

# Ukraine

**Global Medical Community  
unites to support doctors**

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## The medical profession stands united in a changing world

The world seems like a very different place since we published our last newsletter in December 2021. Our colleagues at the Ukrainian Medical Association have heroically been tackling the challenges of war.

Together with the European Forum of Medical Associations and the World Medical Association, we set up the Ukraine Medical Help Fund to enable the global medical community to unite efforts to support our Ukrainian colleagues and the national medical associations in neighbouring countries who are stepping up to support the ongoing humanitarian crisis. You can read more about the medical community's response in a feature article in this magazine.

Through the generous donations of the global medical community, close to €3 million has been raised to support our Ukrainian colleagues and several deliveries of medical supplies have already been completed.

Our association is evolving as well. On 1 June, we were delighted to appoint our new Secretary General, Sarada Das. Having joined CPME in 2009, Sarada has a wealth of knowledge and experience representing the medical profession at European level, and we look forward to working with her to take our association from strength to strength in the coming years. We also welcome Marcin Rodzinka-Verhelle as EU Policy Advisor, who will be responsible for our work on pharmaceuticals and healthcare.

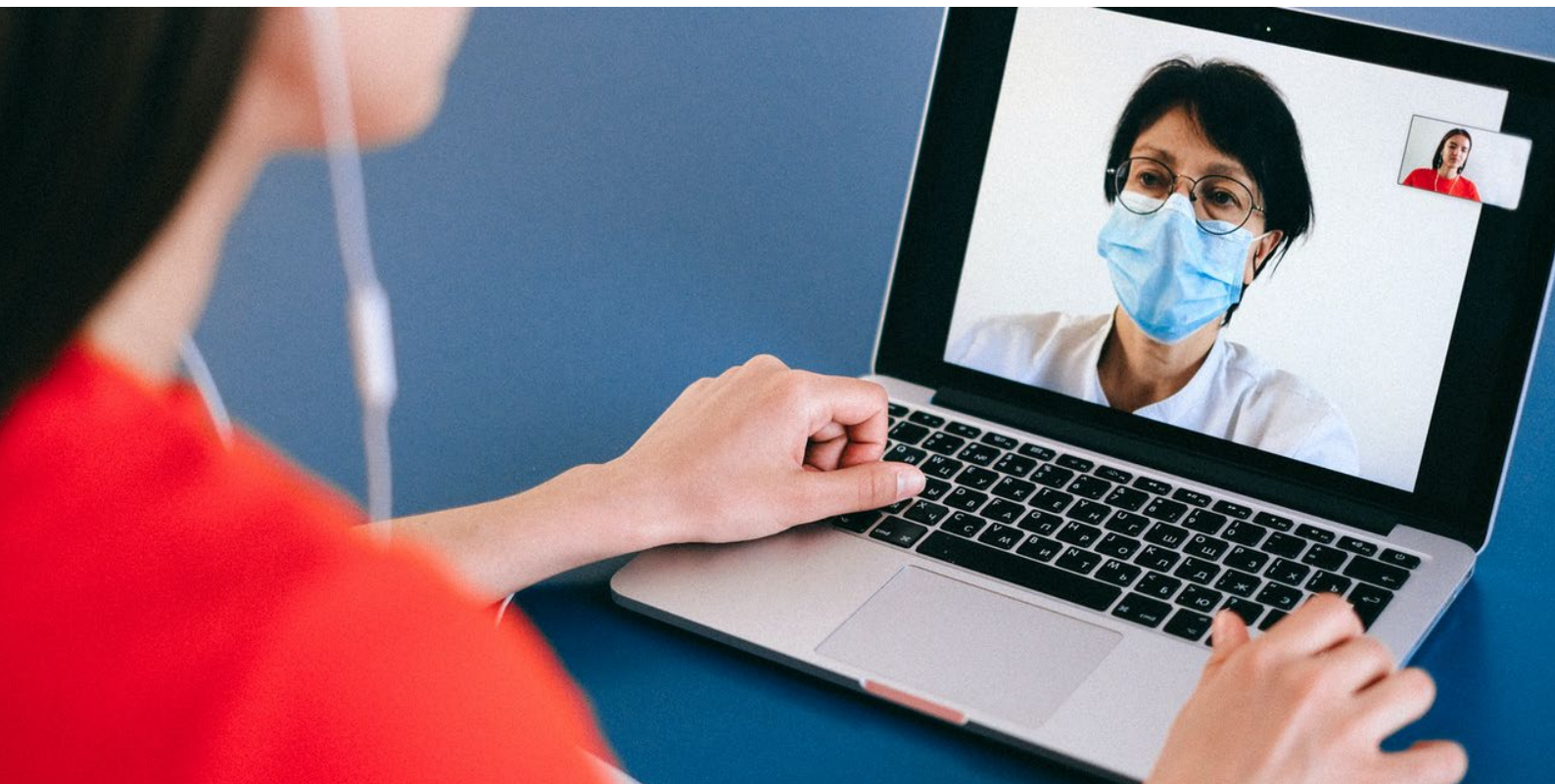
In the spring we launched our new branding, including a new logo and website. This first issue of our new magazine is a further milestone, and we hope you enjoy reading the news and features included.

At a time when the world is changing around us, there is one constant that will always remain: European doctors are united and ready to work with our partners to tackle our challenges together.

A handwritten signature in black ink, appearing to read 'C. Keijzer', written over a light blue background.

**Dr Christiaan Keijzer**

CPME President



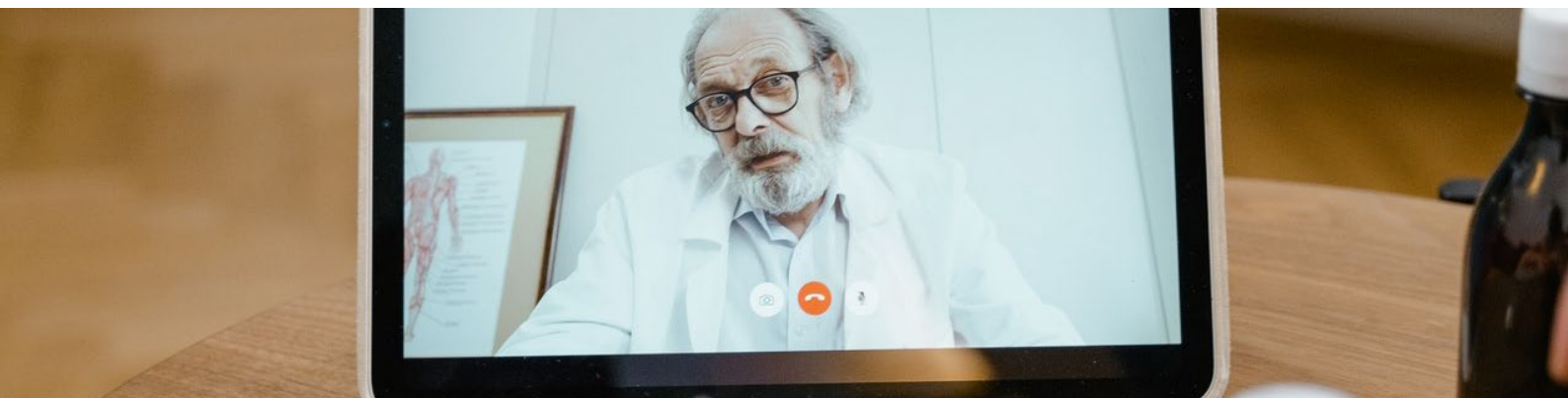
## The impact of digitalisation on the patient-doctor relationship



**Assoc. Clin. Prof. Dr. Ray Walley**  
CPME Vice-President

The COVID-19 pandemic reshaped remote work for many professions and together we have discovered its benefits and limitations. Much industry has prioritised the convenience and flexibility that digitalisation permits, disallowing face-to-face informal conversations where relationships are built, and ideas exchanged.

For the Patient – Doctor consultation, informal conversation is where relationships are built, allowing medical practitioners to build trust and continuity of care over time. It provides vital clues to the wellbeing of our patients: observation allows the clinician to garnish a myriad of information. What is their posture? What is their dressing? Can they arise from a seated position unaided? Can they walk freely without evidence of pain? Even beyond the mask, eye contact can open up a picture of well-being or not.



## Face-to-face consultations and continuity of care should remain the gold standard

This personal interaction allows us to build a wider picture for the care of our patients, complementing a clinical history and examination, and guiding us to optimal care. Decades of international evidence-based medicine supports the pre-eminent importance of face-to-face medicine and continuity of care.

CPME's recent [policy](#) on telemedicine, the practice of medicine over a distance, underlines that face-to-face consultations should remain the gold standard. However, just as the pandemic has accelerated remote work, telemedicine has become increasingly embedded into medical practice. So how do doctors, patients and policymakers reap its benefits whilst mitigating its risks and challenges?

Telemedicine can be a useful additional tool in a number of clinical scenarios, for example, in emergency care where treatment is time sensitive, and the patient cannot access a specialist within a safe time period.

Telemonitoring may be suitable for patients with chronic or long-term conditions and remote follow up where the patient is known to the physician and their condition is stable. Additionally, telemedicine has the potential to provide rapid access to medical care in rural areas.

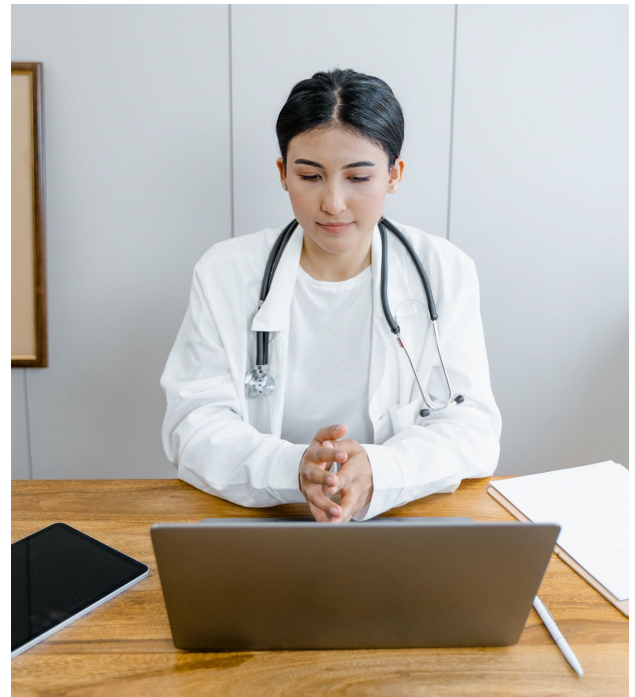
The UK regulator, the Care Quality Commission (CQC), identified that quality of care and safety of patients as great concerns and paramount when considering new digital innovations. Access to telemedicine services is not always equitable and may in fact increase the digital divide. There are concerns that the [Tudor Hart inverse care law](#) may be exacerbated in marginalised populations.

Privacy and patient confidentiality concerns arise as more patient data is exposed in online platforms and apps. This underlines the need for secure and stable platforms, where patient data is encrypted.

The European principles for ethics in digital health, adopted earlier this year, underline that digital health can complement face-to-face healthcare, and that individuals must be informed about the benefits and limits. Indeed, recognising the limitations of a digital consultation, the French Presidency of the Council of the European Union has mandated that when a patient is offered a telemedicine consultation, a face-to-face in person consultation has to be offered contemporaneously.

In Ireland, where the majority of the population are registered with a GP, we have one of the best COVID vaccination rates in the world with low vaccine hesitancy. The personal relationship with patients and willingness to address concerns with a trusted source, their General Practitioner, has undoubtedly been vital in this endeavour.

Just as we have discovered with remote work, online interactions have their drawbacks and patient safety is too important to be sacrificed for immediacy and convenience. Patients deserve the best service possible, and the best model of care remains to have an appropriately resourced service accessible locally, ensuring continuity of care and a trusted long-term relationship with their Family Physician/General Practitioner.



**The best model of care remains to have an appropriately resourced service accessible locally and a trusted long-term relationship with their Family Physician/General Practitioner.**

### Useful links:

- [CPME Policy on Telemedicine](#)
- [European ethical principles for digital health](#)

## Sarada Das appointed Secretary General

We are delighted to announce that Sarada Das has been appointed Secretary General. The appointment took immediate effect from 1 June.

Sarada joined CPME in 2009 and has served as Deputy Secretary General since 2016. Ms Das holds a B.A. in European Studies and an LL.M. in European Law from the University of Maastricht.

Sarada succeeds Annabel Seebohm, who leaves the role after six years of service to take up the position of Secretary General of COCIR. We thank Annabel warmly for her outstanding dedication and capacity and wish her much success in her new professional challenge.

Sarada said "I am honoured and privileged to have been appointed CPME Secretary General and thank the Executive Committee and our members for their trust in me. I thank Annabel very much for her dedication and wish her all the very best.

"Recent years have proven the indispensable role that doctors play in European society and how vital collaboration is across borders and at EU level. I look forward to continuing to support our members and to collaborate with our partners across Europe to make the voice of European doctors heard."



**"I look forward to continuing to support our members and to collaborate with our partners across Europe."**

Christiaan Keijzer (CPME President) said "Sarada was the clear and outstanding choice for the role given her wealth of knowledge and experience representing the medical profession at European level.

"The Executive Committee looks forward to working together to ensure a strong, independent medical profession in Europe and access to the highest quality of medicine for all patients in Europe."

## Challenges of Health Data in Europe - Are we preparing?



Dr Christiaan Keijzer (CPME President) and Dr Patrick Bouet (former President of CNOM)



**Sara Roda**  
*EU Senior Policy Adviser*

On 6 April, in collaboration with the Conseil National de l'Ordre des Médecins (CNOM), we organised within the context of the French Presidency of the Council of the European Union, a conference to discuss and address benefits and challenges of the digital transformation in European healthcare.

Recent years have witnessed the mass introduction of digital tools in the patient–doctor relationship, raising challenges over privacy and security of health data. On the other hand, data sharing can significantly benefit research, services and improve healthcare outcomes, as the COVID-19 pandemic showed.

During the event, expert speakers and panelists addressed the inclusion of digital health in a framework of ethical values and deontological terms, while discussing which tools would be needed to safeguard doctors' data and protect patients' personal data.

Governance structures and transparency were identified to be essential to supervise the use and re-use of health data. Sharing patient data required strong legal safeguards and security.





As recommendations, the different panelists highlighted that:

- i) relevant actors needed to continue to discuss together and express their concerns;
- ii) medical associations should continue to invest in digital education;
- iii) voluntary cooperation between Member States seemed to be no longer sufficient. There was a need to focus on permanent structures embedded in law;
- iv) medical associations should have a specific role in providing secure systems to doctors and in proving the identity and qualification of a medical doctor in the digital world; and
- v) governments needed to play a role too, as there were several operators in the market (e.g. big online platforms) which needed to be regulated to guarantee a safe Europe.

The audience engaged in a lively discussion, questioning among other:

- i) whether patients could potentially sell their health data;
- ii) how to ensure that the purpose in health data exchange served the public interest and not the user
- iii) whether doctors should share their data for research or policy-making purposes, and by doing so should they receive monetary compensation, academic credits, or a symbolic reference; and
- iv) who would bear the costs for the digital transition in small medical clinics / practices, adjusting to the electronic health record or the health data spaces.

Read the full event report [here](#).

## Health in all policies: eradicating health inequalities requires action across all sectors



**Sarada Das**  
*Secretary General*

Our updated policy on health inequalities highlights a range of policy areas where the European Union can act to help people from all social groups live longer, healthier lives.

Health inequalities are unfair and avoidable differences in people's health or in the access and availability of healthcare between different population groups.

A vast range of avoidable factors contribute to and exacerbate inequalities, therefore the 'Health in all policies' principle is needed to take coherent and conducive action across all sectors.

### Effective health workforce planning policies

Doctors and other healthcare professionals have a duty to work towards universal and equal access to better health and healthcare. However, they need the right conditions and resources to make a difference.

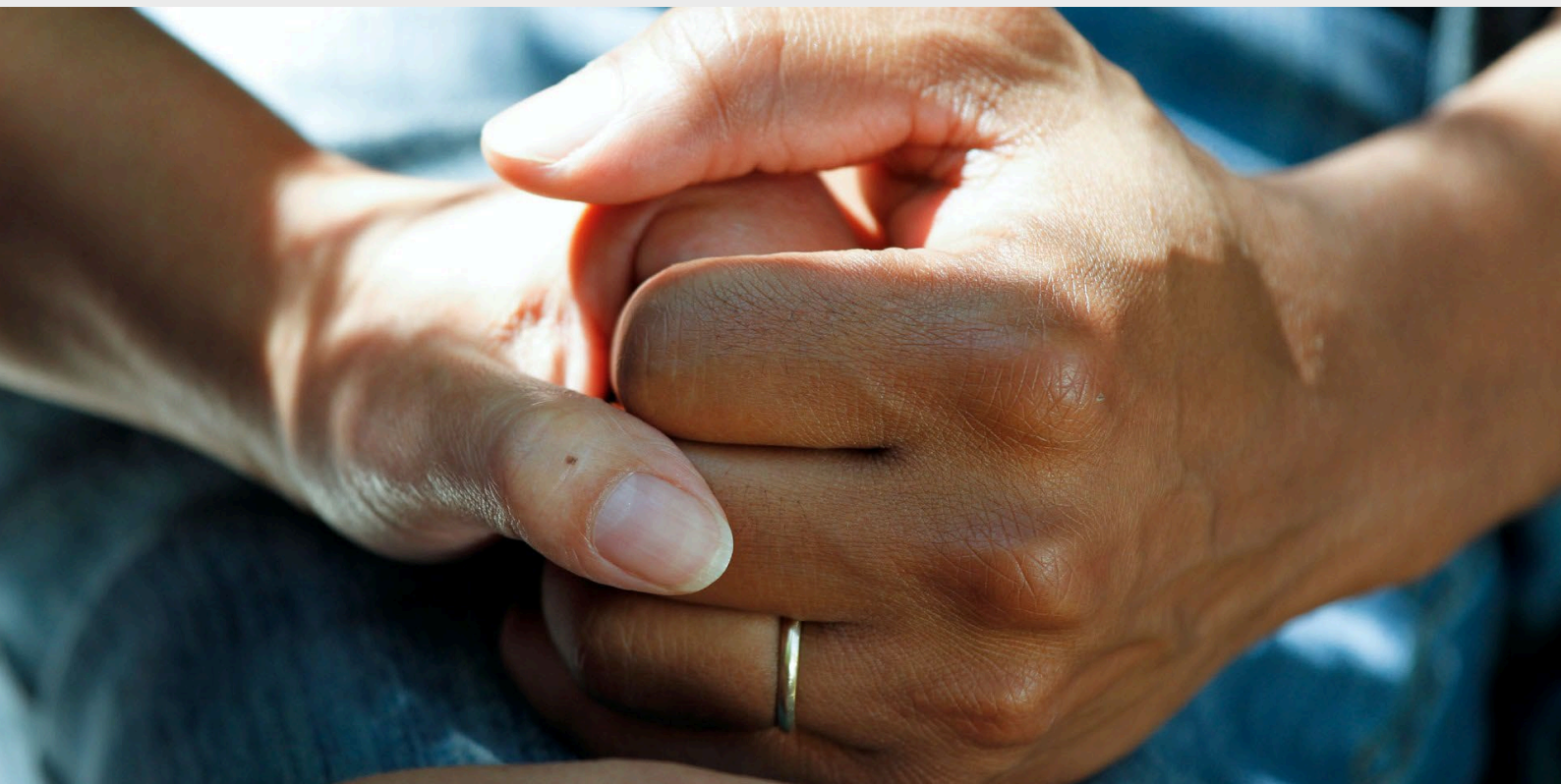


Read the full policy [here](#)

Our policy on the health workforce calls for effective planning policies to be implemented to avoid health workforce shortages making existing inequalities even worse.

### Action against poverty

Financial barriers to accessing healthcare play a major role in inequality, and while low-income households and vulnerable groups, such as refugee populations, are most severely affected, there is an impact following the social gradient. The EU must act against poverty and ensure sufficient health insurance coverage for all members of society.



### **Access to medicines**

Pharmaceutical policy must ensure that access to medicines, including the affordability and availability, does not exacerbate health inequalities.

To achieve this goal, European doctors support the objectives of the European Commission's Pharmaceutical Strategy for Europe and the Oslo Medicines Initiative to advance collaboration and improve EU citizens' access to novel medicines.

CPME remains committed to contributing to the revision of the general pharmaceutical legislation and EU rules on medicines for children and rare diseases as well as to all other measures taken to realise equal access in the EU.

### **Awareness and affordability of healthy diets**

Unhealthy diets and a lack of physical activity are important determinants of poor health and premature death across Europe. Healthy foods and drinks should be available, affordable and attractive, while measures should be taken to discourage consumption of unhealthy foods and drinks. This requires coordinated and coherent action in education, taxation, social, agricultural and industrial policies.

### **Doctors as ambassadors**

Doctors can act as ambassadors of the right to health, drawing the attention of governments to international conventions or charters that secure the right to health, lobbying their health authorities to ensure that every child has the best start in life.

## How the pharmaceutical industry misuses the concept of value to justify high medicine prices



**Piotr Kolczyński**  
*Legal Adviser 2018-2022*

In the past, the standard explanation given by pharmaceutical companies for high prices of medicines was that they were necessary to cover research and development costs and to compensate for the associated risks.

However, as these arguments have become increasingly questioned, the industry is changing its rationale, arguing that R&D costs are actually irrelevant and that medicine prices should in fact correspond to their "value".

### Value-based pricing

The idea of value-based pricing was initially developed by scholars and policymakers to challenge rising medicine prices and to allocate public health budgets more rationally.<sup>1</sup>

In response to significant increases in the costs of new medicines, various value-based pricing models have been developed to provide a standardized approach to prioritising "high-value" medicines.



The implicit purpose of these models is to empower healthcare payers in pricing negotiations.

Most often, the value assessment of new medicine is composed of various factors. It takes into account health benefit components such as medicine efficacy (often assessed through the added therapeutic benefit of the new medicine over existing therapeutic alternatives) and safety outcomes, as well as the improvement in patient quality of life.

The quality of evidence i.e., its sources or scenarios evaluated in clinical trials, is also often considered.

In addition, models using economic evaluation also look into cost-effectiveness<sup>2</sup>, cost-utility<sup>3</sup> or cost-benefit analysis<sup>4</sup>. In several countries, a wider societal perspective<sup>5</sup> is also included in the evaluation process to assess the medicine's costs and benefits.



CREDIT <https://www.istockphoto.com/fr/portfolio/Togapix?mediatype=photography>

**The pharmaceutical industry seems to place a disproportionate weight on economic aspects when determining the value – and consequently the price – of new medicines.**

#### Misusing the concept of value

Against this background, it can be observed that the pharmaceutical industry seems to place a disproportionate weight on economic aspects when determining the value – and consequently the price – of new medicines.

Pharmaceutical companies argue that prices correspond to the “real value” of medicines, which equals the costs they save society (i.e., for example, costs associated with disease management and hospitalisation and long-term societal benefits e.g., patient’s productiveness contributing to the economy and the alleviation of the impact on caregivers).

From this perspective, the medicine price relates to the costs that the disease would cause to society if not treated, or if treated with the second-best therapy. Following this logic, such monetary calculation should indicate the final price.

#### Assessing medicine’s societal value

As noted, it is not uncommon to incorporate societal perspective for economic evaluation, and to consider all relevant costs and benefits related to disease management in medicine value assessments.

The wider social impact of a medicine is most often incorporated in estimates of costs per quality-adjusted life-years (QALY) or disability-adjusted life-years (DALYs) gained.<sup>6</sup>

QALYs capture both the gains from reduced morbidity (increased quality of life) and reduced mortality (quantity of life years added), taking into account, for example, gains in working days or in the productivity for the patient or his/her relatives resulting from reduced sick leaves.



However, the societal perspective may be difficult to apply in practice due to problems with accurately measuring and quantifying the value of non-market resources, such as time for participants, patients and relatives, in monetary terms.<sup>7</sup>

Although healthcare payers may be willing to pay more for medicines that have greater value for the wider society and economy, establishing a clear link between a medicine and societal and economic savings it brings, and calculating them precisely, constitutes a great challenge (even more so for comparative assessments, given little consistency of evidence across products).

### **There is little research on the monetary value of the societal and economic impact of new medicines.<sup>8</sup>**

In addition, when assessing the value of a medicine to society, access considerations must also be taken into account, i.e., the impact of the medicine's price on health budget (and thus the resources available to pay for treatments and therapies for other diseases) and out-of-pocket payments by patients.

### **Fair medicine pricing**

Different value assessment frameworks can measure economic and societal impacts differently and assign them different weights in the process.

### **The logic that the price of a medicine should equal the costs it saves society should be strongly opposed.**

In value-based pricing, social value is typically used to define the boundaries of a fair price (a cost-effectiveness threshold) rather than to set an exact price.<sup>9</sup>

While the idea to measure medicine's value solely in economic terms can be justified from the market perspective, the actual threshold for defining value should include all relevant components.

Medicines should not be perceived as any other commodity. Therefore, the priorities required in pharmaceutical pricing must first concern patient's rights, then be applied to solidarity in care determined by need, and finally concern cost efficiency.



## European doctors advocate a multidimensional approach to pharmaceutical pricing, based on health technology assessment, where various factors are taken into account.

Although the pharmaceutical industry argues that its pricing strategy will result in the public paying more for more valuable medicines, different [studies](#) show the current [lack of a link](#) between specialty medicine prices and the benefits they provide.

On the contrary, the industry's [conceptualisation of value](#) appears to be yet another attempt to avoid the discussion on affordability and access to medicines, public contribution to pharmaceutical R&D and evidence that ever-high prices of new treatments are justified.

Therefore, instead of following the industry's logic, European doctors advocate a multidimensional approach to pharmaceutical pricing, based on health technology assessment, where various factors are taken into account from the added therapeutic benefits and the economic and social impacts to the ability to pay and access considerations.

[1] See: M. Mazzucato, "The Value of Everything: Making and Taking in the Global Economy", Penguin Allen Lane, 2017, pp. 189–195.; OECD, "[Value in Pharmaceutical Pricing](#)", 2013.

[2] Expressing outcomes in terms of health improvements (years or life gained for instance).

[3] Weighting health outcomes by their utility for patients.

[4] Expressing both costs and outcomes in monetary units.

[5] E.g. gains in worker productivity due to any reductions in sick leave, costs that are due to reduced working capacity or even all even all uses of time i.e., the utility of leisure, education or retirement. See: OECD, 2013, op. cit., p.34 and p.44.

[6] Cost-effectiveness is assessed by calculating how much per QALY a medicine costs.

[7] OECD, 2013, op. cit., p.34.

[8] A notable exception is hepatitis C.

[9] G. Persad, "[Pricing Drugs Fairly](#)", 62 Wm. & Mary L. Rev. 929, 2021, p. 957 and OECD, 2013, op. cit., pp.45–46.

Read our statement [here](#).

## A busy year for the Coalition for Vaccination



**Markus Kujawa**  
EU Policy Adviser

This spring, public attention shifted quickly from the COVID-19 pandemic and vaccination to the crisis in Ukraine. The war has led to millions of refugees, half of them children, fleeing especially to neighbouring European countries.

The situation is also worrying from the immunisation point of view, as historical vaccination coverage for polio, measles, and recently for COVID-19 in Ukraine is low compared to the European Union, indicating the presence of vulnerable pockets of un- and under-vaccinated population groups.

**In the current circumstances in Ukraine, the risks of infection from vaccine-preventable diseases are high both for the host and refugee populations.**

The Coalition for Vaccination, which brings together European associations of healthcare professionals and healthcare students, addressed the conflict in Ukraine in its [joint statement](#) during the annual WHO European Immunization Week in the end of April.

It called on European countries to ensure refugee populations, especially children, get easy access to vaccination services.



During its annual meeting in May, the Coalition members discussed how they have been involved in efforts to support healthcare professionals in Ukraine and its neighbouring countries.

CPME, as one of three Coalition co-chairs, has established the Ukraine Medical Help Fund as a joint initiative with the World Medical Association (WMA) and the European Forum of Medical Associations (EFMA) (see page 21).

Moreover, the Coalition's student member organisations presented their upcoming initiative to assess vaccination status amongst incoming refugees. The students will interview healthcare professionals working with the refugee populations to get a more comprehensive picture of the situation.







## European countries should continue providing COVID-19 booster shots for adults, especially the vulnerable and elderly populations, and increase uptake in adolescents and children

The Coalition for Vaccination statement also highlighted that European countries should continue providing COVID-19 booster shots for adults, especially the vulnerable and elderly populations, and increase COVID-19 vaccine uptake of adolescents and children.

The pandemic is not yet over even though many Europeans have decided so. Many European countries have abandoned travel restrictions, city curfews, business closures, COVID-10 certificates, passenger locator forms, and even face masks. Moreover, people are not taking PCR tests as they did earlier during the pandemic.

The good news is that according to the Eurobarometer published in March on attitudes on COVID-19 vaccines, Europeans are largely satisfied with the role of the EU in ensuring access to COVID-19 vaccines and have positive attitude towards vaccines.

The COVID-19 pandemic has led to a decrease in routine vaccination rates in several countries over the past two years. Therefore, the Coalition called on European countries to consider routine vaccination a priority for all age groups, especially children.

The World Health Organization (WHO) and UNICEF data showed that 23 million children in the world missed out on basic childhood vaccines through routine health services in 2020. The figure for 2021 is most probably even higher.

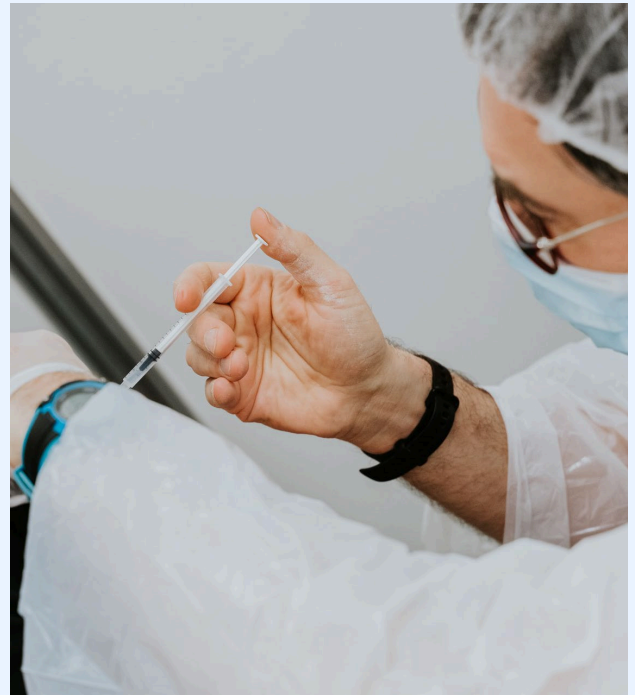
Based on the increase in measles cases in January and February 2022, WHO and UNICEF warned about a heightened risk for the spread of vaccine-preventable diseases which could trigger larger outbreaks, particularly of measles affecting millions of children later this year.

Finally, the statement emphasises the role of healthcare professionals and asks European countries to help them to roll out vaccination campaigns. Moreover, it reminded that healthcare professionals have a vital role in identifying and reminding people about their vaccinations across the life-course as they are their most trustworthy sources of information.

Since April 2021, the Coalition has been supported by a two-year long IMMUNION project which had its general assembly in February. The project partners had a chance to discuss the progress of the project so far and future steps to be taken. They also discussed the collaboration with other vaccination related EU projects and ways to make it more efficient and productive. The final conference of the IMMUNION will be organised in February 2023.

Before that, we can expect the Council of the EU, led by the presidency of the Czech Republic, to work on vaccines in the second half of 2022. The Coalition for Vaccination has its roots in the Council as it is based on the 2018 Council recommendation on strengthened cooperation against vaccine-preventable diseases which welcomed the European Commission to convene such a Coalition to bring together European associations of healthcare professionals as well as relevant students' associations in the field, to commit to delivering accurate information to the public, combating myths and exchanging best practice.

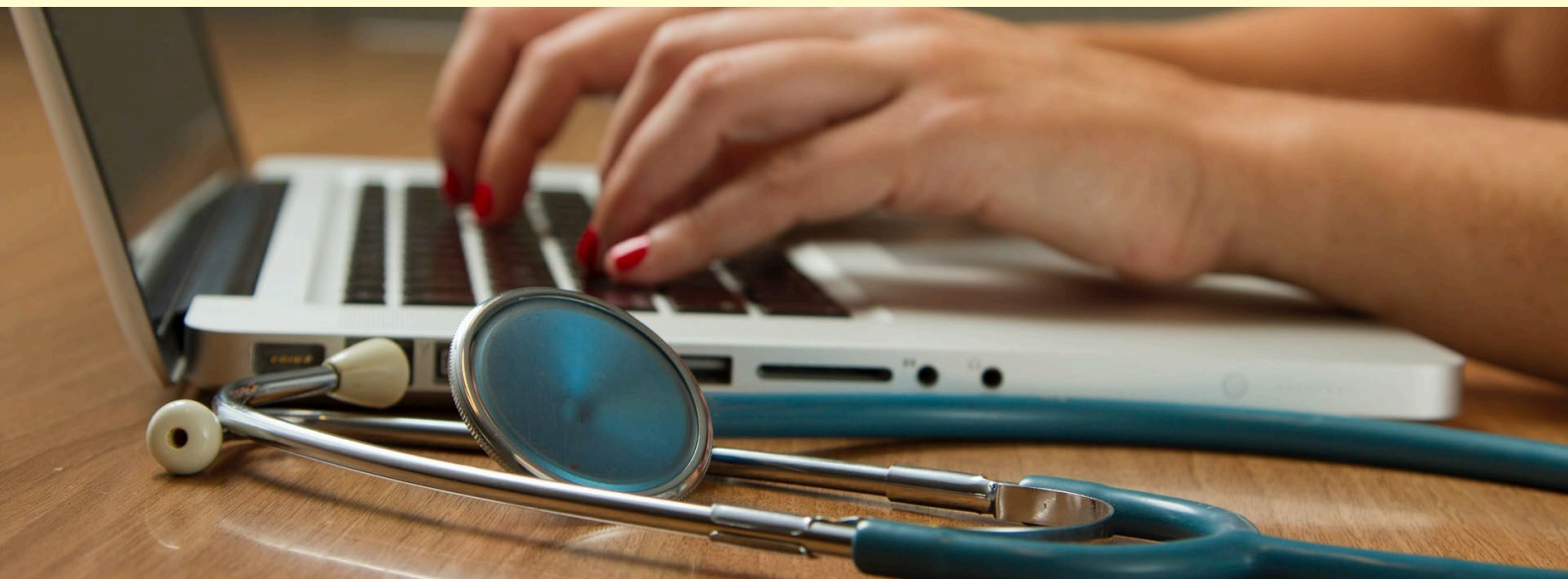
CPME, the other co-chairs, and all its members have since continued working on these topics in close collaboration with the Commission.



**Healthcare professionals have a vital role in identifying and reminding people about their vaccinations across the life-course as they are their most trustworthy sources of information.**

Visit the Coalition for Vaccination [website](#).

## Impact of the European Health Data Space on the medical profession



**Sara Roda**  
*EU Senior Policy Adviser*

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On 3 May 2022, the European Commission presented the long-awaited proposal for a [Regulation on a European Health Data Space](#).

The Proposal establishes rules, common standards, infrastructures and a governance framework for the [primary use of health data](#) (using electronic health data for diagnosis and treatment) and for the [secondary use of health data](#) (using electronic health data for policy-making, research and innovation). The Proposal is the result of a process that included an [impact assessment](#) and an open public consultation to which CPME responded.

CPME has prepared a [response](#) to submit to the Commission's feedback mechanism for new legislative proposals.

The response highlights the cultural shift on health data sharing, the high impact for European Doctors and small practices with increased obligations, costs and administrative burdens, in particular in relation to the primary use of health data, comments on the categories and purposes for secondary use of electronic health data, the importance of consent and research ethics committees in secondary use, the need for a differentiated approach in relation to certain categories of electronic data in secondary use, the re-identification risks in secondary use, and the data quality in the clinical file.



In general, healthcare professionals will be required to register data in a structured and specific way, being responsible for semantic interoperability and data quality, adding to the workload. They will also need to adapt to digital infrastructures, and improve their digital health literacy and competencies.

Many points are left for Member States to decide in order to respect Member States' public health competence, such as the possibility to restrict the rights of individuals to access their electronic health data based on patient safety and ethics, or what individuals can block in terms of access by health professionals.

Member States will also be able to decide which other categories of 'personal electronic health data' should be made available in the electronic health record (EHR), which were not identified as a priority under the Proposal.

For CPME, European doctors must not be obliged to provide health data in disregard to the principles of medical ethics, or when that implies a risk of infringing medical confidentiality and patient's privacy.

It is also important to respect national culture on health data sharing, the principle of data minimisation and individuals' consent. The digitisation of the healthcare sector implies a new way of working which will demand investments and continuous development of technical solutions. It will be necessary to ensure that the tasks which will be performed by the medical profession do not create a disproportionate administrative burden or cost on professionals.

CPME is also preparing a detailed response to the Proposal which will submit for approval at the CPME Board and General Meetings in October, in Prague.

With the recently published [Joint Opinion on the European Commission's Proposal for the European Health Data Space \(EHDS\) by the European Data Protection Board \(EDPB\) and the European Data Protection Supervisor \(EDPS\)](#), CPME will look further into the data generated by wellness apps from secondary use, the obligation of store personal electronic health data in the EU and the interplay between the General Data Protection Regulation and the Proposal in relation to healthcare, among others.

We will keep you posted!

## World medical community unites to support Ukrainian doctors



**Prof. Iryna Mazur and Dr. Andriy Bazylevych**  
Ukrainian Medical Association

In the thirty years since Ukraine regained its independence, cooperation with the world medical community has deepened as reform the healthcare system was introduced and cooperation strengthened to counter shared global challenges.

This spring, the Ukrainian Medical Association (UMA) was preparing to host international medical organizations in two congresses, the first on antimicrobial resistance in March, and a second on endocrine diseases in April.

On February 24, 2022, those plans instantly changed as the world heard the tragic news about the beginning of combat operations by the Russian Federation against Ukraine.

**Doctors know best what war is. The world and European medical community were the first to respond to the bloody events in Ukraine.**

On the second day of the war, colleagues from the World Medical Association (WMA) and the Standing Committee of European Doctors were the first to send an official statement in support of Ukrainian doctors.

With the flow of victims increasing every hour in regions across Ukraine, on 27 February the UMA wrote for humanitarian assistance.

A crucial point was the formation of a list of necessary medicines and medical products. The UMA developed a list to provide medical care to the civilian population, including painkillers, antimicrobial, antiviral, because COVID-19 continues to spread in Ukraine, as well as medical products for surgical interventions, bandages, and antiseptics.

**In response, WMA, CPME, and the European Forum of Medical Associations (EFMA) formed the Ukraine Medical Help Fund and disseminated the appeal across the world.**

The next step was to determine safe routes for the delivery of goods as Ukraine's airspace was closed during martial law.

The Polish Chamber of Physicians and Dentists was the first to respond, by providing humanitarian supplies, hosting refugee women and children, and providing medical assistance.

The second important corridor for the delivery of medical supplies was through Slovakia with assistance from the Slovakian Medical Association and the Slovak Medical Chamber.

Humanitarian aid came from all over the world to three Ukrainian cities – Lutsk, Ivano-Frankivsk and Uzhhorod.

All humanitarian convoys safely reached the humanitarian hubs of cities in western Ukraine to provide not only medical, but also other humanitarian assistance to victims in Ukraine.



The issue of the delivery of humanitarian cargo through the territory of Ukraine remained unresolved. After all, constant bombardments, the work of sabotage and reconnaissance groups in the centre of Ukraine created a danger for the transportation of peaceful humanitarian cargo to hospitals in Ukraine.

Transportation of humanitarian cargo with medicines through the territory of Ukraine in the conditions of war was dangerous, and had to be carried out orderly. Hubs and contact numbers were created and new logistics chains established for transporting goods to the east of Ukraine to the regions affected by missile bombardment.

The major role in the transportation of humanitarian aid was played by the Red Cross, who received cargo at hubs in the west of Ukraine with subsequent transportation to the north, south and east, where hostilities were going on, and many civilians were injured under the shelling of cruise missiles.



Prof Eidelman and Dr. Andriy Bazylevych visiting a field hospital in Lviv

**The coordinated work of medical organisations around the world once again demonstrated the unity of doctors and their desire to save people's lives.**

In the meantime, the Ukraine Medical Help Fund has risen to close to €3 million, including two large donations from the Japanese Medical Association.

In addition donations were received from the medical associations of France, the Netherlands, Denmark, Iceland, Taiwan, Norway, Switzerland and Croatia as well as many other individuals and groups.

Leonid Edelman, President of the WMA in 2018–2019 and Chairman of the Israel Medical Society, acted as the coordinator of the fund, allowing him to collect and deliver the Fund's first large delivery of humanitarian cargo to Ukraine in late March.

An incalculable number of letters were written and sent out to support Ukrainian doctors and the civilian population of Ukraine.

Thanks to close ties and cooperation in the first days of the war in Ukraine, doctors from all over the world were able to unite to fulfill their professional duties, coordinate their actions and send thousands of tons of humanitarian supplies to Ukraine.

The tragic events in Ukraine have become another important page in the history of medical associations of the world, which demonstrated the unity of all doctors worldwide against war! Ukrainian doctors expressed their sincere gratitude in a letter to medical organizations.

The coordinated work of the medical organisations of the world and Europe once again demonstrated the unity of doctors and their desire to save people's lives.

## Long COVID will be part of our professional lives for the foreseeable future. Are we ready?



**Prof. Dr. Martin McKee**  
European Observatory on Health  
Systems & Policies  
For correspondence:  
[martin.mckee@lshtm.ac.uk](mailto:martin.mckee@lshtm.ac.uk)



From early in the pandemic, it was clear that some patients who survived an acute episode of COVID would suffer long-term consequences. In some cases, the cause of their problems was obvious.

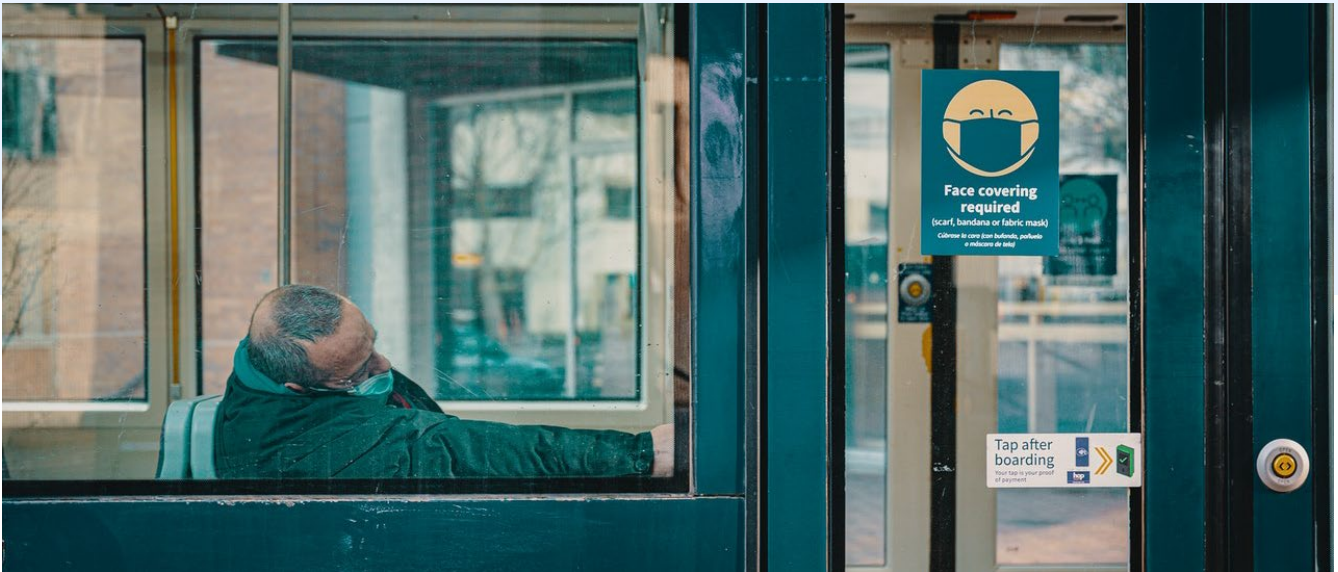
It had become clear that COVID was not just another viral pneumonia. Rather, it was a complex disease affecting many different body systems, both directly, and indirectly through a hyperimmune response.

In some patients, this was associated with increased blood clotting, leading to heart attacks, strokes, and kidney damage. Others, among the most severely ill, had another well-recognised condition, post-ICU syndrome, seen in patients who had undergone prolonged ventilation. But so did others, some of whom had relatively mild infections. Their symptoms varied.

For some, it was as if they had never fully recovered from COVID, with persisting cough, fever, and loss of taste or smell. For others, the symptoms were new and varied, although many described severe fatigue and difficulty concentrating, a phenomenon that would later be called "brain fog".

It took time before their condition would be named, initially, by a patient who gave it the label "Long COVID", now widely used by patients and health professionals, although it has other names, such as post-acute COVID-19 syndrome (PACS).





**Studies show that even those with mild acute infection have increased risk of cardiovascular disease, renal dysfunction and neuro-psychiatric illnesses even at 6 months to 1 year after infection.**

Large studies now show that even those with mild acute infection have increased risk of cardiovascular disease, renal dysfunction and neuro-psychiatric illnesses even at 6 months to 1 year after infection.

As the months went on, the numbers reporting these symptoms increased. Some made a gradual recovery. Others described a relapsing condition, in which the symptoms faded only to return after a short period. But a growing number have not made any meaningful recovery.

The obvious question is, how many people are talking about? This is where it gets difficult. While inflammatory markers in blood have been shown to correlate strongly with persistent symptoms in some studies of long COVID, there is no single clinical picture and there are no diagnostic biomarkers.

A further problem is that some sufferers, especially those who developed it early in the pandemic, may never have been tested for SARS-CoV-2 infection simply because testing capacity was so limited early on.

The World Health Organisation recognises these issues, with a definition that allows for a probable history of COVID-19, a wide variety of symptoms, and a possible relapsing course usually lasting for over three months since the initial illness. However, this is very difficult to turn into a clear description that can be used in epidemiological research.

Despite these challenges, a picture is emerging where between one in twelve and one in three people with COVID-19 have symptoms that persist beyond 12 weeks, with smaller but still significant numbers continuing to report being unwell at a year.



**Fortunately, there is now evidence that the risk is reduced in those who have been fully vaccinated.**

Even if there is still some uncertainty about the numbers suffering from Long COVID and the duration of their symptoms, it is clear that Long COVID will place a substantial burden on health systems in the years ahead.

This will be on top of the increase in people with multiple other chronic diseases resulting from an ageing population. This will require a lot of thought about how to respond. Fortunately, there is an emerging body of evidence that can help.

First, health professionals must work with patients to develop solutions. The varied nature of their problems means that management plans will have to be tailored to the individual, which is good practice with any chronic disease. There are also many patient groups who have themselves become experts in this condition and who can provide advice.

Second, Long COVID requires clinical teams with members from a range of medical specialities, supported by specialist therapists.

Third, patients must be enabled to access these services easily. There are too many accounts of people struggling to get referred to specialist services while those providing those services report that they are seeing little demand.

### Further reading:

- [NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19](#)
- [UK All Party Parliamentary Group on Coronavirus Long COVID Report](#)

## Rapid rollout of COVID-19 vaccines saves lives: healthcare professionals at the heart of national and EU efforts to fight off the pandemic

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Ever since the start of COVID-19 vaccination in Europe in late December 2020 and mid-January 2021, the early, rapid, relentless and effective deployment of COVID-19 vaccines has allowed us to shield to the best of our abilities our most vulnerable population groups.

**COVID-19 vaccines have thus far played a paramount role in averting or reducing significant morbidity and mortality attributable to COVID-19 disease.**

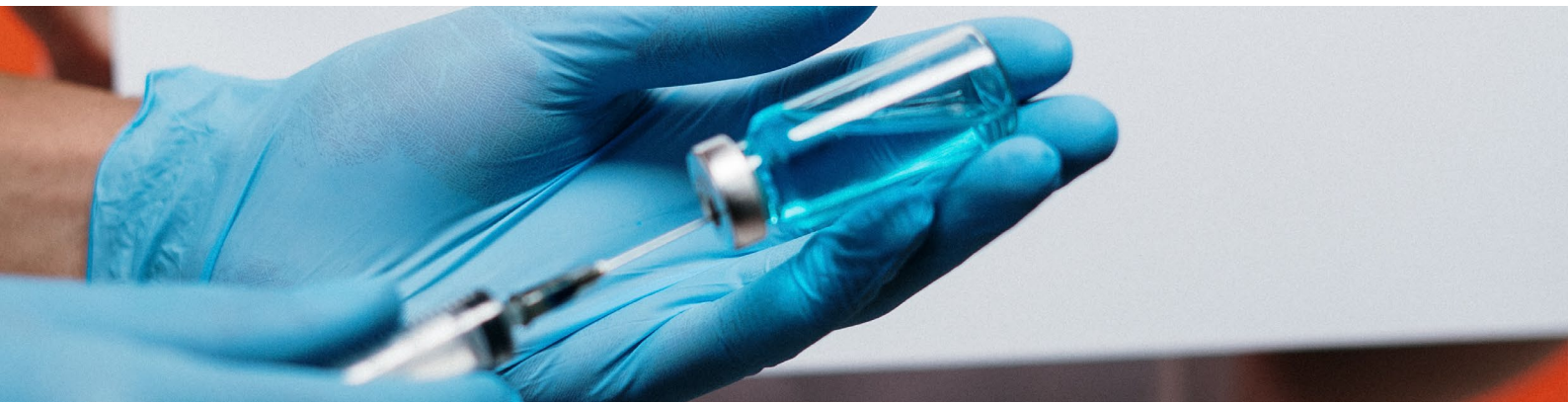
Preliminary and early on joint estimates from the ECDC and the WHO Regional Office for Europe suggest that the widespread implementation of COVID-19 vaccination programmes for older people has averted a median of at least 469,186 deaths in people 60 years and older in the Europe region, and countries with high early uptake have substantially reduced predicted mortality, especially in people 80 years and older<sup>1</sup>.

Such estimates are only an underestimation of the power of these vaccines and neglect to account for the indirect effect of vaccination, including reduction in transmission and significant effect on reduced severe disease outcomes.

Newer estimates and analyses will enable us to see even fuller gains from vaccination, including the certainly amplified impact of booster doses and vaccination of younger age groups.

Moreover, thanks to the EU Strategy for COVID-19 vaccines vigorously spearheaded by the European Commission, all EU Member States have succeeded in having equal access to safe and effective vaccines.

**Vaccines and effective immunisation programmes have proven over and over their extraordinary impact at the individual and population level.**



While we have known this for decades drawing from the well-established past experience of using safe and effective vaccines in fighting pandemics and infectious diseases, it has been truly remarkable to see how, at an unprecedented scale, decades of vaccine R&D investments and rapid deployment infrastructures have enabled us to target the novelty of an unknown and unpredictable disease such as COVID-19.

We know that the COVID-19 pandemic is not yet over, but we might now be transitioning into a new phase offering us all hope for some more stability and a certain degree of return to normality. The future stages of the COVID-19 pandemic and its burden on society over the next months is heavily dependent upon public health investments and policy decisions that will be taken now.

We must recognise that many unknowns still remain, such as whether new and more virulent variants may emerge, how the next autumn and winter season will look like, whether manufacturers can develop newer and more effective vaccines less affected by changes in circulating variants, how long we are really protected from COVID-19 disease following natural infection and/or vaccination, just to list a few.

Nonetheless, at this stage of the pandemic, immunity against the SARS-CoV-2 virus, whether acquired naturally or through vaccination, has significantly increased in the EU population. Given the very high infection rate of the Omicron variant, the most predominantly circulating variant across all of the EU, and considering that about 70% of EU citizens have completed their primary vaccination series, it is likely that a significant number of people will have by now built some degree of immunity against the disease and are thus better protected against the risk of death or severe disease.

**Continuing to bolster vaccination efforts is critical and should not be deprioritised. We must prevent all the preventable.**

We do know that not all countries have achieved the same rates of vaccination coverage, with several Member States lagging behind. In addition, important gaps persist in terms of uptake across regions, population groups and socio-economic fractions of society.

Efforts to increase the uptake of the primary course should still be maintained to reach the many unvaccinated or partially vaccinated, and a booster dose should be offered to all adults starting from at least three months after the primary series.<sup>2</sup>

Over the last two years, all of us, public health experts, practitioners, health professionals across all levels, vaccinators, regulators, policy and decision-makers, vaccine developers (and the list goes on) have been tirelessly working around the clock to build a sustainable way out of the pandemic.

But out of us all, frontline healthcare workers and professionals are with no doubt among those deserving special praise and thanks for their unparalleled individual and collective efforts to keep our healthcare systems going and provide life-saving care in the fight against COVID-19.

**Healthcare professionals at all levels and across all categories have also played an enormous role in promoting and rolling out COVID-19 vaccines, our utmost tool to fight the pandemic.**

While this pandemic has constantly challenged us all to rethink what we thought was certain and taken as a given, it has also confirmed, in many regards, a long-established and well-documented truth that we have been aware of for decades; healthcare professionals remain the most trustworthy voice and source of information on vaccines and vaccination for patients and members of the general public at large.

This has been the case even throughout the pandemic, amidst the growing and more intensive spread of fake news and certainly a great deal of opposition towards COVID-19 vaccines.

This confirms that healthcare professionals truly play a critical role in building a sustainable way out of the pandemic, securing a sustainable rollout of vaccination programmes, and empowering citizens to make informed decision concerning vaccination.

Partnering with healthcare professionals is very critical for ECDC. Without them we wouldn't be able to achieve our mission to improve European citizens' lives no matter what source of infectious disease threat.

This is why we have long been investing in large-scale projects aimed to build tools that can address their needs, strengthen their skills and capability in communicable disease prevention and control as well as, more specifically, in empowering healthcare professionals to address issues of vaccine acceptance, fight misinformation, and motivate their patients to make evidence-based decisions.

All such areas are fundamental for the work of ECDC, and we aim to continue working closely together to be able to assess needs and promptly develop together tools and strategies that can help us build a healthier Europe.

[1] Meslé Margaux *et al.* Estimated number of deaths directly averted in people 60 years and older as a result of COVID-19 vaccination in the WHO European Region, December 2020 to November 2021. *Euro Surveill.* 2021;26(47):pii=2101021. <https://doi.org/10.2807/1560-7917.ES.2021.26.47.2101021>

[2] This article was first contributed March 2022 and ECDC's information is constantly updated on their [website](#).

## How to help consumers make healthier choices? With Nutri-Score!



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Which tomato soup is the healthiest? Should I go for breakfast cereals labelled 'high in fibre' or for those stating 'without refined sugars'?

Consumers face plenty of these dilemmas in their daily lives. Currently food packages are clouded with messages which don't tell the whole story and are mainly there to seduce consumers to buy a certain product over a competitor's.

Ingredients and nutrients information is mandatory on the back-of-pack. Many studies have shown however that consumers are struggling to understand and use this information, especially those with lower levels of education or nutrition knowledge. And, even if someone fully understands the information, comparing products is still a hassle as it requires turning the different packages over to compare the figures – hidden on the back in tiny font.

Easy-to-understand nutritional information on the front of food packages can help consumers make more informed and healthier food choices.

**Nutri-score has been developed based on solid, independent and transparent scientific evidence, free from commercial interests.**

This is urgently needed as today in the EU 1 in 2 adults are overweight or obese. Moreover, while consumption in Europe of saturated fats, salt and sugars is too high the intake of fruit, vegetables and whole grains remains too low.

These factors increase the risk of developing diet-related diseases such as diabetes and cancer.

Among other interventions aimed to improve our 'food environment' (i.e. everything that pushes us to buy one product over another), front-of-pack nutrition labels are a key tool to help consumers. In response to this, the European Commission is due to propose an EU-wide mandatory front-of-pack nutrition label by the end of this year.



**One of Nutri-Score’s key assets is its use of colour-coding, which greatly helps consumers to compare the nutritional quality of food and beverages.**

At BEUC, we have been advocating for simple and effective consumer-friendly front-of-pack labelling for more than a decade. We believe Nutri-Score is the best label currently available. It converts the nutritional value of food and beverages into a simple overall score. It is based on a scale of five colours and letters (dark green A represents the best nutritional quality while dark orange E shows it is the lowest).

The score is calculated by taking into account both the nutrients to limit (calories, saturated fats, sugars and salt) and those elements to favour (proteins, dietary fibres, fruits, vegetables, pulses, nuts, and rapeseed, walnut and olive oils).

Compared to other front-of-pack labels, Nutri-Score is the easiest to understand. Studies have shown that it performs the best in making consumers’ shopping baskets healthier – including for low-income households who are most at risk of becoming overweight or obese.

One of Nutri-Score’s key assets is its use of colour-coding, which greatly helps consumers to compare the nutritional quality of food and beverages. And it is reliable: it has been developed based on solid, independent and transparent scientific evidence, free from commercial interests.



CREDIT The European Consumers Organisation (BEUC)

Seven European countries have so far endorsed Nutri-Score: France, Belgium, Spain, Germany, the Netherlands, Switzerland and Luxembourg. Experience from France and Belgium indicates that consumers benefit from seeing the label on food packages. 94% of French consumers like Nutri-Score and 89% want it to become mandatory.

Academics, public health organisations and consumer groups have thrown their weight behind Nutri-Score. The WHO's cancer body (IARC) calls for a 'widespread and systemic adoption in Europe'.

Over the past years an increasing number of food companies, retailers and food service players have lent support to Nutri-Score and started using it on their products.

But the majority remain reluctant to use it, despite its usefulness for consumers.

And that means that so far, many tomato soups, breakfast cereals and other products on European supermarket shelves display no Nutri-Score, which leaves consumers in the dark.

The only way European consumers can truly reap the benefits of Nutri-Score is when it will be shown on all food products.

That's why BEUC urges the European Commission to choose Nutri-Score to help consumers make better informed and healthier choices.



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