



European Alliance for Personalised Medicine

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www.euapm.eu

May the workforce be with you...

Greetings, and welcome to our latest newsletter as we move into May. (Yes, already!)

Of course, 1 May is International Labour Day/International Workers Day (what you will), and was there ever a better year to celebrate key workers than this one?

With front-line healthcare workers and essential staff in other industries being regularly lauded and applauded, the need that we have for this largely under-rewarded and often unappreciated workforce has become blindingly obvious during this ongoing Covid-19 crisis.

We should all take some time on 1 May to put them at the front of our thoughts.

Of course, when May arrives, we start to think about summer not being far away. As it stands, this summer is not going to be anywhere like the same as any previous ones. Will we even get holidays worthy of the name? Certainly, travel outside of our own countries seems unlikely for many more weeks.

In the meantime, there's plenty to think about brought on by this novel coronavirus and the situation it has put us all in...

Things you didn't know you didn't know...

Most of us probably reckon that we know plenty about the novel coronavirus, or Covid-19, whether we wanted to or not. But do we?

Coming right up are five things that nobody knows for sure just yet, just to put things in perspective as we wander about our homes, or occasionally visit the shops in masks and gloves, in this 'new normal'.

Knee-jerk national lockdowns to stamp on the spread of Covid-19 seem to be working, but the economy and social interactions are basically in the bin for now.

Citizens everywhere are - perhaps prematurely in most cases - asking about exit strategies in general and when restrictions will start being lifted in particular. Some countries are sending kids back to school, some are reopening certain shops...it is not an EU-wide strategy and it all, quite frankly, can seem a bit random from anyone taking an overview.

It doesn't help that even our scientists - supposedly advising Europe's governments - have pretty substantial gaps in their understanding of all the aspects of Covid-19.

In the EAPM pipeline:

- **30 June: Bridging Conference, "Maintaining public trust in use of Big Data for health science" - Brussels, Belgium**
- **18-19 September: ESMO Roundtable - Madrid, Spain**
- **13-14 October: Virtual conference: "Building a decentralised, data-rich testing space to speed better testing and care in a Covid and post-Covid world" - Brussels, Belgium**
- **Ongoing March-October: Biomarker testing series of events**
- **17-18 November: German Presidency Conference - Brussels, Belgium**

Let's take a look at some of the biggies...

Reinfection or immunity?

OK, you had the virus, you came out the other end. Are you immune or can you be reinfected? Also, would you still be able to infect others?

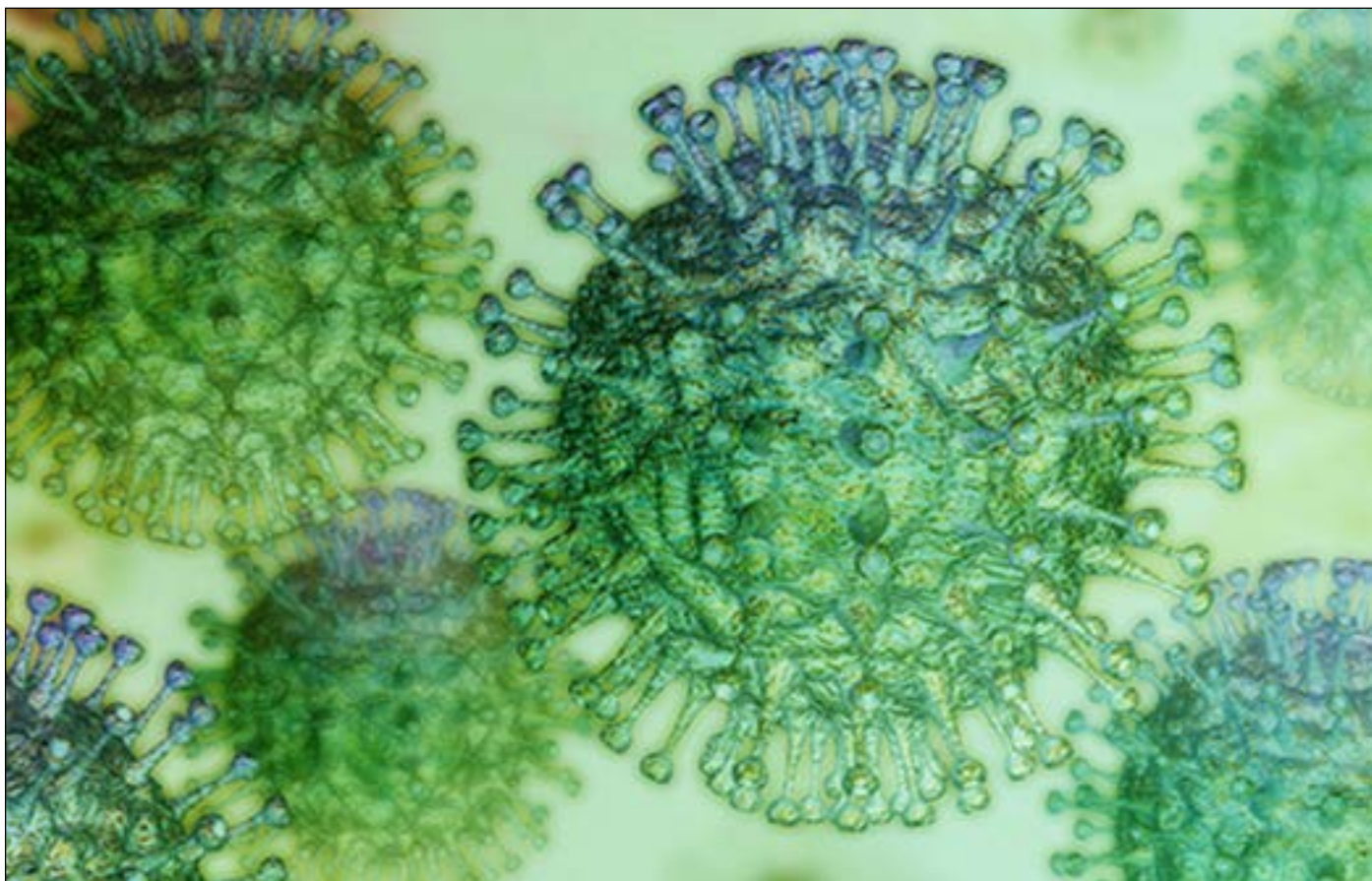
These are big questions. It doesn't help that there have been reports from South Korea that people can become reinfected.

Meanwhile, The WHO has said that there is currently no proof that recovering from the virus brings immunity. Which makes the idea of "immunity passports" a bad joke.

How the virus spreads

Right, well we all know that respiratory droplets are the main suspects here. However, is it really possible to become infected by touching a contaminated surface before touching your face? If it is, how long can the virus survive on different surfaces?

The World Health Organization (WHO) doesn't know, writing: "It is not certain how long the virus that causes Covid-19 survives on surfaces. Studies suggest that coronaviruses may persist on surfaces for a few hours or up to several days."



When tracing and breaking up chains of infections, this makes a difference, making this question important for assessing which safety precautions can slow the spread of the virus.

Meanwhile, masks? Don't even go there. Who knows, right?

Effects of the weather. Are there any?

America's President **Donald Trump**, in an early stroke of his own particular style of 'stable genius', suggested in February that warmer weather in (some parts of) the US, due in April, could make it easier to battle the pandemic.

Well, temperatures are already warm in some parts of the world, and still the virus spreads.

As it happens, sources in the US said today that sunlight, humidity, etcetera might be good for zapping the virus, but we don't know for sure. It happens with the flu, but this is not the flu.

(President Trump's latest bonkers suggestions, condemned as 'dangerous', about ingesting disinfectant, don't even bear thinking about here).

Who's most vulnerable?

We know that Covid-19 is more deadly to older people and those with underlying health conditions, but we're not sure why.

The WHO writes: "While we are still learning about how Covid-19 affects people, older persons and persons with pre-existing medical conditions appear to develop serious illness more often than others."

Teenage and young adult deaths have been connected to the novel coronavirus, although those are exceptions. But we are not

sure why some young and healthy people die from the virus, yet most have only mild symptoms.

How does the virus kill?

This seems to be more about how the infection sometimes becomes lethally dangerous.

Age and underlying health issues are two reasons, and certain scientists believe how much virus a person is exposed to during infection may affect the seriousness of the illness.

On top of this, genetics could be important to response - good or bad - but which genetic variants increase or decrease the risk remains a mystery.

So now you know. Or not.

It's all about data

Clearly what we have to rely on is data, data and more data, whether through testing, enhanced use of genomics, and so on. But this of course requires pan-EU Member State cooperation and coordination as well as interoperability for exchange purposes, in order to help answer these questions as quickly as possible.

For EAPM's part, we have proposed from the onset that systems in the EU need be interoperable to allow better data flow. It's good to note that our own MEGA+ initiative, as well as the European Health Data Space, are key ongoing initiatives aimed at making such goals reachable.

It has become abundantly clear via the current crisis (despite the fact the EAPM and its partners and stakeholders already knew it) that we need better systems of data collection, reporting, centralisation and visualisation.



Some good systems of surveillance exist in this context but, unfortunately, in the case of crisis situations, they have not been stress tested and arguably do not work effectively. (Remember the banking system of the 2008 crisis? The similarities are scary and, yet, we still have the banking system.)

Meanwhile, despite being theoretically data-rich, we do not accurately know how many deaths there actually have been from Covid-19 across the EU, given that each Member State employs its own methodology. This hardly helps to formulate a truly effective response.

On top of this, health security has been shown to be inadequate, in the sense that - EU-wide - health resources have not been rationally moved from point A to point B when needed.

Healthcare besides and beyond Covid-19

So here we are in the eye of the Covid-19 storm. However, other illnesses are still ongoing for many EU citizens, and a lot of our people are suffering due to resources being shifted.

In some countries, even chemotherapy has been suspended temporarily and, meanwhile, many patients are missing key appointments due to the practical difficulties of travel during lockdowns.

It is not just cancer patients, either. Many of those with diabetes, neural diseases, sight issues and more are also experiencing the thin end of the wedge at the moment.

Coming up soon is the EU's new health programme, which the Commission plans to present next month. EAPM will be closely following this, alongside our core partners and various MEPs in the European Parliament. We are also working with these multi-stakeholders on optimal/minimum testing.

During the **Germany Presidency of the EU**, which begins on 1 July, this will be a key area of focus. This is not least because a special task force of three of Germany's cancer organisations have expressed concern that focusing on Covid-19 could put early diagnosis of cancer at risk.

Gerd Nettekoven, Chairman of the Cancer Aid Foundation, has said: "In principle, oncological therapy in Germany during the COVID-19 pandemic has so far been secured and we have not seen any threatening supply shortages for cancer patients."

But he went on to say that with the care system "noticeably stressed" the resulting restrictions "may have negative effects for cancer patients".

And **Michael Baumann**, who is Chairman of the Cancer Research Centre, said that "suspension of early detection and clarification measures can only be tolerated for a short period of time, otherwise tumours might only be detected at an advanced stage with a worse prognosis".

Courtesy of the European Commission, the EU now has its **Beating Cancer Plan**. Which is good news. Just so long as the plan adequately faces up to, and overcomes, the challenges of early diagnosis and access for those with any of the many forms of cancer.

So, yes, we are right in the middle of the viral crisis, but other illnesses are still ongoing for many EU citizens, and a lot of our people are suffering due to resources being shifted. In some countries, even chemotherapy has been suspended temporarily and, meanwhile, many patients are missing key appointments due to the practical difficulties of travel during lockdowns.

It is not just cancer patients, either. Many of those with diabetes, neural diseases, sight issues and more are also experiencing the thin end of the wedge at the moment.



Of course, that's assuming that, in normal times, they would have been diagnosed and had decent access to the best treatment available in any case.

Focusing on cancer, it can take many months (even years in some cases) before a cancer is finally diagnosed, albeit with the best will in the world. It often seems to be the last stop once all other possibilities have been exhausted.

EAPM has, of course, down the years pushed for screening programmes in, among others, lung, prostate and colon cancers to ease the path to diagnosis, but there is still a long way to go.

And the reality is that, once the patient has finally been diagnosed, that's merely the beginning of the story...

Imagine a patient who needs an intense course of radiotherapy, every day, spread out over several weeks. This treatment may not always be available near his or her home, which basically means relocating in some cases for a couple of months, say.

Once we accept that, we're talking money for another apartment, or a hotel, lots of logistics, loneliness in a strange town and place...as well as the treatment itself, which in the case of intense radiotherapy and chemotherapy is not pleasant.

Then there is the stress, the constant pain, the non-stop drugs and the exhaustion... Even before coronavirus-induced social distancing, this was always hard.

Society and most healthcare models are simply not geared up to help these people and the last thing they need to be doing is stressing out and struggling to find solutions while facing weeks of therapy.

So, aside from the above, what are the main access issues facing patients, disregarding the added burden of the devastation being caused by Covid-19?

Access for patients to the best treatment available sounds simple enough as a concept in the 21st century. Yet it's not

happening often enough nor fast enough. So, where did it all go wrong?

Access to optimal healthcare across EU Member States has often, even in 'normal' circumstances, been proven to be varied and inequitable, and of serious concern to an ageing population now suffering, in a growing number, from more than one disease.

The problems caused to society as a whole by long waiting times, a lack of the best drugs available, inadequate implementation of cross-border healthcare, a shortage of hospital beds and other barriers is huge, leading to loss of quality of life for citizens and even of life itself.

And, lest we forget, we already have the ability to provide early diagnosis through tools such as screening programmes yet, to the consternation of many, this is not being used in a bid to thwart such a big killer as lung cancer, despite the overwhelming proof of efficacy shown by, for example, the NELSON programme's results.

We know, and are happy to know, that our policymakers want to support improved access - but while they are experts at 'mechanisms', it is making these processes fit-for-purpose that is an issue.

Different mechanisms are currently coming under the microscope, not least the concept of mandatory EU-wide HTA. Also, consider the arguments over healthcare funding in the current EU budget discussions and how much cash down-the-line will feed translational research.

The shortages of medicines and equipment is another issue, which predates Covid-19 and varies from Member State to Member State. But is clearly a problem everywhere.

The UK was (and still is) particularly worried about the medicines issue as Brexit drew ever closer. Anybody remember Brexit? It will still be around if and when the Covid-19 pandemic is finally tackled.



Investment is another issue. What we need in large part in Europe is more investment in innovation to meet the needs of an ever-growing cohort of patients who, these days, are often dealing with more than one chronic disease at the same time.

Early diagnosis, easier access and preventative measures are all hugely powerful weapons in the battle against bad health, but a large part of this is getting innovative medicines and treatments out there for all to use.

When it comes to innovation, as a multi-stakeholder group we need to find more ways to stimulate research and development. We have to find ways of diverting public funding into R&D and letting public interest lead the way if society's unmet medical requirements are ever to be met.

Yes. It is clear that investment in innovation is required, not least in diagnostic approaches, such as the use of IVDs and more screening, certainly in cancers.

Speed of access is important in respect of novel products, obviously, but we can't ignore that fact that safety is a huge concern. Effectiveness is one factor and safety is vitally important, so navigating along the line between those two aspects and the speed-of-delivery requirement is not easy.

And it must be remembered that, with all the new diagnostics etcetera, up-to-the minute education is desperately needed for healthcare professionals who are facing a brave new world in which personalised medicine is a game changer. They need to understand what is now available (including next-generation sequencing), as do their patients.

Fortunately, treatment and medicine is moving from health professional-led decision making to evidence-based shared decision making. A number of European guidelines have been developed in specific disease areas, such as in the areas of urology, respiratory medicine, gastroenterology and cardiology.

But it is still important to address the major gap in engagement between the scientific community and key

stakeholders as users and beneficiaries of guidelines.

Given the new understanding of disease at molecular level (especially in cancers), the promise of personalised medicine is real.

As we aim to tailor treatment according to the characteristics of the individual patient, it is now a clinical reality as testing for certain mutations to guide treatment is now part of routine clinical practice. However, we still have too few validated biomarkers.

Unfortunately, despite their widely recognised promise, the use of diagnostics in clinical practice across Europe is still limited. Healthcare systems in Europe are not designed to support personalised medicine approaches and related innovative diagnostic technologies. This is reflected in a lack of appropriate patient access and pathways for reimbursing molecular diagnostics.

At the end of all this, and with Europe's Beating Cancer Plan starting to roll - albeit under the shadow of a global pandemic - the battle against cancer should remain a priority and our key task of minimal and optimal testing should become a core pillar of this.

Hopefully Commission President **Ursula von der Leyen's** (above) and her team's new cancer initiative will deliver what we all hope for - earlier diagnosis and better access in the fight against this deadly set of diseases.

New report on cancer drugs

On the topic of cancer, a new OECD report on how it thinks countries can deal with challenges in access to cancer medicines has recommended that the use of such drugs should be tracked based on each type of disease they can treat.

Says the report: "This could serve a number of purposes, including informing ex-post price adjustments where needed, and supporting the monitoring of expenditures linked to oncology medicines, as well as contributing to 'real world'



Hrvatsko predsjedanje
Croatian Presidency of the
Vijećem Europske unije
Council of the European Union

evidence of the performance of medicines." The report also calls for improvements to the design of performance-based managed entry agreements by which many new cancer drugs are reimbursed.

"This would require the collection of information on both utilisation and relevant clinical outcomes for products subject to these agreements," it says.

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Information sharing among payers and countries, particularly for medicines targeting a small number of people, is "highly desirable," the report adds.

Conference coming up

We'd like to take this opportunity to let you know that registration is set to open for our upcoming Croatia-Germany EU Presidency conference which will be a 'virtual' event, held online, on 30 June.

The conference is entitled "*Maintaining public trust in the use of Big Data for health science in a Covid and post-Covid world*".

Despite us not being able to meet face-to-face, events such as this still allow the pulling together of leading experts in the arena of personalised medicine drawn from patient groups, payers, healthcare professionals plus industry, science, academic and research representatives.

A key role of any EAPM conference is to bring together experts to agree policies by consensus and take our conclusions to policy makers.

And this time, we go even further into the realm of expertise, given the huge crisis that we are all facing.

It's fair to say that, in certain quarters at least, 'experts' have had a hard time of it. It's a little like critics determined to hammer a stage play, or a football pundit picking on a player - quite often it says more about the critic than the expert.

For example, very recently we've seen America's leading infectious disease expert **Anthony Fauci** come under fire from his own president, while Fauci's Italian counterpart,

Walter Ricciardi, has felt the ire of populist League leader **Matteo Salvini**.

Right now, with a pandemic on our hands, and with lives literally depending on the next moves by governments and health bosses, we absolutely need experts from all kinds of arenas and trying to ignore them, contradict them or even tear them down can, at the very least, be counter-productive and, worse, deadly.

Testing one, two, three...

One of many important topics thrown into focus by the current crisis is testing - when to test, who to test and how to do it most effectively. Of course, EAPM has campaigned for screening for lung and prostate cancers down the years, for example, but questions have been asked about specific testing in this Covid-19 environment.

Slovenia has just announced the launch of a 3,000-person survey to find out more about asymptomatic infection rates. The Statistical Office and the Faculty of Social Sciences in Ljubljana invited citizens from across the country to be tested for the coronavirus while giving a blood sample.

Results should be ready by 1 May. Meanwhile, in **Malta**, it seems that many citizens are missing their appointments to be tested for the virus.

Despite this, Malta is doing well in the testing context, behind only Luxembourg and Iceland.

Spain has said it is planning large-scale antibody testing for Covid-19 to try and figure out what percentage of the population has contracted the virus.

The country's health ministry plans to work together with regional authorities to check 36,000 households, which should help to determine who, if anybody, has developed an immune response.

Over in **the UK**, 18,000 people are due to be hired to help with contact tracing, as part of its "test, track and trace" plans. Among several questions raised by scientists, however, is how under-the-cosh local public health systems will manage to support it all.

Testing in a healthcare context is a fulcrum of



personalised medicine, not just in cancer and the novel coronavirus, but also Alzheimer's, for example. Alongside its stakeholders, members and -yes - experts! - EAPM is currently working on developing an optimal and minimum framework for testing.

Obviously there is a link here to the use of diagnostic information and the value which this can and does bring. Yet there is a debate going on with respect to what constitutes a valuable healthcare intervention in a health system, and the corollary consideration of what governments are willing to pay for a certain health intervention.

Until recently, the value of information in general had not been part of the discussion. However, investment in diagnostic information can be a key development as information may guide more effective and efficient healthcare and help maintain an affordable health system.

EAPM believes that what is required is a holistic framework that accounts for the full range of potential benefits of diagnostic testing, beyond the traditional clinical and health economic domains, and that it is essential to recognise, measure, and fully leverage the benefits of diagnostics for patients, healthcare systems, and society.

Public right to know?

It turns out that **Italy** already had a Covid-19 plan ready to rock-n-roll back in January, but didn't want to scare the public, so said nothing. According to La Repubblica, early worst-case scenario forecasts turned out to be pretty accurate, apart from its speed - it happened much more quickly than predicted.

Part of the plan was the urgent acquisition of personal protective equipment (PPE).

Which brings us finally, almost inevitably, to the UK... Despite government assurances to the contrary it transpires that Britain's decision not to join an EU procurement scheme for PPE was not about lost messages and missing deadlines. Word is it was about Brexit.

Simon McDonald, who is head of the diplomatic service

at the UK's Foreign Office, was asked at a recent House of Commons' foreign affairs committee about the policy advice given to ministers.

McDonald said: "It was a political decision." We all know what that means... Then it was rescinded, surprise, surprise.

The British Prime Minister **Boris Johnson**, meanwhile, lately in recovery at his country residence from a serious brush with the virus and due back at work in Downing Street this week, has clearly moved on from such matters. He was on the phone recently to agree a "coordinated" response to the coronavirus with US President **Donald Trump**.

Whether UV lighting was in use in other office remains unclear...

Cooperation beyond Covid-19

Given our constant calls for 'more, not less, Europe in healthcare' it was encouraging to hear in April Health Commissioner **Stella Kyriakides** (above) tell the European Parliament's ENVI Committee that the EU needs more competence in public health to really improve coordination and allow the EU "to step in".

Alongside Crisis Management Commissioner **Janez Lenarčič**, Kyriakides also defended the Commission's response to the pandemic, not least its setting up of an EU stockpile of medical goods.

Staying with the Commission - it has just launched a data-sharing platform for scientists to publish their coronavirus research. This could include DNA sequences as well as data from pre-clinical studies.

The idea is to simplify the sharing of data and discoveries among scientists working on the coronavirus. Great news!

Above and beyond the Covid-19 issue, EAPM believes that the EU should of course champion equal access to basic healthcare and the best treatments available. This would deliver European solidarity going way beyond a political soundbite, that would forge bonds beyond a perceived East-West and North-South 'divide'.



Specifically to the current virus, in this sense when a vaccine does come online, we need to ensure that everyone has access to it. There should be no more recurrence of pan-European competition for resources (such as we have also in the US and Asia, for example).

It is certainly good to note that the G20 has committed to sharing timely and transparent information and materials for research. This as well as vowing to expand manufacturing capacity to meet the need for medical products and to make them widely available, at an affordable price, on an equitable basis, where they are most needed, as quickly as possible.

This doesn't take away from the direct challenge, however, as there is currently adequate global manufacturing capacity for emerging diagnostics, for a start, which may push public health decisions towards compromising health outcomes. So we need a rethink.

One intriguing question that we've heard asked in and around the EAPM corridors is whether more authoritarian regimes have done a better job over the course of the crisis than democracies.

That's an uncomfortable question for voters everywhere, isn't it? One that asks whether western societies are prepared to forgo (hopefully temporarily) their freedoms and privacies.

Although we work hard to keep a watchful eye on intrusion, there is no denying that down the decades we have given up much - lots of data, even through social media, CCTV cameras everywhere, most licences, biometric passports, running all the way back to the dawn of fingerprinting right up to DNA.

Where's the line to be drawn in the sand? Especially in exceptional circumstances such as the ones we find ourselves in.

Making contact

As exit strategies are already being talked about across Europe it has become clear that tracking apps are expected to play a part by all capitals.

But we're back to privacy versus health again, it seems. As well as effectiveness.

For example, on the latter point, Italy reckons that about 70% of the population will need to install the government's preferred app for it to be effective. (Also in Italy, Milan - above - is set to host the first "bio-bank" for Covid-19, which will consist of a database of related blood and tissue samples.)

On privacy, the UK's **Ada Lovelace Institute** has published a review calls for the establishment of a Group of Advisors on Technology in Emergencies to oversee any process of deploying a digital contact tracing app with, perhaps, add-on "immunity certificates".

France is also a little bit twitchy about the scope of such apps, while Germany has issued cybersecurity guidelines.

Cash for care

According to European Commission chief Ursula von der Leyen, the next seven-year EU budget should be used to trigger loads-a-money to help the EU's economic recovery in a post-Covid world.

"We're not talking about a billion, but we are talking about a trillion, looking at the investment initiative that has to be done," said von der Leyen during the presentation of her roadmap for exiting the lockdown.

Keep on tracking

The European Commission has very recently been talking about the use of tracking apps during the Covid-19 crisis. But it's not the only use of hi-tech devices that are suddenly becoming 'all the rage' as telemedicine has been given a major boost due the current circumstances.

Once sceptical and, occasionally, fearful healthcare pros have had little choice but to embrace the trend - not least because many of their offices are closed.

It transpires that for, say, normal pregnancies, many obstetricians are now doing most prenatal check-ins via virtual visits. Meanwhile, dermatologists are finding it convenient to diagnose the more-minor skin conditions via the use of cellphone cameras.



Of course, telemedicine is much more cost-efficient as it means physical contact is not necessary, and it frees up office visits for patients with the more complex conditions. After-hours care is also made easier which, in turn, leads to less hospital visits from concerned patients.

In respect of hospital beds, meanwhile, most hospitals have now raised the bar on when a bed is required, in order to keep as many as possible available for Covid-19 patients. Very sick non-corona virus patients are still being admitted, of course, but the end result is more beds for those that really need them.

All-in-all it's been a case of 'needs must when the devil drives' with the practical upshot that we have learned once and for all that many, many patients can be properly treated without being hospitalised.

Vax to the max

As we twiddle our thumbs at home, not only are we all waiting for life to return to a semblance of normality (some way off) and lockdowns to end (also some way off), we are also waiting for a vaccine to thwart Covid-19.

European Commission President Ursula von der Leyen has bluntly stated that, until the latter happens, life will not return to normal.

Von der Leyen added in a newspaper interview that researchers are working "flat out" to find a vaccine, with two of "the most promising teams" located in Europe aiming to start trials "soon".

Interestingly, some British MPs have taken the time to say that any future potential vaccine should be available to all. Well, of course it should!

To not do so would fly in the face of the EU principle of solidarity - especially if the vaccine were made on EU territory and not made readily available to all citizens, both 'locally' and globally.

In a letter to Prime Minister Boris Johnson, the All-Party Group on Vaccinations for All said the government must put in place several safeguards to ensure that there are no barriers to accessing a vaccine or treatment.

Chair of the group, Scottish National Party MP **Philippa Whitford**, said: "Just as coronavirus does not see borders, it is absolutely crucial that the fight against the virus is a worldwide effort."

Fair enough. But let's not forget the case of insulin and today's access to the life-saving drug. In 1922, researchers at the University of Toronto announced its discovery, and sold the patent for \$1 so that it would be available to all.

Unfortunately, almost 100 years later, it is being charged at around \$300 a dose. Not a happy precedent...

Three European biotech companies (namely Italy's ReiThera, Germany's LEUKOCARE and Belgium's Univercells) will cooperate to develop and manufacture a novel adenoviral vaccine against Covid-19, with clinical trials pencilled in for summer.

Any Covid-19 vaccine is, of course, going to be costly. Very. Some in the know suggest that the cost of development will run into billions of euros. For example, the Coalition for Epidemic Preparedness Innovations has put the cost at \$2 billion without manufacturing costs.

Will the EU pay? Who knows right now?

Meanwhile, the International Association of Mutual Benefit Societies wants any EU public funding for a vaccine be tied to accessibility clauses.

This is to make sure that citizens can actually get their hands on it.

"Intellectual property deserves a specific attention as they



maintain prices high, which mechanically prevents access,” the Association says.

The great escape

Over the weekend, Italy’s Prime Minister **Giuseppe Conte** announced that economic activities in the country will gradually re-open from 4 May, while French Prime Minister **Edouard Philippe** has begun to drop hints about his country’s upcoming strategy (due 11 May).

Prime Minister Philippe confessed to contemplating making masks mandatory in public, with Health Minister **Olivier Véran** saying 17 million masks could be produced every week.

Over in Spain, the country’s Ministry of Health has assembled a panel of experts to draw up a plan on lowering lockdown measures in due course. Meanwhile, it is letting young children outside for an hour a day.

Not so in the UK, which is planning no changes for now. While Belgium has certainly raised eyebrows with what many feel are premature moves to scale back measures.

To ease restrictions, or not...

Mixed messages are coming out from all over the planet with some places already starting to relax movement to a degree, and others saying that, for them, it is way too early.

The frustration as the good weather hits in Europe and near-Europe is palpable, but most people seem to understand and are generally doing as advised. Not all, but most.

What is clearly proving difficult is for citizens in one country to see restrictions lessened in other near-neighbouring countries and, with all the different information on everything from the usefulness of masks to the merits or de-merits of ‘herd immunity’ happening at the same time, it is psychologically tough for many.

And there is no coordination between Member States. Which has once again raised the question about whether the EU should have a bigger role in public health – and particularly in the provision of health technology. This, of course, would impinge upon the closely guarded Member State competence in healthcare so, if this were to happen, how would that be?

Another question is how can the now very evident gaps be bridged to in order to better protect protect Europe’s health ahead of another crisis? What are the priorities? The broader question, as mentioned above, is whether it’s time to give the EU a bigger role in Europe’s health protection.

As the pandemic has unravelled and lethally struck at the heart of Europe, the deficiencies in availability and supply of necessary assets for responding have become overtly clear.

There have been huge shortages of personal protective equipment (PPE), such as face masks, as well as too little basic ICU equipment, devices and and infrastructure.

On top of this, there has been inadequate provision of high-tech procedures and processes, for testing (both for infection and for immunity), a shortage of medicine for symptomatic treatment, for any curative therapy, and (not surprisingly given the timescale) for preventive vaccines.

There is much to discuss at our Bridging Conference and, again, it would be great to have you take part.

EU roadmap

Meanwhile, in the Belgian capital Brussels, the European Commission has thrown out a few ideas regarding an eventual ‘exit strategy’ from this unholy mess we’re in.

In a text entitled ‘*European Roadmap towards lifting COVID-19 containment measures*’, it suggests that, because contact-tracing apps are an “effective tool”, these should be part of the exit strategy. When containment measures are being lifted they will be very useful for “when the infection risk grows as more and more people get in contact with each other”.

And, surprise, surprise, the EU Executive has said that harmonised data gathering and sharing across Europe is “essential to better manage the lifting of measures”.

It adds that social media and mobile network operator data has the potential to help forecast the pandemic if “pooled and used in an anonymised, aggregated format”.

Meanwhile, says the Commission, countries should “expand testing capacity and harmonise testing methodologies”.



World Health Organization

“The availability of large-scale testing that can provide fast and reliable results is key to tackle the pandemic and also a precondition for lifting social distancing measures in the future.”

And, down the line, a vaccine would be “game-changing to help put an end to the Covid-19 virus. Its development and fast track introduction is therefore essential”.

The Berlaymont says it is also “streamlining the needed regulatory steps from clinical trials to marketing authorisations, to ensure an acceleration in the process”, as it will also do in the case of any possible cure. Good news among the mostly bad, it has to be noted.

In the news from EAPM

[#COVID-19 – What we didn't know we didn't know](#)

[#EAPM – Why we need more Europe, and experts, in healthcare](#)

[#EAPM – To ease restrictions, or not....to improve testing, the role of digital!](#)

[#EAPM – Update: Von der Leyen wants 'trillions' for eventual economic recovery strategy \(and health care?\)](#)

[#EAPM – Exit stage left, pursued by a virus...](#)

[#EAPM – EU and WHO in firing line. But is it fair?](#)

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About EAPM

The European Alliance for Personalised Medicine was launched in March 2012, with the aim of improving patient care by speeding development, delivery and uptake of personalised medicine and earlier diagnostics, through consensus.

EAPM began as a response to the need for a wider understanding of priorities in personalised medicine and a more integrated approach among stakeholders. It continues to fulfil that role, often via regular major events and media interaction.

Our stakeholders focus not just on the delivery of the right treatment for the right patient at the right time, but also on the right preventative measures to ensure reliable and sustainable healthcare.

The mix of EAPM members and its broader outreach provides extensive scientific, clinical, caring and training expertise in personalised medicine and diagnostics, across patient groups, academia, health professionals and industry.

Relevant departments of the European Commission have observer status, as does the EMA, and our engagement with MEPs and Member State health ministries in key policy areas is a crucial part of our ongoing work.

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