ECDC DIRECTOR'S PRESENTATION

Multi-drug resistant tuberculosis in the EU

Exchange of views with the Committee on the Environment Public Health and Food Safety (ENVI), European Parliament, Brussels, 21 March 2012

Thank you Chairman for inviting me to contribute to this exchange of views.

When I appear before this Committee, I like to give you a balanced view. I aim to give you some good news along with the bad news. But, when I look at multi-drug resistant tuberculosis – or MDR-TB, as I will call it – I find it hard to be optimistic.

Since 2006, fighting MDR-TB has been a priority for ECDC, the Commission, WHO and Member States. For example, fighting MDR-TB is central to the EU's action plan on TB, and to the work ECDC has done with its TB network. MDR-TB has received a lot of expert attention in the EU. It has also had some political attention.

But, during 2006-2010, we achieved no more than a small decrease in the number of MDR-TB cases in the EU. That was all we achieved in the good years – the years when money was available for public health.

It does not make me optimistic for the next few years – the years of austerity and economic crisis.

Why am I pessimistic?

Because the continuing economic crisis in Europe means two things:

- Firstly, health budgets being cut
- Secondly, more people falling into poverty

Both of these have an impact on our ability to control TB.

TB is often called a disease of poverty. Middle class, professional Europeans rarely get TB. For affluent Europeans, it is an invisible disease. But TB still exists in the EU.

In 2010, nearly 74,000 cases of TB were reported in the EU. Of these, nearly 1,500 were MDR-TB

The people ill with TB in Europe are usually the poor and marginalised. They are migrants and refugees. They are drug addicts and prisoners. They are the Roma, the homeless and the inner city poor. These are the groups most vulnerable to TB in the EU.

As the economic crisis continues, more Europeans will fall into these vulnerable groups. More Europeans are becoming poor, more Europeans are becoming homeless. We are likely to see more crime, more drug addiction and more alcohol abuse. This again increases the vulnerable population. Prisoners, alcoholics and people who inject drugs are all vulnerable to TB.

But while the number of Europeans vulnerable to TB increases, resources to fight TB are becoming harder to find.

Why does this matter?

Because TB is **difficult to diagnose** and **difficult to treat**. And in the health system, difficult means "resource intensive".

Do you know what the "classic" first symptoms of TB are?

Tiredness, fever and coughing. Those are the same symptoms as many other diseases. The only way for a doctor to be sure that a patient has TB is to order tests. The doctor needs to send a sample from the patient to a **laboratory** with the **right expertise**, and the **right equipment**. So even just **diagnosing** TB takes significant resources.

What are the symptoms of MDR-TB?

No different to ordinary TB. The only way to diagnose MDR-TB is to run additional tests on a sample from the patient. **Diagnosing MDR-TB takes a high level of skill, and a well resourced laboratory**.

ECDC supports a network of TB laboratory specialists across the EU. We have put a lot of effort into defining standard testing methods for MDR-TB, and disseminating the know-how to run these tests. But the basic staffing and resources for national TB laboratories are paid for by the Member States.

If Member States cut their basic TB control infrastructure – such as laboratories and expert staff – we will not be able to diagnose normal TB – let alone MDR-TB – properly. Patients will be diagnosed late, and so continue spreading TB longer.

Do you know how long it takes to treat a TB case?

Six months, if they have got ordinary TB. Nearly 2 years if they have MDR-TB The treatment regime even for ordinary TB is complex. **Just for ordinary TB**, the patients needs to take:

- Four different antibiotics for the first two months.
- Then two different antibiotics for the remaining four months.

Treatment for MDR-TB involves more drugs – and more side effects. In all cases, TB treatment needs to be closely monitored by health professionals. If patients don't take all their pills correctly, their TB may become drug resistant. Incorrect and incomplete treatment is what drives the emergence of MDR-TB.

So controlling ordinary TB, and MDR-TB, requires resources for:

- Laboratories to diagnose TB
- Medicines to treat people with TB; and
- Health professionals to monitor their treatment
- Finally, national public health institutes need to monitor and evaluate the impact of treatment strategies

I am not confident that all EU Member States will make sufficient resources available for TB control in the coming years.**But Parliamentarians** in this House – and in national parliaments – **can play an important role in making sure TB control gets the priority it deserves.**

I hope the evidence ECDC provides will help you do this. You will find some of this in your committee documents. ECDC has provided you information on how many TB cases were reported in each EU and EEA Member States in 2010. You can compare the incidence of ordinary TB and MDR-TB in different European countries. Incidence is the number of cases reported per 100,000 population. This gives you a feel for the relative state of the TB epidemics in each of the different countries.You can see that the EU, in general, has lower incidence of both ordinary TB and MDR-TB than its neighbours. You can see that 21 EU Member States are considered to be low incidence countries. That is, they report fewer than 20 cases per 100,000 population.

If you look at the trend since 2006, the overall incidence of ordinary TB in the EU has declined. However, if you look at the trend for MDR-TB since 2006 it is rather flat. You need to look very closely to see a decline. And the picture in the low incidence countries is not as good as it may seem. Some of their cities have pockets of high TB incidence. A study by the Metropolitan TB network showed cities such as London, Paris, Copenhagen and

Rotterdam having three times the national incidence of TB. Milan had nearly five times the average incidence for Italy.

The common factor in the big cities is poverty. In the big cities you tend to have more homeless people, more newly arrived migrants and, over all, more deprivation.

The last item in your information pack I want to draw your attention to is a short case study on the financial crisis in New York City in 1975. The austerity measures applied in New York included major cuts to the health service. The work force was cut by nearly a third, and a TB hospital and several chest clinics were closed. Poverty increased, while the capacity of the TB control programme collapsed. This resulted in an upsurge of TB cases in the 1980s, which continued into the 1990s. The upsurge was equivalent to 10,000 additional TB cases. A study, referred to in your information pack, estimated the direct healthcare costs of treating the extra TB cases at half a billion US dollars.

This shows that cutting TB control is a false economy. Chairman, I hope this is something health policy makers in Europe will reflect on.

I end with an invitation to Committee members. Tomorrow in London, and on Friday in Barcelona, Rotterdam and Milan there are World TB Day events. I will be at the one in Rotterdam. Each of these will focus on the issue of urban TB. ECDC, and the cities organising these events, would very much welcome your involvement and support.