ECDC European Centre for Disease Prevention and Control

ECDC DIRECTOR'S PRESENTATION

Review of 2012, priorities for 2013 and beyond

Annual exchange of views with Committee on the Environment, Public Health and Food Safety (ENVI), European Parliament, Brussels, 11 October 2012

Thank you Chairman.

In the past, political interest in infectious diseases has tended to be driven by high profile outbreaks:

- Like the H1N1 influenza pandemic in 2009; or
- The EHEC outbreak in the EU last year

This year, though, infectious diseases have received a lot of attention from this Committee without such an outbreak**.**

In March you held an exchange of views with ECDC, WHO and the Commission on tuberculosis. Yesterday you adopted your report on the Serious Cross-Border Health Threats Decision. And next month you will adopt an opinion on the Rising threat from Antimicrobial Resistance.

Chairman, I would like to congratulate you and your members for this far sighted approach.

The threat from infectious diseases is always there – even when it is not getting media attention. Indeed, many of the key threats the EU faces in this area are long term challenges, such as Antimicrobial Resistance, rather than short dramatic crises.

What I want to do over the next few minutes is to give you an overview of:

- ECDC's main activities and achievements over the past year;
- Our priorities for 2013; and
- Some initial thoughts on our Strategic Multiannual Programme for 2014-2020

Let me turn first of all to ECDC's activities over the past year. When I spoke to you last year my four top priorities for 2012 were:

- Advancing measles elimination in the EU;
- Strengthening laboratory capacity;
- Collaboration with EU enlargement countries; and
- Health inequalities with particular emphasis on migrant health and vulnerable populations

All four of these are long term challenges. They will continue to be top priorities for us in 2013.

In the area of enlargement we have been working with Croatia this year. Over the next 12 months we will work with Iceland, Montenegro and Serbia.

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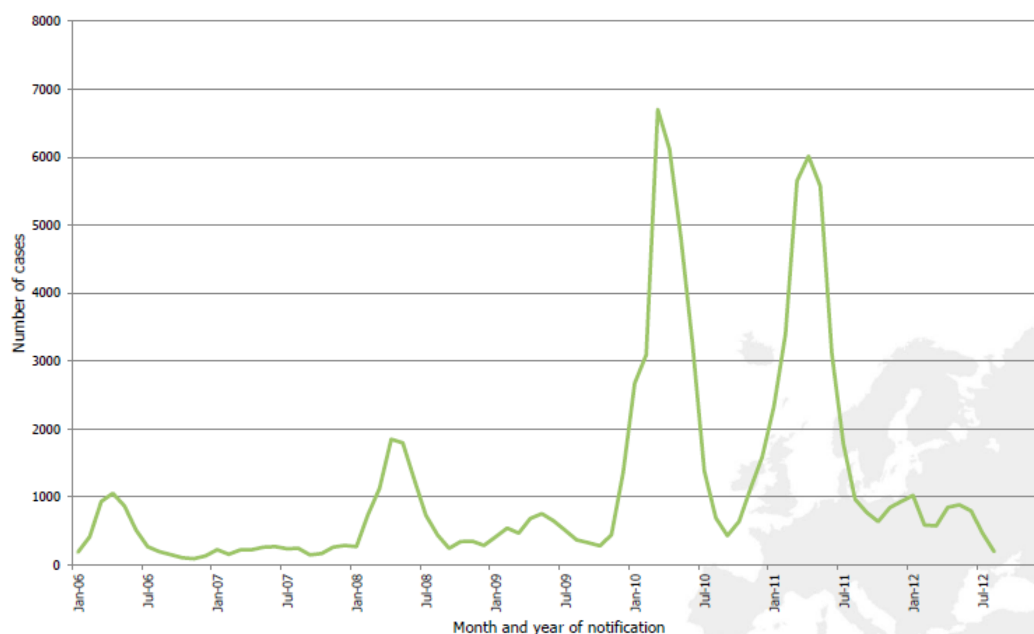
In the area of measles, we continue to see outbreaks of this preventable disease in the EU. For example, this spring the City of Liverpool in England saw its worst measles outbreak since the 1980's – more than 200 cases of measles and nearly 40 children hospitalised. Across the EU as a whole, though, the number of cases was down. In 2011, EU countries reported more than 30,000 cases of measles. The figure so far for 2012 is just over 5,000 cases. The peak season for measles transmission is the spring, so we are not expecting this number to increase substantially. 5,000 measles cases is still too many. The EU's goal is zero cases.

But in comparison to recent years, we had a mild measles season. I am not going to try to take credit for that!

If you look at the graph of measles cases in the EU since 2006, you will see that it goes up and down.

Measles cases by month of notification
01/2006 to 08/2012, EU/EEA countries



Total number of cases 01/2006 to 08/2012 is 93,639 3

Just because things are quiet this year, it doesn't mean they will be quiet next year.

This brings me to why both measles and health inequalities are multi-year priorities for ECDC. Measles is a highly infectious virus. If we are going to eliminate measles in the EU we need to achieve and sustain 95% vaccination coverage across all Member States, and all communities.

Individual countries cannot do it on their own.EU countries with high vaccine coverage are still finding measles cases. They are importing the problem from their neighbours.

But also, we cannot eliminate measles without talking about health inequalities. Even in those Member States where vaccination coverage overall is high, there are what we call underserved populations. These include migrants, the Roma and other disadvantaged groups. Vaccine uptake in these groups is often low. As a result, we see repeated measles outbreaks in these communities. That is why, in developing ideas on how to boost vaccination coverage, ECDC has put particular emphasis on underserved populations.

In Dublin last month we had a very good meeting with Member State experts, representatives of the Roma community and the Irish travellers' community. This meeting agreed a set of ten practical proposals for how countries can increase vaccination uptake among vulnerable groups, and the general population. I will present these proposals to Member States and the Commission next week at an EU meeting on Childhood Immunisation.

On supporting, and reinforcing, Member States' laboratory capacity it has also been a busy year. This is a long term endeavour, which I will say a bit more about it when I discuss our future activities. But I would like to give you an example of how ECDC and its partners recently made practical use of new laboratory techniques.

Last month, the Commission asked ECDC and EFSA to produce a joint risk assessment on a multi-country outbreak of food associated Salmonella. This was a new experience for both Agencies, in that we used ECDC's "rapid risk assessment" approach to produce a joint document in a matter of days. Even more interesting, though, is that we coordinated the use of advanced laboratory testing techniques on Salmonella samples from the health system and from the food chain. This gave us solid evidence that:

- Patients in several different Member States were infected with an identical strain of Salmonella
- Turkey meat was the most likely common source of the human infections, though a contribution to the outbreak from other food sources could not be excluded

This successful joint laboratory work, and our excellent cooperation with EFSA, makes me optimistic about supporting rapid identification of the source of future outbreaks. The technology, and partnerships, we have available to us are improving every year.

Finally, of course, a key part of ECDC's work in 2012 was responding to unusual or unexpected events. This is one of the things ECDC was established to do.

For example, last month we got confirmation of two cases of severe illness caused by a new type of Corona virus – the same family of viruses as SARS. ECDC had a team of experts working through the weekend to produce a Rapid Risk Assessment. In parallel, expert European laboratories in the Netherlands, UK and Germany, with support from ECDC and a DG RTD funded project, rapidly developed specific tests for the new virus.

The EU level experts and experts in the Member States worked together - there was no duplication of effort. At 9pm on Sunday evening the Commission posted ECDC's Rapid Risk Assessment on the EU's Early Warning and Response System, along with information on the new tests. This meant that the following Monday, when this new virus started getting media and political attention, Health Ministers across the EU had the same "state of the art" information about it.

In my view, this is the right way to use Europe's limited public health resources. When facing common threat, we should work together and do the scientific work once, rather than 27 times. Taking this approach also means that Member States and the Commission have a solid basis on which to coordinate their response to the threat in the Health Security Committee.

You have details on more than 30 other threats examined by ECDC in our briefing note in the meeting documents.

Diseases	Rapid Risk Assessment	Epidemiological Update	Grand Total
Anthrax	1	2	3
Cholera	1		1
Ebola	2		2
Emerging (novel coronavirus)	1	1	2
Enterovirus	1		1
Flu	2	1	3
Foot and Mouth	1		1
HAI	1		1
Hand Foot and Mouth Disease		1	1
Hantavirus	1		1
HIV	1		1
Legionnaires' Disease	2	6	8
Malaria		1	1
Measles	1		1
Salmonella	1		1
Schmallenberg Virus	1	1	2
Typhoid	1		1
Viaspan	1	1	2
West Nile	1		1

Grand Total	**20**	**14**	**34**

I would now like to take a few minutes to talk a bit more about ECDC's plans for 2013 and beyond. There are some important milestones in 2013 that I would like to signal to you.

Firstly, 2013 will be the year we implement a new, reinforced policy on scientific independence. This updates and extends the work we already do to manage and prevent conflicts of interest.

Secondly, we will be undergoing an independent external evaluation in 2013. Here we have contracted the evaluators and the process of data collection will start this year. We should get the final report in 2013.

Thirdly, we should adopt our Strategic Multi-Annual Programme for 2014-2020. Preparatory work on this has already started. Last month in Stockholm we had a Joint Strategy Meeting, bringing together senior experts from the Member States' national public health institutes and our Advisory Forum. This gave us some initial technical input. We will use it to develop a consultation paper which we will share with partners, including this Committee, of course.

What struck me during our discussions with our national colleagues is the demand for continuity in the substance of ECDC's work. But the way we do things will have to change.

Of course, part of this may be learning to do more with less resources. I recognise that budgets in the health sector across the EU will continue to be under pressure in the coming years. I believe that doing more at EU level is a way to "do more with less". And I would like to thanks this Committee, and its budget *rapporteur* Jutta Haug for having made this case.

But let me give you two other examples of change.

The first is the way we present our surveillance data on infectious diseases. This should be very different by 2020. New digital technologies should enable us to gather the data more quickly, and present it in a more user friendly way. You should be able to get all our data as a little App on your Smart Phone – or whatever it is we are using in 2020. Big fat paper reports should be a thing of the past.

The second is public health microbiology. By 2020 we will have seen a dramatic evolution in the technologies being used in Member States' microbiology laboratories for detecting and tracking human pathogens. Our national partners want ECDC to help them coordinate the introduction of these new technologies for public health purposes. EU cooperation means they will be able to:

- Compare data with each other; and
- Learn from each others' experiences

But most of the diseases we are testing for in 2020, and many of threats we face, will stay the same.

If I am lucky enough to still be appearing before this Committee in 2020, I am sure we will still be talking about:

- Antimicrobial resistance
- HIV/AIDS
- Tuberculosis;
- Influenza
- Pandemic preparedness

And so on.

I very much hope the EU will be making good progress on all these diseases by then. But I am sure ECDC will still be working with Member States and the Commission to address them – as well as helping the EU react quickly to unexpected threats.

Thank you for your attention. I look forward to your questions.