPATIONAL HEALTH CAMPAIGNS

On 12 October, the European Agency for Safety and Health at Work (EU-OSHA) launched their two-year-long Healthy Workplaces campaign ‘‘Lighten the Load’’, which focuses on the prevention of work-related musculoskeletal disorders (MSDs). CPME has been a member of the EU-OSHA’s Healthy Workplaces partnership since 2011 and will also be a partner in the new campaign.

MSDs are one of the most prevalent types of work-related health problem in Europe. Based on the recent EU-OSHA study, about 60% of workers in the EU report MSD complaints. Backache and pains in the upper limbs are counted among the most common work-related MSDs. Posture-related hazards, exposure to repetitive movements or to tiring or painful positions, and carrying or moving heavy loads are the most common risk factors for causing MSDs.

The new campaign aims to raise awareness and take a comprehensive view of the causes of MSDs. CPME and the other campaign partners will disseminate high-quality information on the subject, encouraging an integrated approach to manage the problem. EU-OSHA will offer practical tools and solutions that can help at workplace level.

On 13 October, CPME joined forces with other professional organisations, trade unions and patient groups to launch a ‘‘Stop Cancer at Work‘’ campaign. It aims to ensure that the current fourth revision of the Carcinogens and Mutagens Directive (CMD) includes reprotoxins as well as groups of carcinogenic and mutagenic hazardous drugs, which cause cancer and were not included in the European Commission’s proposal that was published in September 2020.

Cancer is the leading cause of work-related deaths in the EU, with over 120,000 work-related cancer cases recorded each year according to EU-OSHA. Millions of workers across the EU are being put at risk by being exposed to deadly carcinogenic, mutagenic and reprotoxic substances in their workplaces. The new campaign aims to eradicate occupational exposure to deadly substances and put an end to work-related deaths caused by cancer and other health problems, such as miscarriages. It also invites people to sign a petition calling for the EU institutions to take action.

On 9-10 November, Germany will host a two-day EU presidency conference dealing with protection from work-related cancers as part of the Roadmap on Carcinogens. Germany will address this priority together with European and national occupational safety and health representatives, experts from the European Chemicals Agency and the European Commission.

Markus Kujawa, EU Policy Adviser

EU HEALTH DATA SPACE

On 19 February 2020, the European Commission published a 'European strategy for data' with an ambition to enable the EU to become the most attractive, secure and dynamic data-agile economy in the world. It outlines a number of policy measures and investments needed to achieve this goal in the next five years.

1- It aims at creating a single market for data, where data flows between Member States and sectors, where clear rules on data governance, data access and data use exist and where data is available respecting European values and rules.

2- The strategy foresees developing common European data spaces in strategic economic sectors and domains of public interest, such as the common European health data space. The strategy is part of a wider package of strategic documents, including a communication on Shaping Europe's digital future and a White Paper on Artificial Intelligence – A European approach to excellence and trust.

The preparatory work conducted by the European Commission includes a study which assesses Member States' rules on health data in light of the General Data Protection Regulation (expected this Autumn), and a study on regulatory gaps in cross-border digital healthcare (launched in August and running until the first quarter of 2021).

The preliminary results of the first study, presented at the July Informal Meeting of the Healthcare Ministers, indicated *"(…) the potential of health data exchange that is compliant with data protection requirements for purposes of research, diagnosis and treatment, while showing that more challenges still exist for cross-border use of health data in the EU."* Hence, much is expected from the future Joint Action on the EU Health Data Space (JA EHDS), projected to start at the beginning of 2021.

Led by the Finish Innovation Fund, SITRA, the JA EHDS will be structured into four main areas: i) clear data governance and rules to govern the EU data space; ii) data quality and interoperability; iii) technical infrastructure set up, and iv) building sufficient capacity and digital skills, from public/private authorities to administer the health data space, as the case may be at national level, to healthcare professionals and patients to make better use of data. SITRA is inspired by the architectural models of the International Data Spaces Association, iSHARE and IHAN (for further information see SITRA's white paper on *Data sovereignty and soft infrastructures are key enablers for the next phase of the European data economy*).

CPME is closely monitoring EU developments and is taking part in the ongoing discussions (please see CPME policies on data management here). A proposal for Regulation on data governance is expected to be published before the end of 2020, along with a Communication on Building a European Health Union: preparedness and resilience. In relation to the EU Health Data Space, CPME will be looking to understand how patients' consent will be obtained and their rights enforced – robust procedures and trustworthy mechanisms are required. Other hot topics that we intend to look at include the challenge of mixed data sets (personal and non-personal data), technical interoperability, sustainability of the EU Health Data Space (financially and regarding human resources), and ensuring fair and equal access.

Sara Roda, EU Senior Policy Advisor

LATEST NEWS

CPME ACTION ON COVID-19 AND HEALTH INEQUALITIES

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CPME holds the long-standing belief that doctors must take action against health inequalities. The COVID-19 pandemic has underlined this. The status reports that CPME has been collecting from its members since March in order to understand how doctors are experiencing the COVID-19 pandemic have confirmed existing and new inequalities in terms of access to healthcare.

One source of barriers to access in healthcare are the shortages in health systems' capacity. Many countries came into the pandemic with a pre-existing shortage of doctors that consequently worsened. In other countries, the need to reallocate health professionals from across the healthcare system to the treatment of COVID-19 patients created new shortages. Twenty three countries approached medical students or retired doctors in order to build up surge capacity. CPME is therefore calling for a review of health workforce planning at national level to build a baseline capacity which is sufficient to ensure universal health coverage, as well as surge capacities which can be deployed to deal with extraordinary situations.

The backlog of treatments caused by official decisions to suspend all nonurgent surgeries, as well as the hesitancy of patients to visit their doctor, is also concerning. Some CPME members report that there was already a waiting list even before the pandemic and that this has been exacerbated. In Germany, an estimated 900,000 surgeries were postponed. From Sweden it was reported that it could take up to three years to cope with the backlog. In Bulgaria, a campaign was launched advising patients "Do not postpone your treatment", aimed in particular at patients with chronic diseases to ensure that they seek timely medical care. CPME also underlines the importance of continued access to healthcare, including preventive treatments such as vaccinations. As co-chair of the European Coalition for Vaccination, CPME recently campaigned to promote the take-up of flu vaccines among healthcare professionals and patients during Influenza Awareness Week.

Inequalities among patient groups have been aggravated by the pandemic. It was reported that hard-to-reach communities who do not engage with media or authorities, for example for religious reasons, could not be informed effectively. Data from the United Kingdom shows that Black, Asian and minority ethnic populations are disproportionally represented amongst the COVID-19 deaths, also amongst deaths of healthcare professionals. The situation of refugees living in overcrowded facilities has been especially acute. CPME has supported calls for their resettlement, in particular after fire destroyed the camp at Moria on Lesbos, but so far there has been only limited action at EU level.

But it is also important to prevent new inequalities. In a letter to the G20 calling for a 'Healthy Recovery', CPME joins the appeal to ensure that investments in restarting economies and building resilience do not have detrimental health and environmental impacts. The cuts to the EU budget for health show that health is still not prioritised at the highest political level. Lastly, current efforts to find a medical breakthrough against COVID-19 must be based on transparency and solidarity. CPME has joined other health stakeholders in supporting a set of 'Principles for Global Access, Innovation and Cooperation' that underline the need for fair and affordable pricing of innovations so that they can be provided free to the public at the point of care in all countries.

The experience of the pandemic shows that fighting for access to healthcare for all continues to be a priority, especially in a health emergency as we are seeing now. European doctors are committed partners in ensuring that the right to health is a reality for every patient.

Sarada Das, Deputy Secretary General

EUROPEAN DOCTORS KEEP MEDICAL MOBILITY POST-TRANSITION ON THE AGENDA– WHAT NEXT FOR EU-UK TALKS?

Following 'Brexit' on 31 January 2020, the transition period during which EU laws continue to apply in the United Kingdom will end on 31 December 2020. European doctors have been concerned at the reports from the negotiations towards an EU-UK free trade agreement, where progress is marred by continuing differences on fisheries, governance mechanisms and the 'level playing field' of rules and standards.

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The issues which have been a priority for European Medical Organisations, in particular the future of doctors' mobility, have received little attention. To seek clarity on possible future scenarios on the mutual recognition of doctors' qualifications post-transition, European doctors reviewed the negotiating parties' approach to this topic.

Since the current system established by the Professional Qualifications Directive cannot be replicated as such, both parties have proposed new regulatory models to process future recognitions. The EU has proposed a framework setting up mutual recognition agreements. If there is sufficient economic value and compatibility of the respective regimes, interested professions can initiate the conclusion of an agreement which is then elaborated by a joint committee. This approach has been previously adopted for example in the EU-Canada free trade agreement. However no such agreements are operational so far.

The UK government, on the other hand, has proposed to include a chapter in the free trade agreement itself, which creates a mechanism close to the 'general system' provided in the Professional Qualifications Directive. Here, competent authorities can assess on a case-by-case basis if qualifications are substantially different from that of the host country, in which case compensatory measures can be required before recognition is granted.

Having reviewed both proposals, the European Association of Senior Hospital Physicians (AEMH), the European Council of Medical Orders (CEOM), the Standing Committee of European Doctors (CPME), the European Junior Doctors Permanent Working Group (EJD), the European Medical Students' Association (EMSA), the European Union of General Practitioners (UEMO) and the European Union of Medical Specialists (UEMS) found the most workable option to be the proposal put forward by the UK government. This has the benefit of being effective immediately upon entry into force, thus avoiding any gaps and uncertainty as to applicable regime. It would also deliver an EU-level solution, which accounts both for the current degree of harmonisation of the applicable regulatory framework and any dynamics which may occur in future. In addition, the solution proposed by the UK government draws on processes that are familiar to national competent authorities thus allowing swift implementation.

The European Commission however continues to favour the solution of mutual recognition agreements, despite admitting that the mechanism proposed by the EU will not be operational on 1 January 2021. For the interim, bilateral agreements between the UK and individual EU Member State governments would be the only solution; as they would be in case no deal is reached at all. While some EU Member States have already concluded such arrangements, many EU-trained doctors considering working in the UK, as well as UK-trained doctors seeking employment in the EU, would be left in limbo. Equally students who find themselves outside their 'home' jurisdiction on 1 January would face many questions as to their eligibility to future recogniton. While mobility is likely to be reduced in the immediate aftermath of the end of the transition period, the dynamics of the medical employment market will entail cross-border flows of doctors in the foreseeable future. The European Medical Organisations will therefore continue to seek clarity and legal certainty for doctors across Europe and keep medical mobility on negotiators' agendas.

Sarada Das, Deputy Secretary General

COVID-19 IN THE CZECH REPUBLIC

The Czech Republic has a population of 10.5 million people and the first COVID-19 case was revealed on 1 March 2020. The epidemic caught us unprepared. We experienced shortages of personal protective equipment and disinfectants. Out of sheer desperation, the government set up an air bridge with China for mask and respirator transportation. Despite everything, with a fair amount of luck the spring wave was eventually well managed thanks to rapidly implementing tough measures (lockdown), which were endorsed by the majority of people.

The first COVID-19 death in the Czech Republic was recorded on 22 March and, by the end of May, 317 deaths had been recorded in total. During the spring wave of COVID-19, 11% of all cases were among health workers. One nurse and two members of other healthcare staff died. There were no fatalities among doctors at that time.

Over the summer, everything that could go wrong did go wrong. The loosening of restrictions was hasty and chaotic despite explicit warnings from epidemiologists. Nobody was using a mask any more and the politicians in power made big statements about the Czechs being the best at fighting the epidemic. Emotionally overwhelmed and tired people acknowledged this approach with thanks and tried to enjoy the summer as much as they could. Despite the protests of the Czech Medical Chamber, the Minister of Health even abolished compulsory mask-wearing in healthcare facilities.

A number of media savvy and respected doctors also had a negative impact on the situation, objecting to ‘pointless’ mask use and proclaiming that COVID-19 is nothing but a ‘regular flu’. The more exorbitant the statements, the more media attention they gained. This was in spite of the fact that these experts were mostly professionals in other fields (stomatology, oncology, surgical cardiology, psychiatry), and neither epidemiologists nor infectious disease experts.

By the end of July, the number of new cases was growing by more than 200 a day. Nonetheless, the government ignored this and the suggestion by epidemiologists to require mask-wearing again before the school year started on 1 September was rejected by the Prime Minister, Andrej Babis, who tried to retain the illusion of success until the regional elections at the beginning of October.

> *“Considering the population of the Czech Republic, we are currently the country with the fastest growing number of new COVID-19 cases in Europe. Worldwide we are among the countries with the highest death toll.”*
>
> *Dr Milan Kubek, President of the Czech Medical Chamber*

However, the situation has become unsustainable. The standing of the Czech Republic has changed from being a success story in combating COVID-19 to becoming the rotten apple of Europe, with neighbouring countries closing their borders to us. By 17 September, 3,126 people had tested positive, prompting the young and popular Minister of Health, Adam Vojtěch, to announce his resignation on 21 September. Shortly afterwards he was replaced by a former soldier, professor of epidemiology Roman Prymula. With effect from 5 October, a state of emergency was again declared and, after a delay of more than one month, the epidemiologists’ recommendations to reintroduce anti-epidemic measures were finally implemented. On 14 October, these measures were tightened, e.g. schools and restaurants were closed.

Considering the population of the Czech Republic, we are currently the country with the fastest growing number of new COVID-19 cases in Europe. Worldwide we are among the countries with the highest death toll. Every ten days, the total number of active cases approximately doubles, as does the number of people hospitalised - including those in a very serious condition – as well as the number of fatalities per day. The statistics are merciless. Every ten days, the number of infected health workers also doubles.

Today, we have 75,000 active COVID-19 cases and 2,700 hospitalized people, of which 350 are in a critical condition. Two hundred and fifty six people died last week, compared to 136 people who died a week earlier. On 8 Sep-

tember, the first fatality was reported among doctors. At present, there are 1,200 infected doctors among 5,500 infected health workers. Yesterday, 133 doctors tested positive in a single day.

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We hope that the new anti-epidemic measures will start working soon, however, it is clear that the situation will only get worse in the coming two weeks. We must do everything we can to avoid the collapse of the health system due to the onslaught of patients with COVID-19. Hospitals are postponing all planned surgeries except oncological ones. The goal is to set aside 10,000 extra beds for patients with COVID-19.

The Czech Medical Chamber calls on citizens to be disciplined, careful and to show consideration for others. We hope to be successful in overcoming this crisis. However, we look to the future with concern. Please, keep your fingers crossed for us.

Dr Milan Kubek, President of the Czech Medical Chamber

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COVID-19 PANDEMIC IN GREECE

The COVID-19 pandemic in Greece is part of the worldwide pandemic of coronavirus disease(COVID-19). The first case in Greece was confirmed on 26 February 2020. On 10 March, with 89 confirmed cases and no deaths in the country, the government decided to establish a general lockdown, including restrictions on all non-essential movement throughout the country. In order to support the economy, a series of measures worth a total of around 24 billion euros (14% of the country's GDP) was announced.[1] It must be pointed out that a special bonus was provided for health and civil protection workers.[2]

Since there was a remarkable deficit in Intensive Care Unit (ICU) beds in the country, the Hellenic Ministry of Health created more than 500 new ICU beds and more than 1,200 job openings for health workers were announced. Shortages of consumables and medicines were not noted, while there was a plethora of private donations concerning medical equipment (ventilators, monitors, ICU beds etc.). The availability of tests is now sufficient and healthcare professionals are regularly tested in order to be able to work. Since the beginning of the pandemic our National Medical Association (NMA) had launched a helpdesk in order to provide advice and recommendations to doctors.

The measures put in place in Greece are among the most proactive and strictest in Europe and have been credited internationally for having slowed the spread of the disease and keeping the number of deaths among the lowest in Europe.[3]

Starting from 4 May, after a 42-day lockdown, Greece gradually began to lift restrictions on movement and to restart business activity. Following the loosening of measures and the opening of the borders to tourism, there was an expected increase in cases, the management of which has on the whole been satisfactory. However, the phenomenon of face mask naysayers is widespread in Greece, as in other EU countries, which is leading to a growing concern among the leadership of the Ministry of Health, in combination with the increase in cases. Local mini lockdowns have been imposed in various areas of the country.

By 14 October, the total number of confirmed cases had risen to 23,495, and the death toll to 469, while 9,989 people had recovered[5]. Despite the spread of COVID-19 cases, the current situation is critical but manageable since the NHS can cope with the pandemic.

Refugees and migrants

It is estimated that 150,600displaced persons are located in Greece.[4]More than 40,000 are living in squalid conditions in camps on the Aegean islands, which have a capacity to house 5,400. The numbers in the camps have reached such levels that an outbreak of infection within the camps could not be contained. The government announced that the movement of refugees outside the camps would be restricted as facilities are prepared for confirmed cases[4],and that it would only allow small groups of refugees and migrants to temporarily exit the camps to obtain basic supplies. After the fire that burnt down the Moria camp on Lesbos, 7,064 people who were resettled in a new camp were tested and 243 of them were found to be positive[5]. By late September 2020 it was announced that half of the COVID-19 patients in two major hospitals in Athens were immigrants[5].

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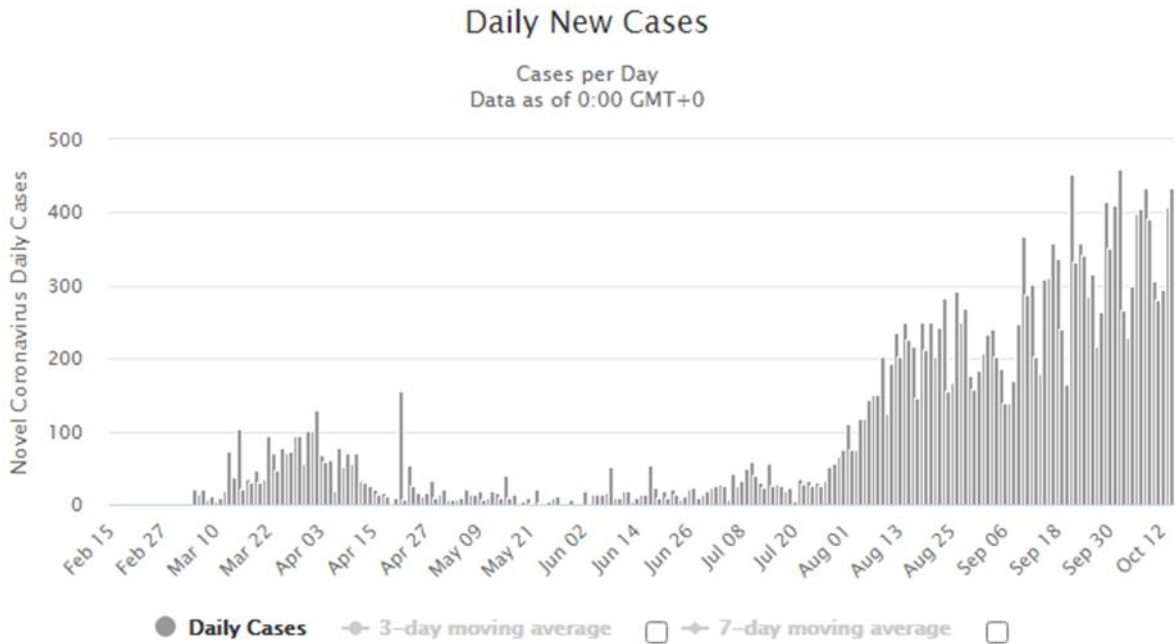
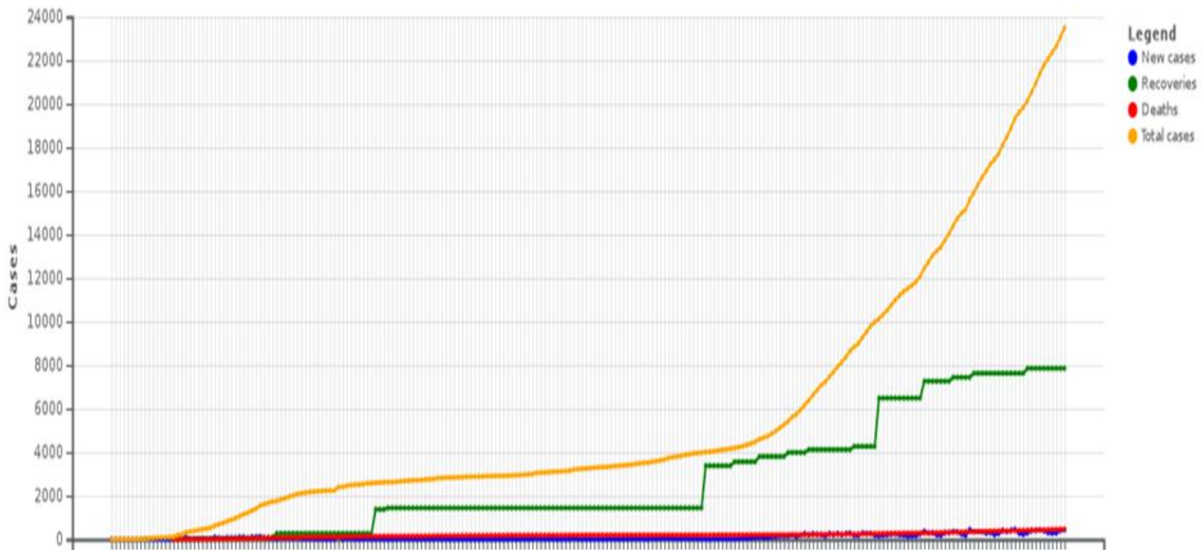
5 Official websiteof the GreekNational Public Health Organizationwith information regarding the progress of the pandemic in the country.

Daily New Cases in Greece



| updated 8 October 2020 Only total cases not by state | Source:https://lab.imedd.org/covid19/?lang=en



Dr Marily Passakiotou,
CPME Delegate of the Panhellenic Medical Association

COVID-19: ISRAEL'S SECOND WAVE

ההסתדרות
הרפואית בישראל
Israeli Medical
Association

The first cases of COVID-19 were identified in Israel at the end of February and a two-month lockdown was imposed in March. However, a quick opening of schools and the economy followed. Today, Israel is in the midst of a second wave and the rate of morbidity is one of the highest in the world. Israel currently has 29,857 active cases and 2,248 people have died. At its peak, the daily number of new cases reached 9,0001.

A much tighter one-month lockdown began on 18 September. Some of the measures included: the closure of, e.g. schools, offices, shops and restaurants unless the bodies concerned provide vital services (e.g supermarkets, pharmacies and banks); and a travel restriction of up to one kilometre from people's homes.

The government has planned a considerably slower easing of restrictions in this second wave with a phased exit plan spanning four months and eight stages, which will come into effect on Sunday 18 October. It will begin with the reopening of preschools, the removal of the one-kilometre distance restriction and restaurants being able to offer takeaways.

The second stage of easing is planned for 1 November, depending on the number of daily cases falling to below 1,000. At this stage, schools will open grades 1-4 and elective medical procedures will resume.

In addition to this, a traffic light system divides cities into red, orange and green according to the severity of the pandemic. It is possible that the different local areas could see different timelines according to their infection rates.

Opinion polls suggest that only about a quarter of Israelis have confidence in government policies to contain the spread of the virus and many people are not abiding by the restrictions currently in place.

Testing protocol

In early March, the Israeli Ministry of Health initially claimed that extensive tests were not needed, but only in cases such as: those returning from abroad; contact with a verified patient and clear signs of a chest infection. Their assumption was that COVID-19 was not yet widespread in the community and therefore mass tests would produce extreme errors and not provide a reliable picture. It should be noted that, at that time, there was a shortage of cell spreaders and reagents (the reactive material needed for testing). Therefore, it is possible that Israeli policy was also influenced by the actual situation at that time.

Subsequently, there was a significant change in policy. The tests were gradually expanded to a large extent with the purchase of the necessary equipment and an increase in the rate of infection in the community. Today, Israel's testing system is the backbone in the fight against the epidemic.

Two types of tests are used to detect the virus. The molecular tests (PCR) identify the coronavirus in the patient's body and serological tests (antibody tests) detect the presence of the virus several days after the onset of the disease. The main test used in Israel is the laboratory PCR test, in which swabs are sent to 40 laboratories across the country. The swabs are collected by Magen David Adom (MDA) at the examinee's home and at mobile drive and test facilities. Drive and test complexes have been set up throughout the country. In addition to this, COVID-19 tests are performed at MDA and health fund clinics.

The testing system was heavily criticised as regards issues including a lack of manpower, which threatened to lead to the collapse of the laboratories; the tests not reflecting a representative sample of the population; inaccurate results; and claims of hypersensitivity of the test and monitoring and surveillance, which lead to a serious violation of the rights of the individual.

The testing system does not operate alone but as part of a whole coping system. The test has no value without additional action: Maintaining physical distance, cutting off the chain of infection, monitoring carriers, caring for patients, informing and strengthening public trust in the leadership and professionals, enforcing guidelines and their observance by the public.

Health workforce

The healthcare workforce has been extremely committed to treating patients from the beginning of the outbreak, simultaneously being mindful of the need to preserve energy and limit contact. In the first wave, the Israeli Medical Association held bargaining agreements, securing doctor's salaries and changing their work schedules. Doctors worked in capsules and shifts and, when not on a shift, they were expected to stay out of the hospitals. Today, as we know more about how the virus is contracted, less personnel are put into isolation.

During the first wave, elective procedures were cut down. In addition to this, the public were less likely to seek medical care. Advertisements were made, encouraging people to seek care when needed. During the second wave, elective procedures have not been cut down and all other services are open. We still see less people being treated, which is a concern, and we are working to get people back on track.

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A state of emergency was activated for the health system due to a lack of manpower. On 21 September, 'A Call for Action for Retired Physicians to Join the Ranks and Reinforce the Hospitals'was made by Professor Zion Hagay, President of the Israeli Medical Association, and Professor Chezy Levy, the Israeli Ministry of Health's Director General. Hospitals and the community clinics are in most need of interns, intensive care specialists, emergency medicine specialists, General Practitioners (GPs) and paediatricians.

In addition to this, plans are being put in place to prepare the healthcare system ahead of the winter. The coming winter will pose a very significant challenge to the health of Israeli citizens. For several weeks, a special committee have been preparing for the scenario of dual morbidity with influenza and the coronavirus.

The Israeli health system continues to struggle to cope with the crisis. This is largely due to the neglect of the public health system for many years. Medical teams are extremely busy and burnt out, which is exacerbated by the failure to cut off chains of contagion due to a lack of manpower. In addition to this, there was a lack of coordination and agreement on an action strategy among professionals and decision-makers. Finally, the public's distrust in the leadership makes it difficult to enforce the guidelines and restrictions in place.

Nevertheless, after a month-long national lockdown, the second one in about half a year, signs of improvement can be observed. Israel's COVID-19 R value is currently well below one (0.6). The number of daily confirmed cases per one million people has plunged in a month by about 75% from more than 400 in the middle of September to approximately 100 cases today. Similarly, the number of 'red cities' has dropped sharply from 40 on the eve of the lockdown to eight today. This encouraging data gives hope for a successful continuation of the fight against the epidemic in Israel.

Adv. Leah Wapner,Secretary General, Israeli Medical Association.

COUNCIL OF EUROPE COMMITTEE ON BIOETHICS: CALL FOR EXAMPLES OF GOOD PRACTICES IN MENTAL HEALTHCARE

The issue of mental health is expected to be one of the biggest challenges facing healthcare systems in the future. It is vital that the rights and self-determination of all patients, including persons with mental health difficulties, be promoted and that they can actively participate to the greatest possible extent in all decisions regarding their treatment and care.

To assist the Council of Europe's 47 Member States in achieving these objectives, the Council of Europe's Committee on Bioethics (DH-BIO) is, within the framework of its Strategic Action Plan on Human Rights and Biomedicine (2020-2025), currently developing a compendium of good practices to promote voluntary measures in mental healthcare, both at a preventive level and in situations of crisis, by focusing on practical examples.

To instigate this project, the DH-BIO organised a round table with stakeholders in November 2019 in the Council of Europe's Brussel's office, in which Dr Jacques de Haller, its past President, participated on behalf of the CPME. The participants expressed their support for the project and exchanged ideas with the Rapporteur and the Secretariat of the DH-BIO on the approach to be adopted. The results of this fruitful exchange helped in refining the scope and methodology of this project.

Based on this concept, the Secretariat of the DH-BIO is currently (until the end of 2020) collecting proposals for examples to be included in the compendium. Examples should cover practices carried out with the aim of preventing recourse to involuntary measures; as well as practices aimed at other purposes, which have also contributed to reducing/preventing recourse to involuntary measures. This can include actions taken in the context of healthcare, employment, housing, training/education, social policies or in another context. The focus is on providing practical examples demonstrating what can be done in this area, even on a small scale and with limited means. In order not to exclude promising and innovative practices, the absence of a formal assessment does not rule out inclusion in this compendium, provided that there has been some form of evaluation which allows a link to be to established between the practice and the prevention of recourse to involuntary measures. The current pandemic situation has put a strain on mental health care service providers and users alike, and this may have led to the development of innovative practices, which would also be worthwhile sharing.

A concept note, together with a form for submitting examples, can be viewed on the DH-BIO's dedicated website: https://www.coe.int/en/web/bioethics/compendium-of-good-practices-in-mental-healthcare.

The Secretariat of the DH-BIO is ready to provide any further information on this call for examples and is looking forward to receiving replies from the CPME's members and partners.

Katrin Uerpmann

Deputy Secretary of the Committee on Bioethics

Council of Europe

GUEST ARTICLE

A NEW VISION FOR WHO'S EUROPEAN REGION: UNITED ACTION FOR BETTER HEALTH

I would like to start by thanking the CPME for its great and useful contribution to the European Programme of Work – 'United Action for Better Health in Europe' (EPW). This EPW was endorsed by Ministers of Health and public health leaders from the 53 member states of the WHO European Region last month, during the annual WHO Regional Committee for Europe. Under the EPW, WHO Member States are called to implement three core priorities - guaranteeing the right to universal access to quality care without fear of financial hardship; protecting against health emergencies; and building healthy communities, where public health actions and appropriate public policies secure a better life in an economy of well-being.

Moreover, WHO/Europe has responded to the issues that Member States find critical by identifying and highlighting four flagship initiatives to act as accelerators: : 1) The Mental Health Coalition; 2) Empowerment through Digital Health; 3) The European Immunisation Agenda 2030 and 4) Healthier behaviours: incorporating behavioural and cultural insights. I would like to focus on the CPME's contribution through the EPW consultation process as the issues you raised are vital to the core priorities of the EPW.

First, **human resources for health.** These need to be strengthened to achieve universal health coverage. They also play a vital role in building the resilience of communities and health systems to respond to disasters, as witnessed in the COVID-19 pandemic. Essentially, there is no health system without health workers. WHO/Europe will work hand in hand with Member States in the formulation of national strategies for improving working conditions and retaining and motivating the existing workforce. This also involves the training and education of the health workforce to respond to population needs but also to work to address personnel shortages of health workforce, which is a great challenge for us all.

Second, **immunisation**. Needless to say, vaccinationis one of the most cost-effectivewaysof avoiding disease. The European Region, thanks to immunisation programmes, has been free from poliomyelitis since 2002 and many Member States have also stopped the endemic spread of measles and rubella. Despite these great achievements, many challenges lie ahead, such as inequalities in vaccination coverage between and within countries; constraints in the supply and delivery of vaccines; and the need to confront vaccine hesitancy and the spread of misinformation. The CPME and its members can help to mobilise efforts to lead to an upward convergence of vaccination coverage between countries. Moreover, the anticipation that a new vaccine could bring relief to the COVID-19 crisis gives a new sense of urgency to this initiative.

Third, **inclusive partnerships**. It is clear that to advance the health agenda and to achieve Sustainable Development Goal (SDG) 3, we need to maximise the partnerships and strive for synergy, coordination and efficiency at global, regional, national and local level. In this sense, I would like to highlight the agreement, between WHO/Europe and the European Commission that boosts our strong collaboration and partnership as well as adapting our work to the new health priorities and emerging challenges. We have identified five priority areas of shared interest: 1) health security against health emergencies and other threats; 2) effective, accessible, resilient and innovative health systems; 3) a comprehensive response to noncommunicable diseases with a focus on cancer; 4) sustainable food systems and health; and 5) health cooperation with non-European Union countries in the WHO European Region.

We are currently working to elaborate the details of our cooperation and next steps and I would be more than happy to inform the CPME about these developments in due time.

I would like to conclude with a quote by our Regional Director, Dr Hans Kuge, who said that "*achieving health and well-being is a whole-of-society endeavour*". We count on CPME and other partners in health to work together with us to continue to improve people's health and well-being in the European Region.

Ms Oxana Domenti

WHO representative to the European Union

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