Health in a post-pandemic EU
Health in a post-pandemic EU

BY ALEJANDRO TAUBER

As this magazine goes to press, the World Health Organisation has registered just shy of seven million global deaths due to COVID-19.

It also has registered over 13.5 billion doses of vaccines administered.

This is an astonishing feat, especially given that these vaccines did not exist a mere three years ago.

In June of this year, New York Times journalist David Wallace-Wells, who did fantastic health reporting throughout the pandemic, wrote an article titled ‘Suddenly, It Looks Like We’re in a Golden Age for Medicine.’

In a newspaper normally not given to hyperbole, he describes the advent of a whole new wave of pharmaceutical innovation that might drastically change our relationship with diseases over the next couple of decades.

Just take mRNA vaccines, which were so successfully used to push back the coronavirus, and the potential offered by the precise engineering of genetic material to combat illness.

Currently, mRNA vaccines are being developed to fight some of the most deadly infectious diseases on the planet; from malaria to H.I.V., to dengue, zika and tuberculosis. The same method is also showing promising results against certain types of cancers.

The better understanding of disease pathways is also leading to scores of new drugs, some of which seem to be performing at previously unimaginable efficacy.

Targeted chemotherapy against certain types of breast cancer have extended life expectancy by one hundred percent. A small group of patients receiving a new drug that fights rectal cancer were actually cured.

And then we haven’t even gotten into developments in gene therapy, which could be a life-saver for people with single-gene mutations, drugs that effectively treat obesity and preventative detection methods.

In this magazine, we take a look at some of these developments, and why there is reason for hope on many fronts - while at the same time also exploring new health risks due to climate change, shifting demographics and future pandemics.

When it comes to health, it’s truly an extraordinary period to be alive. And to stay alive, if all works out as it seems to be doing.
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Two months after Danish pharmaceutical company Novo Nordisk launched Wegovy, its blockbuster weight-loss drug, in Europe, demand has exploded. Overweight Germans are desperate to get a hold of the drug, hoping to lose weight. 48-year-old Philipp Lang from Bad Homburg, near Frankfurt in Germany is one of them.

Lang has a background in investment banking and IT. He runs a family business, acting as the managing director of an illumination company in Friedrichsdorf while running restaurants in Frankfurt on the side. Lang is a busy man.

From his car, he tells EUobserver about his weight journey. Like many, Lang gained weight during the COVID pandemic. His weight peaked at 120 kilograms. In August 2022, he was hospitalised for psoriasis spreading out as arthritis and went through cortisone treatment, a steroid hormone that relieves pain and inflammation.

He started taking Ozempic, a diabetes drug commonly used to obtain weight-loss, to prevent weight gain as a result of the cortisone treatment. Where Wegovy (which contains the same active ingredient, semaglutide, in a higher concentration) was made available in Germany, he immediately took it.

"It worked well," Lang says. Without implementing lifestyle changes, he quickly shed weight and is now at 105 kilograms.

Ozempic and Wegovy mimic a hormone called glucagon-like peptide-1 which targets parts of the brain that regulate appetite. The hormone slows down the rate of ‘gastric emptying’, which means people feel fuller and have less desire to eat. It also encourages the body to break down fat.

In 2018, Ozempic was approved in the EU for type 2 diabetes, but not for weight-loss. By the end of 2021, the European Medicines Agency (EMA) approved the drug in a higher concentration, under the brand name Wegovy, for chronic weight management in the EU.

The share price of Novo Nordisk, the company behind the popular weight-loss drugs, surged by almost 120 percent since the debut of Wegovy on the US market in June 2021, making it Europe’s second-most valued, listed company and transforming the economy of its home nation, Denmark.

Rival obesity drugs are already under way. Mounjaro, a diabetes drug produced by Eli Lilly, an American drugmaker, was approved by the US Food and Drug Administration in May for diabetes and is expected to expand to weight loss soon. Novo Nordisk is currently advancing its next-generation offerings with high hopes for CagriSema, another obesity drug, currently in phase 3 development. Amgen, AstraZeneca, Pfizer and smaller biotech companies are racing to develop new drugs as well.

Appetite-suppressing drugs have generated popular excitement, and endless coverage in mainstream media, but potential side effects and addiction issues mean the drug revolution is not happening without concerns.

A growing problem

Globally, obesity rates have almost tripled since 1975. The COVID pandemic compounded this problem. A 2022 World Health Organisation report estimates that 59 percent of adults in the European region are overweight or obese.

Overweight can have devastating effects, causing more than 1.2 million deaths across the European continent every year, according to WHO estimates. Being overweight can lead to heart disease, stroke, diabetes, fatty liver, increased risk of cancer, knee pain and a myriad of other health issues.

A ‘cure’ for obesity

Following the success of diabetes drugs for weight loss, concerns remain about long-term effects – both for health and society.

By MIE HOEJRIS DAHL
**A ‘CURE’ FOR OBESITY**

The economic costs are considerable as well. The World Obesity Federation predicts that the global cost of overweight and obesity will reach more than $3.4 trillion USD annually by 2033 – almost three percent of global GDP.

Until now, many obese people felt they had few options to tackle their weight problems. But combatting obesity holds the promise of economic benefits, improved livelihoods – and ultimately saved lives.

**Sky-high expectations**

Last year, doctors granted more than 5 million prescriptions for key weight-loss drugs – a 2,000 percent increase from 2019, according to Komodo Health, a healthcare data-insights platform.

In the first six months of 2023, our obesity care grew by 157 percent at constant exchange rates, mainly driven by Wegovy® in the US,” a spokesperson from Novo Nordisk wrote in an email statement. The drugmaker is proud of its blockbuster drug. “Wegovy represents significant innovation for obesity treatment,” the spokesperson highlights. In phase 3 clinical trials, Wegovy led to an average of 17 to 18 percent weight loss over 68 weeks. Data shows the drug reduced the risk of major adverse cardiovascular events by 20 percent, according to the company.

“Teasing Ozempic to people with diabetes, who prefer it over other drugs due to its weight-reducing properties. Weight-loss drugs provide a solution for patients who are not overweight enough to undergo surgery, like Lang, and with a weekly jab, it’s less invasive too.

Wegovy allowed Lang to continue eating and drinking as he used to. He asked himself: “What’s the worst thing that can happen? Nothing. I can just go off the drug,” Lang concluded. He never experienced any issues.

But patient excitement may be grounded in the fact that risks are not discussed enough, says Kimberly Dennis, a doctor specialised in eating disorders.

Dennis says there have been aggressive marketing campaigns from Big Pharma. “I get suspicious when Big Pharma advertises drugs at bus stops,” she says. Novo Nordisk and other drugmakers have been criticised for lobbying doctors and insurers, as well as running biased educational campaigns for patients.

**Doctors warn about hitting a weight plateau; the body acclimates to the drug and establishes a new normal.**

“There’s a lot of excitement amongst people with diabetes,” says Tanja Thybo; head of research at the Danish Diabetes Association. She says general practitioners experience pressure to prescribe Ozempic to people with diabetes, who prefer it over other drugs due to its weight-reducing properties.

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Doctors warn about hitting a weight plateau; the body acclimates to the drug and establishes a new normal. “If you stop taking the drug, you’ll regain weight,” Thybo explains. These drugs are thus intended for lifelong use.

In our fat-phobic society, weight-loss drugs may reinforce weight stigma. Sylvia Weiser, who runs an obesity clinic near Frankfurt, fears the drugs will be misused by individuals who are not obese. “The body adapts to the drugs. Giving the medicine to people without disease may actually cause the disease,” she says.

Weiser says obesity must be recognised as a disease. “People often think it’s just about lifestyle and mindset, about willpower. That’s simplified and wrong.” She says underlying biology can keep people from losing weight, and that gut hormones are responsible for most obesity cases. It’s often because of miscommunication between the brain, the gut, the liver, and the pancreas. “The body simply won’t accept weight-loss,” she says.

“For you have a disease, medicine will help,” Weiser says. “Medicine is a way of accepting obesity as a disease.” She says obesity must be recognised as a disease. “People often think it’s just about lifestyle and mindset, about willpower. That’s simplified and wrong.” She says underlying biology can keep people from losing weight, and that gut hormones are responsible for most obesity cases. It’s often because of miscommunication between the brain, the gut, the liver, and the pancreas. “The body simply won’t accept weight-loss,” she says.

“Patient safety is a top priority for Novo Nordisk,” the company spokesperson writes, explaining that Novo Nordisk collaborates closely with authorities. “EMA continuously monitors for safety signals and so does Novo Nordisk. Novo Nordisk remains confident in the benefit-risk profile of the products.”

Dennis however fears these drugs are too radical for many patients, and that they’ll create severe addiction problems. “Like what we saw with the opioid crisis.”

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**Risks and rewards**

Since July 3, several weight-loss drugs are undergoing a review by the EMA, after reports about successes amongd users. In an email response, the EMA says the review is expected to conclude in November 2023.

Nausea, diarrhoea, vomiting, constipation, and stomach pain have been reported as common side effects of the weight-loss drugs. The drugs also come with warnings about more serious side effects such as increased risk of thyroid cancer, inflammation of the pancreas, gallbladder issues, low blood sugar, damage to kidneys and retinas, and suicidal thoughts.

What awaits

However effective these drugs are at treating obesity, we need to intervene earlier, according to Dennis. Structural inequalities like limited access to affordable healthy food, limited access to quality healthcare, particularly mental health care, and limited access to green spaces to exercise for some population groups exacerbate obesity issues.

But the drugs are not here to tackle the root causes of obesity. They’re here to profit from the treatment of it. While there’s a huge potential to help obese patients, there’s a need for caution too.

“This looks different for each patient. Why they’re obese and how they’re best treated,” Weiser says. She hopes there’ll be more research on the topic and better patient and doctor education.

For Philipp Lang, the drugs have made his life better. But perhaps the pharmaceuticals’ promises won’t hold for everyone.

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**About Mie Hoejris Dahl**

Mie Hoejris Dahl is a Danish freelance journalist based in Mexico City, Mexico. She reports on politics, economics, health and social issues.
Who cares?

Europe’s future health problems are here today, emphasising the need for policy makers to focus on providing more avenues for caring for an ageing population.

By CHARLES EBIKEME
Across Europe, over the last 50 years, life expectancy has increased considerably. Europe is getting older, and people are living longer. By 2050, those aged 65 and over are expected to make up one quarter of the population in Europe. Most babies born since 2000 in France, Germany, Italy, and other developed countries are expected to live to celebrate their 100th birthdays. The projected population pyramid, as a result, will look top heavy. As such, the health challenges faced by the population is going to see a dramatic shift.

The paradox at play is that better health has been the main driver of increased longevity of people in Europe, while living longer comes with additional health problems such as cardiovascular disease, diabetes, lower-back complaints, arthritis, leg ulcers, hypertension, and asthma. Diseases previously thought of as ‘silent’, such as type 2 diabetes, hypertension, and some cancers, now get diagnosed earlier and receive better treatment than before. Overall behavioural changes in lifestyle over the years, including reduced exposure to carcinogens such as tobacco smoke have also contributed to increased longevity in the population.

This overarching shift means health systems now must focus less on acute care and the prevention of premature death to focusing on providing a continuum of care that promotes health across the life course. With an ageing population, the ‘care’ in healthcare needs to become more prominent, experts say.

Confronting inadequacy

According to the World Health Organization, within the European Region 135 million people are living with disabilities, and nearly one in three older people cannot meet their basic needs independently.

“The lessons of the pandemic are clear. But are we better prepared now to face a challenge of this scale? What we know is that we need to invest more in our health systems, including in the way we deliver long-term care to those who need it,” said Dr Natasha Azzopardi-Muscat, WHO Europe’s Director of Country Health Policies and Systems.

The COVID-19 pandemic exposed the vulnerabilities of care systems, including inadequate long-term care services and poor integration with health-care delivery. In the European Union alone, the initial waves of the pandemic resulted in approximately 200,000 deaths among residents of long-term care facilities.

“Medical care can’t address the many issues that we are facing right now,” explains Alfonso Lara-Montero, CEO of the European Social Network, a pan-European network for public authorities with responsibility for social services. “We need to put in place a system which as much as possible supports people in their communities, in their homes, and in their communities by creating an ecosystem of care”.

Such demographic and epidemiological transitions that are taking place in Europe suggest a potential problem of resource allocation to the health care sector, and more concretely expose a current lack of staff in the service sector, with subsequent consequences for the future design of healthcare workforces and services.

Integrating care

In 2018, the European Commission undertook a study of national policies on long-term care. The report found that in most countries, long-term care for the elderly is not a distinct social policy field, with provisions characterised by a fragmentation of responsibilities and consequently a lack of integration between health and social aspects of care provision. As such, there is a lack of formal long-term care facilities across much of Europe, leading to a high incidence of informal care.

Across Europe, many actors are pushing for more integrated delivery of care – when people can access the care they need in a timely and comprehensive way, with services ranging from prevention, treatment, long-term care to rehabilitative or palliative care.

“Some choices have been made at a policy level to significantly invest in secondary and specialist health care, but not in community care. Community care includes both health and also social care,” Alfonso explains. Investing in community care allows for more work on prevention, which in turn prevents older people from being hospitalised.
Within Europe, the split between formal, informal, community, and facility-based care differs from region to region. Home care services and community-based care are often the most difficult to access, since they are underdeveloped in many countries. Home and community-based services are most developed in the Nordic countries such as Denmark and Finland, while countries in the southern region face insufficient availability of home care provision. One of the consequences of the priority given to home care and community-based provision has been that the availability of residential care has been decreasing in several European countries over the past 25 years.

“Population ageing is often treated as a threat to the sustainability of health systems. As such, policies are often framed around reducing overall costs and the financial burden to states. In 2021, the Economic Policy Committee produced a set of long-term projections of age-related expenditure, finding that age-related expenditure as a share of GDP is projected to increase in coming years, driven by long term care and healthcare. However, analysis done by the European Observatory on Health Systems and Policies explored the possibilities of ‘win-win’ politics that produce good outcomes for people of all ages, with a focus on embracing social determinants of health and allowing economic productivity even at old age.

In order to keep healthcare systems affordable and sustainable, governments are increasingly taking into consideration the reliance on informal care provided by family members, friends, or neighbours. The assumption is that more emphasis on this type of informal care will eventually alter societal norms towards more family responsibility in care provision, so that people will become more inclined to take care of ageing family members themselves.

Informal care has been estimated to have an economic value equivalent to 50 to 90 percent of the overall cost of long-term care across the EU. Researchers estimated that around 80 percent of all care received by people of all ages in the EU is provided by informal carers – of which two thirds are women.

Gender inequalities are a constant challenge in health delivery, and even more so in the context of ageing. The devaluation of care work and the fact that women deliver the majority of both paid and unpaid care are as a result of structural power imbalances that should be addressed in policy.

“This is a human rights issue,” explains Alfonso. “We talk about the European social welfare model. So let’s make sure in the first place that we are supporting people in the best possible way.”

Alfonso Lara-Montero
The EU’s ongoing revision of the General Pharmaceutical Legislation has the potential to impact healthcare across Europe for decades to come.

I am committed to helping this revision be a success and I think to do so requires EU legislators, the life sciences industry and all involved to recognise our interdependence in providing the best possible healthcare for patients.

It is only if the solutions in this legislation work for all that Europe will have a future characterised by high quality healthcare. One prerequisite is the presence of a strong innovation sector across Europe. This boosts patients’ health through access to the latest innovations and heightens EU competitiveness on the global stage.

Currently, whilst almost all parties are united in their belief we need to improve access to care in Europe, there are clear signs that more openness and collaboration is needed before a pragmatic way forward can be found.

Unfortunately, as it stands, some of the proposals, whilst laudable in ambition, are simply not practical. To give an example, the EU is proposing to remove two years of regulatory data protection (part of intellectual property protections) from any product that a pharmaceutical company fails to launch in all EU member states within two years of receiving marketing authorisation.

No one could disagree that we should take steps to address the considerable delays in access to innovation we see in some areas of Europe. The problem with this proposal is that it is not solely within the gift of the life sciences sector to make it happen. While filing for new medicines is our responsibility, the speed of the final reimbursement decision is not down to us alone. It is dependent on many local factors such as a country’s health technology assessment (HTA) process, and the availability of clinical expertise and budgetary processes.

We therefore believe it is unrealistic to expect new products to become available in all 27 member states within two years. Our counter-proposal – as part of our membership of EFPIA – is for innovators to commit to file future products for reimbursement within two years in all EU countries. This is something the industry can control and deliver on.

As mentioned before I believe that we are all trying to achieve the same outcome with this new legislation: excellent healthcare for the citizens of the EU. I believe, too, that we face similar challenges: economic downturn, inflation, instability of war, forcing us all to prioritise budgets and spending even more than before. I therefore believe that the impractical elements of the EU’s proposed reforms are not down to different ambitions, but instead because we are not working closely enough together to design solutions that will truly improve patient access in Europe.

We know that when industry and policymakers engage closely, it can be transformational for patients. For instance, the life sciences industry recently worked closely with the EU Commission to examine the European Medicines Agency’s review processes. This has now resulted in the introduction of faster and more flexible methods when the EMA assesses highly innovative products. This welcome move has the potential to speed up patients’ access to the most life-changing innovations.

My call therefore is for EU legislators and the life sciences industry to use the coming months to work together to revise the proposed reforms to the General Pharmaceutical Legislation, ensuring that the final text provides a sustainable and competitive environment for life sciences innovators across Europe that enables a true change for patients.

Europe has long had strengths that set it apart from other parts of the world, from excellent scientific talent to expansive health coverage for citizens.
In March 2020, following a statement from the World Health Organization, Europe began to shut its borders for the first time in over 70 years. Airports like Paris Orly, Dusseldorf and Heathrow saw planes grounded, sitting idle. Little thought of airport equipment on misused laneways arose when it became apparent that we were all for now immobile and in quarantine. Schools, offices, cities and countries shut down. COVID-19 resulted in millions of deaths. Unprecedented pneumological symptoms and medical ineptness filled up hospitals, funeral parlours and cemeteries.

When the pandemic hit, European Commissioner Stella Kyriakides was just one year into her term as Commissioner coming from a Council of Europe (CoE) Parliamentary Committee on social affairs, health and regional development. Her largest project focused on child sexual abuse. But even as far back as 2014 and 2015, when her term at CoE began, she would wear a pink beat cancer button on her lapel. Earlier still, in 2004, she had been President of the European Breast Cancer Coalition.

“We are not where we were three years ago,” the Commissioner says, when asked about the EU’s post-pandemic situation. “But we need to remain cautious and vigilant. The virus is still with us. Our protection is now significantly better, but it is still circulating and evolving, and some uncertainty remains,” Commission Kyriakides said. Overall spending on healthcare-related measures that member states committed to through their national Recovery and Resilience Plans amounts to over €43bn. This is an important investment that can make a real difference and clearly shows that health is a priority in the EU.

The European Union pulled together and pooled purchases of covid vaccines, which on the one hand seemed to make these vaccines more readily available, but on the other still raises questions on the methods used. The Commissioner sees this only as a strong spirit of cooperation developed among the EU’s member states during the pandemic.

“We saw how much more we can do together in the area of health. This is where the project to build a strong European Health Union was born. Our Vaccines Strategy is the most evident case in point – both in its real-world impact in terms of lives saved, but also in terms of how we should move forward in tackling the pandemic and so many other challenges in the area of health,” Commissioner Kyriakides says.

“At the end, we have taken our biggest challenges and made them into an opportunity to redefine EU health policy,” she says.

Learning from her long – more than 27 years – of medical history and involvement in fighting cancer, we asked the Commissioner about the mRNA vaccines that have resulted from this pandemic necessity and the EU’s investment. What would their role be in developments for future health challenges?

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What would their role be in developments for future health challenges?

“During the pandemic, we saw very clearly the important potential of mRNA technologies. A scientific and industrial endeavour made in Europe, for the world. A discovery that provided the basis for millions of the lifesaving COVID-19 vaccines, and have proven to be adaptable to different variants of the same disease.

“We should recall that the discovery of the COVID vaccines was developed on the experience of developing mRNA vaccines for cancer. Because of its adaptability, there is also a possibility that this technology could be used for personalised medicine tailored to the needs and characteristics of each patient,” the Commissioner said.

A clear example of this is happening currently, with several vaccine manufacturers building on the COVID experience to conduct research into mRNA vaccines for cancer.

Of course, there is still work to be done to fully ascertain the viability of mRNA technology for these purposes, but based on the COVID vaccine model, there are signs of promise.”

### About Alia Papageorgiou

Alia Papageorgiou is President of Press Club Brussels Europe, she has worked as a journalist in Australia, Greece and Belgium covering the EU.
For people living with a rare disease, it can take at least five years to get the right diagnosis — but that timeline could get a lot shorter if a European Union-funded effort succeeds.

Rare diseases affect more than 300 million people worldwide, including more than 30 million in Europe, and delayed diagnoses can make it harder for patients to find relief, given treatments are also scarce. There are more than 6,000 known rare diseases worldwide, yet only 5% have at least one approved treatment.

In order to be catalogued as a rare disease in the EU, the condition must affect fewer than 1 in 2,000 people. These diseases include forms of neurological conditions, intellectual disabilities, some cancers, autoinflammatory diseases and other health issues, and they can be disabling and even life-threatening.

A European collaboration called Screen4Care bets on genetic testing and new tech to speed up diagnoses for rare diseases.

By GABY GALVIN

For people living with a rare disease, it can take at least five years to get the right diagnosis — but that timeline could get a lot shorter if a European Union-funded effort succeeds.
A new approach

Now, a European collaborative is working to detect rare diseases earlier through a two-pronged strategy called Screen4Care.

The first arm involves deploying widespread newborn genetic testing to identify babies who may develop rare diseases, 72 percent of which have genetic origins. The second prong is to use artificial intelligence (AI) to create a meta-symptom checker for patients struggling to understand their complications, and to flag patients at risk for rare diseases based on their electronic health records.

The five-year, €25 million project launched in late 2021 and has about three dozen academic, government and industry partners across 14 countries. Governed in part by patient advocacy groups, housed by the Innovative Medicines Initiative and funded by the EU and the European Federation of Pharmaceutical Industries and Associations, Screen4Care aims to create a framework for rare disease detection that can be adapted across the bloc and beyond.

The goal is to deliver “trained and tested” algorithms that can flag at-risk patients based on their medical records before the project wraps in 2026.

“More diagnosis will lead to more research and overall improving outcomes for so many rare disease patients that don’t have a treatment, that don’t have a care path,” said Nicolas Garnier, patient advocacy lead for rare diseases at the pharmaceutical giant Pfizer and Screen4Care’s EFPIA project lead.

After a couple of years in the planning and development phase, the group is preparing to launch five clinical trials early next year to test the newborn screening tool in Germany and Italy.

Heel prick 2.0

Newborn genetic testing is a tried-and-true public health tool – the heel prick test has been practiced since the 1960s – but the Screen4Care trials will look for several hundred rare diseases, aiming to make newborn genetic screening cheaper and thus more broadly accessible.

Meanwhile, the consortium is rethinking its second prong, which focuses on AI and machine learning, given the explosive growth of generative AI tools in 2023. The Screen4Care initiative was initially dreamt up in mid-2019, and Garnier said he wants to “future-proof” the AI tools to prevent them from becoming obsolete as that technology evolves. The goal is to deliver “trained and tested” algorithms that can flag at-risk patients based on their medical records before the project wraps in 2026.

At that time, Garnier said the consortium will present EU policymakers with a list of recommendations to expand on its work. One key policy area is equity, given gaps in rare disease detection are stark even within Europe. As of 2022, Italy screened newborns for more than 45 diseases, for example, while France tested for fewer than ten and Romania and Cyprus looked for only two diseases in their national programs.

“Even right now, with similar technologies available across different countries, the adoption is really different,” Garnier said.

That’s due largely to public policy. The logic follows that if a disease isn’t treatable, don’t screen for it, Garnier said. But he wants these conditions to be identified anyway, to better understand the size of the patient population for specific rare diseases and to incentivise drug companies to invest in research and development to treat them.

Equitable detection

Over time, regional disparities could become even more apparent across the globe. Within ten years, Garnier said that widespread genetic newborn screening will likely be commonplace in the EU and the U.S., but that some countries could fall behind due to a lack of resources.

The Screen4Care program is internationally adaptable, Garnier said, but its long-term success will depend on policy efforts to prioritise rare disease diagnosis – the first step toward widespread access to treatments for the millions of people globally living with rare diseases.

“Science and innovation are going to move a lot faster than policy – that’s not new,” Garnier said. “The limiting factor is really going to be policy. That will be the challenge, and that will be the deciding factor for what rare disease diagnosis looks like in 2033.”

More diagnosis will lead to more research and overall improving outcomes for so many rare disease patients that don’t have a treatment, that don’t have a care path

Nicolas Garnier

About Gaby Galvin

Gaby Galvin is a freelance journalist based in Amsterdam. Her work has appeared in Euronews, U.S. News & World Report and Healthcare Brew, among others.
Europe has faced numerous global health challenges in recent years, with the COVID-19 pandemic being the starkest reminder of our vulnerability. While SARS-CoV-2 has demonstrated that we cannot stop the evolution of viruses, it has also highlighted the importance of safeguarding our healthcare systems.

Today, there is another looming threat that demands immediate attention from European government and industry stakeholders alike: Disease X.

The concept of Disease X arose from the recognition that new infectious diseases can emerge unexpectedly, as demonstrated by previous outbreaks such as MERS and COVID-19. Its possible emergence arises from the constant evolution and adaptation of pathogens, increased global travel, urbanisation, changes in human-animal interactions, and other factors that can facilitate the emergence and spread of novel infectious diseases such as climate change.

In 2018, the World Health Organization (WHO) identified priority pathogens that could cause deadly future pandemics, such as Zika, Ebola, and ‘Disease X’. In parallel, the scientific initiative Global Virome Project identified around 1.67 million unknown viruses, including 827,000 that had the potential to be transmitted to humans.

Defined as “an unknown pathogen that could cause a serious international epidemic,” Disease X stands out as a global public health challenge.

To anticipate uncertain but potentially dangerous epidemics, healthcare organisations must prepare to provide a sustainable response to a scenario that could become a reality sooner than we think. Key technologies and innovations should be leveraged towards this objective, including mRNA technology for vaccine development, which has proven its value and potential during the COVID-19 pandemic.

mRNA technology is one of the major keys to preventing future pandemics. The value of mRNA lies in its ability to rapidly adapt to new viral strains, making it a vital tool in the fight against emerging variants and pathogens.

Furthermore, mRNA technology offers several advantages, including faster development timelines, scalability, and improved safety profiles compared to traditional vaccine approaches. Its versatility enables rapid response to future pandemics, as scientists can quickly design and manufacture mRNA-based vaccines tailored to specific viral threats. The profound impact of mRNA technology on pandemic preparedness cannot be understated, making it a cornerstone in our collective efforts to safeguard public health.

While the potential of mRNA is extensive, pandemic response begins with pandemic prevention. To this end, at Moderna, we have a broad portfolio of vaccine programs that target emerging or neglected infectious diseases that threaten public health. Those include respiratory threats with high pandemic potential, like influenza and beta-coronaviruses, and pathogens identified by WHO and the Coalition for Epidemic Preparedness Innovation that frequently cause localised outbreaks and inform future preparedness for Disease X. By the end of 2022, Moderna had 12 Global Public Health programs in research and development.

Other actions we have taken to improve pandemic preparedness include the creation of a collaboration-based program, mRNA Access, allowing disease experts around the world to translate their understanding of immune markers of protection into effective mRNA vaccines. Researchers can utilise Moderna’s mRNA technology platform to pursue research in their lab to design novel vaccines against emerging and neglected infectious diseases. As of today, 15 geographically dispersed institutions are participating in the program.

A key pillar of our global health strategy is building regional manufacturing capability. We have previously announced plans to build facilities in Australia, Canada, Kenya, and the United Kingdom, which can be deployed in response to a pandemic outbreak.

One of the key aspects of our mRNA platform is that a single manufacturing facility can be used to manufacture any of our mRNA medicines. Specifically in Europe, Moderna has worked closely with established contract manufacturers in Italy, Spain, and Switzerland to set up a manufacturing and supply network in the region. Spain has since matured into Moderna’s largest end-to-end production hub outside the US.

The world must learn from past experiences and prepare to act faster when faced with the next pandemic. As recently witnessed, mRNA technology offers a potential solution in the fight against future pandemics and Disease X, providing a versatile and effective defence mechanism. Our responsibility is to collaborate and work to maximise its potential to build resilient healthcare systems capable of combating future threats and safeguarding public health.
A candid talk with ECDC chief Andrea Ammon about communicating in times of crisis, and how to build trust when things calm down.

BY ALEJANDRO TAUBER

European Center for Disease Control (ECDC) chief Andrea Ammon spoke candidly about how her organisation is preparing itself to help the EU be prepared for the next pandemic.

Ammon has been heading up the ECDC since 2017. Trained as a medical doctor, and specialised in public health, she is an alumni of the first cohort of the field epidemiology programme (EPIET) offered by the ECDC. She joined the organisation in 2005, building the European surveillance system, and slowly making her way to the top job.

The ECDC was thrust in the spotlight during the COVID-19 pandemic, and since then has seen its mandate expand through new regulations.

Our conversation ended up revolving around communication, and what both the ECDC and the media could do better in – hopefully not anytime soon – a next pandemic.

Alejandro Tauber: I’d like to briefly talk about new regulations and changes to the ECDC mandate. Can you run me through some of the policy changes we’ve seen since the pandemic?

Andrea Ammon: The serious cross border health threat regulation aims at regulating all the different elements connected to health emergencies. That starts with the surveillance, the laboratories, but then also the response to emergencies. So that’s the risk assessment and risk management package. Now, our regulation is tailored for the ECDC, and it has a lot of cross references to the serious cross border health regulation.

So a lot of what is in the serious cross border health regulation actually refers to...
The particular emphasis now, which has been evolving in the past year, is the emphasis on the workforce.”

Andrea Ammon

What were some key lessons learned from the pandemic?

We must enhance our surveillance, and improve preparedness and risk communication. The particular emphasis now, which has been evolving in the past year, is the emphasis on the workforce. Every country has experienced the same scene – the health workforce has massive issues. There are people leaving the service due to burnout, and we have the looming prospect of not going to retire in the next five to 10 years, without sufficient supply in the pipeline.

That is verging on labour communication, or maybe workforce policy, rather than infectious diseases. Exactly. That is where our mandate and our influence is limited. Of course we can advocate, and that’s what I’m also doing. But in the end, the real turning of the tide can only be done with policy changes in the countries that we cannot do ourselves. Although we can of course provide training for people that would like to be specialised in public health. But we cannot, you know, change the salary structure, the career perspective, the working conditions, that is something that has to happen in the national systems.

That must be frustrating to see. Well, when you come to work for an agency like this, you know where the remits of the mandate lie. And then you have to work within these remits and see how you can advocate for anything that you find important for the mandate.

That’s really interesting. The pandemic has shown that the remit of the ECDC expands quite a bit beyond the gathering of relevant data and the coordinating and communication of responses to that data. So for example, on infectious diseases, into the realm of communication – the more soft science of bringing across a certain scientific message or a way to evaluate risk for both public health officials but also for citizens. Has that changed the organisation a lot? It has brought some changes, yes, especially in the way we do our work, not so much in the substance that we are dealing with. There is an article on communication in the new Founding Regulation that has actually not changed.

However, there are other elements in the regulation, which influenced the communication. For instance, that our mission statement has been expanded not only that we identify, analyse and communicate threats to human health from infectious diseases, but we also make reports thereof available and easily accessible.

This ‘accessible’ doesn’t mean that we put it free of charge on the website, but that they are also formulated in a language that politicians and policymakers understand. So here we have to change our communication.

We are a scientific organisation, and we have our scientific reports, but we have to now add a summary with key messages for public health decision makers, so that they can be used to actually implement and apply in public policy and practice.

Right. So messages like, for example, like ‘flattening the curve’, which were very successful, but it was making the communication around masking which was slightly less successful. Well, I think we have positive and negative examples in abundance over the three years. I think it’s not about slogans only, it’s really about explaining. And that is why, when you have seen our lessons learned document, one of these four lessons that we put forward is Risk Communication and Community Engagement.

And I think this community engagement was something that really did not work very well in most places. People at one point during the pandemic had not understood why they still had to wear masks, stay at home, keep that distance, get tested, and so forth. That is where I think our messaging should help. It should help local politics to translate this to the general population, but also then to specific populations, like young people, for instance.

What do you base best practices on? Is there actually a lot of science around effective communication during public health crises and community engagement? Is there something that you can fall back on? Yes, there is. And that’s the interesting part, that the fact that it hasn’t been used to its full potential is not because there is no science behind it – there is science. But these scientists were not necessarily part of the crisis groups. More and more countries have recognised that social scientists, risk communicators, ethicists, behavioural insight specialists, should be part of the crisis team. And we have also now assembled a small team here at ECDC that deals specifically with that.

Risk communication is a very difficult thing to do I can imagine. Risk is dependent on a lot of variables, and bringing across a complex message is very challenging for the general public to understand. So for example, I didn’t know the risks for someone over eighty when vaccinated are vastly different from those for a person over 60 who is also vaccinated. I think that tailoring specific messages like that must be very complicated.

Yeah, and I think that the risk communication has to evolve during the course of such a crisis, but it’s important that it starts at the beginning with clarifications that everybody can understand.

At the beginning of the pandemic, these differentiated weren’t even possible, because we didn’t know about all the different risks to different people.

And that, I think, has to be very clearly said at the beginning. What is known, what is not known, where there is evidence and where there are decisions based on analogy with similar infections. I think people can understand that there is an evolving situation, so that the fact that one day, they hear one message, and the next day something else, is not necessarily interpreted as ‘they don’t know what they’re doing’.

That touches on something else as well, because up to now, we’re talking about proactive communication based on evidence. But another phenomenon that the pandemic showed was that the importance of reactive communication to counter explicit misinformation is also a huge part of public health communication.

That is true, part of this risk communication is also health education, in which the basics are explained to the population. In general, if we could increase the health literacy of the public, then misinformation would have a bit of a harder time getting through. But that is of course, not something that you can do in a crisis, that is something that needs to be built into the preparedness.

My background was in science journalism. And if I know one thing, it’s that it’s very hard to interest people in something that is not going on at that moment, but that might have importance later. Is raising the bar for public health knowledge among the citizens part of the next pandemic preparedness plan? In my view, it should be a chapter in the pandemic preparedness plans that are now being looked at and reviewed. And in terms of people not being interested, we have to learn a bit from advertising, because in the end it concerns them as persons. Moreover, we have health issues ongoing with mosquitoes, with climate change, with West Nile virus, with influenza, with measles. These diseases are there, and we could use each of these as opportunities to take aspects of health to help people become more in-depth informed.

Right. What role could the media play in that? And how could they do better? It’s not just the media of course who could do better, but it’s also from the scientist’s side. Some initiatives have to go out into media briefings, so that it’s not just a sensational story to report, but also to help inform the media so that they know where certain pieces of information fall into.

I think this is something that we probably will not succeed one hundred percent. But you have to try your best and see what could reasonably be done to put out trustworthy information. Even when there is weak evidence there, so that people know that we are not fabricating things. And that is a reputation that you have to build in non-crisis time, so that you can count on this in times of crisis.

About

Alejandro Tauber

Alejandro Tauber is publisher of EURobserver, and previously was editor at VICE’s Motherboard, and publisher of TNW, with a background in science and tech reporting.

“IT’S NOT JUST ABOUT SLOGANS”
Preventing the death of 200 people per hour

Preventing cardiovascular disease – a cost or an investment in EU health resilience?

By HASEEB AHMAD, President, Europe, Novartis.

What would you say if I told you that we could invest in healthcare now, potentially save the lives of 200 people an hour dying of a preventable disease, and spend less in the long run?

Because we can. Cardiovascular disease (CVD), a collection of conditions affecting the heart or blood vessels, is the leading cause of death and disability in the EU.

Up to 80% of CVD, including heart disease and strokes, can be prevented by investing in early detection and treatment, which saves lives and lowers overall costs. Without a systemic mindset shift, however, putting prevention into practice is anything but straightforward.

As it stands, there’s still a tendency to think of money that goes into managing a chronic disease as a cost, rather than an investment with real returns for people, the sustainability of the healthcare system, the economy, and society.

The shift in focus from treating CVD-related illness to preserving wellness can take many forms, from realigning hospital incentives, to implementing routine screenings, to leveraging data to identify at-risk populations. And no single organisation can take these transformative steps alone.

Genuine change also requires policy support, and the upcoming revision to the EU Pharmaceutical Legislation could be just the opportunity. With the right amendments, the legislation can help the EU’s life-sciences ecosystem evolve, supporting competitiveness, innovation, and better, more equitable healthcare across Europe.

CVD’s economic cost

For households throughout the EU, the workplace is an essential source of financial security – particularly amid continued economic challenges. But the impact of diseases like CVD means too many are denied the ability to work. This is an avoidable hit to households’ financial security and the overall EU economy.

According to the 2023 Economic Burden of Cardiovascular Diseases in the European Union study published by the European Heart Journal, the cost burden CVD puts on the EU economy is massive, standing at around €282 billion every year. Yet only 55% of that sum (€155bn) goes to healthcare costs. Productivity loss (17%) and informal care for people living with CVD (28%) make up the remaining €127bn.

In fact, a London School of Economics (LSE) report “Trends in Avoidable Mortality from Cardiovascular Disease in the European Union” published in April 2023, found that the largest portion of avoidable deaths from CVD occur among the working-age population. All in all, this amounts to 2.43 million years of lost life.

In Europe, an average patient with acute coronary syndrome lost 59 (37-79) workdays. Caregivers lose 11 (0-16) workdays every year, with a total mean indirect cost per case of €13,953 (€6641-€23,160).

Surely we cannot afford to be complacent about losing workers due to treatable conditions?

No household should be made to bear the brunt of this financial loss, and the impact stretches beyond the household to the wider EU economy. As the population of older people living in the EU grows, so too will the need for EU countries to maintain a strong active workforce that contributes to the tax base and funds welfare commitments.

The best way to avoid the economic loss related to CVD is to prevent chronic illness and premature death in the first place. And that starts with an investment in early identification and treatment.

Prevention’s return on investment

Yes, prevention costs money, but it pays off in the long run. If we prevented half of the EU’s CVD events, the bloc would see an annual GDP growth of 2%, according to research by the WiFor Institute. Similarly, a global report by McKinsey concludes that every $1 invested in known health improvements can generate up to $4 in GDP in return.

These gains can go a long way in strengthening Europe’s health systems and societies more broadly. COVID-19 won’t be the last pandemic the world faces, and CVD isn’t the only chronic disease that burdens healthcare systems. In the long run, savings made from preventing CVD can be reinvested into building more resilient healthcare systems that are better prepared to withstand shocks and manage future challenges.

At Novartis, we’re ready to play our part, partnering with governments, businesses, and civil society organisations to help make CVD prevention possible.

Haseeb Ahmad, President, Europe, Novartis.
Keeping an eye on AI-powered drugs

The European Medicines Agency is exploring ways to regulate how artificial intelligence is used to find and develop new drugs and medicines.

By GABY GALVIN

Medicines created using artificial intelligence could be coming to a pharmacy counter near you – but just how soon depends on whether they live up to the hype in clinical tests.

AI may have become the buzzword of 2023, but major pharmaceutical companies and startups alike have been investing in the tech for years. In 2020, Britain-based Exscientia became the first company to launch human tests for an AI-designed drug molecule, with the hopes of treating obsessive compulsive disorder. Since then, dozens of AI-powered drugs have entered clinical trials, and many more are on the way.
The British-Swedish AstraZeneca $1.2 billion pact with Atomwise to sort deals to expand their AI capabilities. Pharma giants have announced major opportunity, pouring at least $10 billion into AI research and development, only for many to fail during clinical trials.

Money pours in

Investors have taken note of the opportunity, pouring at least $10 billion into startups targeting AI in early drug development since 2019, while European pharma giants have announced major deals to expand their AI capabilities.

France’s Sanofi, for example, inked a $1.2 billion pact with Atomwise to sort through small molecules in 2021, while the British-Swedish AstraZeneca expanded its partnership with the United Kingdom’s BenevolentAI to hunt for treatments for systemic lupus erythematosus and heart failure, in addition to chronic kidney disease and xiphoid pain.

As of 2022, there were nearly 270 companies working on AI-powered drug discovery around the world, with Western Europe serving as a growing hub, according to consultancy firm McKinsey & Co. “We believe that there is huge promise from artificial intelligence in terms of medicines development,” said Peter Arlett, head of data analytics and methods for European Medicines Agency, which oversees pharmaceutical products for the European Union. Notably, the use of AI for drug discovery is generally considered low-risk because if a potential medicine fails, it fails in a simulation, not a patient. Instead, AI likely poses a greater risk in later stages of drug development given the potential for ethical issues, risks of human bias to work their way into algorithms or flawed data analyses that are used in a drug’s application for regulatory approval.

Regulating pharma AI

As pharmaceutical companies lean more heavily on AI across the therapeutic pipeline, regulators are catching up to ensure these tools are used safely. The EMA published a draft paper this summer on the path forward for AI in drug development, and will hold a workshop in November to solicit feedback from the pharma sector and other stakeholders.

“We see it as the start, the very start, of [AI] guidance and regulation in the pharmaceutical sector,” said Arlett, who is also co-chair of the EMA’s Big Data Steering Group.

Money pours in

There is a surfeit of AI and machine learning models to sort deals to expand their AI capabilities. Pharma giants have announced major opportunity, pouring at least $10 billion into AI research and development, only for many to fail during clinical trials.

Just from drug discovery to clinical development, that span is about five and a half years,” said Aarti Chitale, a senior industry analyst for health care and life sciences at the advisory firm Frost & Sullivan. “Some of the leading AI vendors are able to bring that duration down to only about 18 months.”

The industry responds

The industry is keeping tight-lipped ahead of the November workshop, though executives from some leading firms, including Exscientia, have pushed back against proposals to establish AI-specific drug discovery regulations.

In a statement, the Brussels-based trade group European Federation of Pharmaceutical Industries and Associations said that new AI policies should “balance benefits and risks of AI while supporting and fostering innovation,” and that “we already have a robust framework for handling statistical and predictive models and software that will apply to many uses of AI in medicines development.”

Regardless of looming changes to the regulatory landscape, drugmakers still need to figure out how to bring AI-powered medicines to market – and prove that they’re more beneficial than existing treatments. Ultimately, clinical success will be the key determinant for how widely AI is used for drug discovery, rather than time or cost savings, as noted by the Boston Consulting Group.

Transforming pharma

In Europe, the use of AI isn’t limited to the early stages of research into potential blockbuster medicines. EFPIA, the drug industry trade group, said major pharma companies are “employing AI and ML approaches across the entire lifecycle of medicines development” – from drug discovery and manufacturing to safety monitoring and beyond.

About Gaby Galvin

Gaby Galvin is a freelance journalist based in Amsterdam. Her work has appeared in EuroNews, U.S. News & World Report and Health Care Brew, among others.
By DR. ERWAN GICQUEL, PHARM.D, MSC, HEAD OF EU GOVERNMENT AFFAIRS FOR MILTENYI BIOMEDICINE.

The missing piece of the puzzle

A regulatory environment that values innovation will put Europe at the forefront of global research in cell and gene therapies

...
Prescribing our way out: The EU’s fight against antimicrobial resistance

The silent pandemic that’s still too silent.

By CHRISTOPH SCHWAIGER

“It’s not going perfect,” said Danish MEP Pernille Weiss (EPP) about the EU’s fight against antimicrobial resistance (AMR).

With 35,000 citizens dying every year directly due to AMR, it’s an issue Europe is struggling to contain. Apart from the significant loss of life, it also hits economies hard, costing around €1.1 billion to the healthcare systems of EU/EEA countries. Weiss is the lead negotiator for the EU’s pharmaceutical directive. She also sits on the EP’s ENVI committee which deals with the topic of AMR.

Bacteria are said to be resistant when, despite being in the presence of antibiotics meant to kill them, they manage to survive and continue to cause illness. Similarly, parasites, viruses, and fungi can also develop a resistance to drugs that target them. In 2022, the European Commission designated AMR as one of three priority health threats.

Should the EU step in?

Despite the clear and quantifiable consequences of inadequate measures against AMR, a joint report by the European Centre for Disease Prevention and Control (ECDC) and WHO in 2019 found that...
As of 2017, the country visits have been conducted as country visits and will include a substantial part covering AMR, healthcare-associated infections, and infection prevention and control, with corresponding indicators. The methodology is under development, including for the AMR-related areas,” the ECDC spokesperson said.

Health First Europe, an alliance of patients, professionals, and the industry, finds that policymakers are becoming more aware of the threat of AMR. However, a spokesperson for Health First Europe described the situation as a “silent pandemic that is still too silent.”

Setting a deadline and threatening to take away a country’s authority isn’t an option that increased and coordinated. The MEP says the member states know what they have to do and that there are member states that can help others improve.

**Working together**

Countries aren’t completely left to their own devices. The ECDC has been visiting member states to discuss AMR issues since 2006. While a country’s efforts against AMR are assessed, the purpose of these visits is also to provide any assistance and exchange of knowledge that a state could benefit from. As of 2017, the country visits have been conducted jointly with DG SANTE to also consider the animal health and environmental aspects of AMR (the One Health approach). The results of a 2022 study on what barriers countries are facing to effectively implement their AMR policies “should soon be available” the spokesperson said.

**A silent pandemic**

A new set of assessments is scheduled to start in 2024 as part of the implementation of EU Regulation 2012/275 which was adopted with the aim of creating a stronger EU health security framework. By the end of 2024, all EU/EEA countries should have each received at least one visit.

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Asked about what its AMR Patient Group thinks about the robustness of the current national action plans in place, the spokesperson said they don’t comment on policies.

“We see our objective in raising awareness on AMR. We don’t take positions on policies. In our recommendations to policy-makers, which are part of our declaration, we demand clear actions by policy-makers to tackle the issue,” the spokesperson for Health First Europe said.

**Fighting AMR**

Health First Europe has three main proposals for the EU to strengthen its fight against AMR. These involve increasing awareness among patients and healthcare professionals, improving infection prevention and control measures, and investing in and promoting the use of medical technologies.

An emphasis on education has long been part of the global fight against AMR. Despite this, countries still struggle to convey some of the most basic facts about this pressing health issue to their citizens. Nearly two out of five (38%) respondents in the EU incorrectly think that antibiotics kill viruses, and more than one in ten (11%) indicate they do not know if they are effective against viruses.

“To address these knowledge gaps, what more can the EU do now that it hasn’t already done in the past? Weiss says the focus should be on educating both members of the public and healthcare professionals.

“I’m 55 so I was lucky to have learned the old-fashioned principles of hygiene in school. But we’ve lost a couple of generations where hygiene has not been part of the curriculum in schools,” says Weiss.

**Wash your hands**

It sounds like a simple measure but promoting hand hygiene and better hygiene in hospitals can more than halve a patient’s risk of death due to AMR.

Before entering politics, Weiss was a homecare nurse. “Today she sees a number of nurses jumping to conclusions that a certain infection needs to be treated by antibiotics. The MEP suggests that the EU should invest more in rapid test technologies that can help healthcare practitioners when they’re at a patient’s bedside to determine the best treatment plan.

“This would allow healthcare professionals to only use antibiotics when there’s nothing else they can do better, cheaper, or in a way that doesn’t create this resistance threat,” she adds.

While there is a consensus that all these measures are useful, it still remains critical to ensure timely access to both new and existing antibiotics. It can take 10–15 years and around €4 billion to develop a new antibiotic. Luckily, with advancements in the field of generative AI, the time and money required may be reduced.

“The key to a successful fight is cooperation. Every group, including pharmaceutical, medical, policy-makers or HCPs are part of the solution and we see fruitful discussions,” said a spokesperson for Health First Europe.

**Involving pharma**

Weiss sees that agreeing to say that the pharmaceutical industry has been very proactive and wants to be part of the solution.

The European Observatory on Health Systems and Policies said in a report that the EU has a major role to play by supporting antibiotic research and development saying that increased and coordinated funding at the EU level can support both push (e.g. grants and tax incentives) and pull (e.g. accelerated approval and liability protection) incentives.

The European Commission wants to introduce a system of transferable exclusivity vouchers to reward the development of novel antimicrobial products. These vouchers can be used to extend the time a more profitable drug from a company retains its market exclusivity.

Led by the Netherlands, 14 EU states came out strongly against this controversial proposal. While acknowledging that the current system of incentives had failed and that new ideas were required, they said such vouchers don’t directly incentivise the creation of new antibiotics and will actually stifle innovation. One of their proposals is for direct financial incentives, such as an increase in market entry rewards for companies that bring a product to the market.

**Prescribing our way out: The EU’s fight against antimicrobial resistance**

The coronavirus pandemic provided Europe with a wake up call, said Weiss, adding that the pandemic highlighted how vulnerable citizens with health complications become when AMR national plans aren’t functioning optimally.

Is it time for the EU to step in and take over? Weiss is optimistic and thinks that it’s still a matter of national competencies.

“I am a true believer of the member states as the best authority to have the responsibility for almost everything related to healthcare,” Weiss said.

An emphasis on education has long been investing in and promoting the use of prevention and control measures, and awareness among patients and healthcare professionals to only use antibiotics when there’s nothing else they can do better, cheaper, or in a way that doesn’t create this resistance threat,” she adds.

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**Overcoming the threat of AMR will require a multidisciplinary approach. For a solution to be truly effective, the approach will also need to be a global one. Herein lies an opportunity for the EU.**

“We could make the EU world champions in combating antimicrobial resistance. Because if we can make it in the single market where people, food, and animals can cross borders without increasing AMR, then the rest of the world can of course also learn from Europe,” Weiss believes.
Over half of journalists and campaign workers have had their accounts hacked. Google is partnering with the International Foundation for Electoral Systems and PUBLIC to provide cybersecurity tools and training to candidates, journalists, and election officials across Europe.

Learn more at safety.google/cybersecurity