EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HEALTH AND FOOD SAFETY

Public health
Health Security and Vaccination

Luxembourg, 5 October 2020

Health Security Committee

Audio meeting on the outbreak of COVID-19

Summary Report

Chair: Wolfgang Philipp, European Commission, DG SANTE C3

Audio participants: AT, BE, BG, CZ, DE, DK, EE, ES, FI, FR, HR, HU, IE, IT, LT, LU, MT, NL, PT, RO, SE, SI, NO, CH, UK, AL, ME, MK, XK, UA, MD, DG SANTE, DG ECHO, ECDC, WHO

Key Conclusions

1. COVID-19 testing: rapid antigen tests and mutual recognition of tests

The Chair started the meeting by reopening the discussions on the use of rapid antigen tests in EU countries and the mutual recognition of RT-PCR results in the EU, particularly at airports. A short survey was circulated to the HSC on these two topics to obtain further details and input from countries on their current state of play, views and experiences as regards rapid antigen tests and mutual recognition of test results. 15 MS as well as NO, IS, LI, CH, ME and the UK had replied to the survey.

Regarding rapid antigen tests, five EU countries are currently using such tests and all other EU MS had replied that they are either carrying out validation studies or pilots with rapid antigen tests, or are considering their use. Iceland was not interested in the use of rapid antigen tests. Different types of antigen tests are being used or considered to be used by countries. The most common option is the rapid antigen test produced by Abbott and the SD-BIOSENSOR. The criteria for the selection of antigen tests vary, and different specificity and sensitivity thresholds are being used. Regarding testing of symptomatic cases, countries often refer to a period when the rapid antigen test should be taken: the maximum number of days of symptoms from onset during, but there is no consistency for this duration (3, 5 or 7 days). The (foreseen) purpose of using rapid antigen tests also varied greatly between countries (e.g. use at airports, for screening in local outbreak clusters, in specific settings of for certain target groups or to replace RT-PCR due to restricted capacities, unavailability of the RT-PCR test or geographical difficulties). Several countries indicated that a positive test result should be confirmed by RT-PCR, while others responded that a negative test result should be confirmed.

The results of the survey thus show that there is a strong interest in the EU for rapid antigen tests, however, a large variation exist regarding the scope and purpose of their use, the types to be used and the validation of results. The Chair opened the floor, asking HSC members in

particular if there is a need for a more harmonised approach concerning the use of rapid antigen tests in the EU?

IE took the floor asking if the results of the survey, particularly the responses for each of the MS, could be shared with the HSC members. It would be helpful to review the responses when considering if there is indeed a need for aligning approaches. EE agreed that it would be helpful to see what other countries are doing.

The Chair confirmed that the results will be shared once the analysis has been finalised by the Commission.

CH raised a question to IT, as the country is using rapid antigen tests in low prevalence settings (airports and ports) and therefore there could be a risk of a high number of false positives.

IT replied that they will look into it and make the relevant data available to the HSC.

ES took the floor, further elaborating on their national testing strategy which now includes the use of rapid antigen tests. The National Centre for Microbiology validated the test that is being used in Spain and which is having a sensitivity of ± 98% and specificity of 99% in symptomatic patients with 5 days or less of symptom evolution. Asymptomatic cases are only tested with the rapid antigen test if there is no other possibility or in specific settings (e.g. healthcare personnel), and it is thus not recommended as a general rule.

SE informed the HSC that the country is currently not using rapid antigen tests but that it is currently preparing guidance on how such tests should be used.

The Chair raised the suggestion that it could be an option to organise a Joint Procurement for rapid antigen tests, and that it would be helpful if countries could consider this option and get back to the Commission in case they indeed consider this useful.

The Chair informed the HSC that, the majority of the countries that responded to the survey had indicated that mutual recognition of RT-PCR test results is overall not problem for travellers from and to EU countries. FR and PT had indicated in the survey response that they have noted problems with the recognition of test results produced by non-EU countries and they are currently investigating this issue. ME mentioned that the test results produced by their labs are not recognised by all MS. Based on these results, it seems that there is no need for further action on this, e.g. the development of an EU platform. The Chair opened the floor, asking MS for comments and views on this topic. No further comments were made.

Follow-up:

- *The Commission will share by Wednesday 7/10 the results of the short survey on rapid antigen tests.*
- *The HSC will consider if there is a need for a more harmonised approach in the EU concerning the use of rapid antigen tests, and if a Joint Procurement would be helpful.*

2. Quarantine and isolation for COVID-19

The Chair reminded the HSC that a matrix of isolation and quarantine measures has been produced, which includes information on duration of the measures and details regarding timing and ending of the measures. The matrix showed that there are clear differences in the approach

with regards to isolation and quarantine, not only for the duration of these measures (from 7 to 14 days) but also concerning the timing and criteria for ending the measure (e.g. end after 24h, 48h or 3days without symptoms, negative PCR tests, etc.).

The ECDC noted that the agency recommends 14-day quarantine for persons who have had contact with confirmed SARS-CoV-2 cases, which can be shortened to 10 days after exposure, if a PCR test at day 10 is negative. For isolation of cases, ECDC noted that, depending on the health status, cases should isolate for a minimum of 8 days, 14 days for more severe cases and could go up to 20 days for immunocompromised cases.

SE updated on some of its measures, namely that a case should be fever free for at least 2 days and at least 7 days since symptoms began to end isolation. A 14 day isolation is in place for more complicated symptoms. Details for isolation are not easy to determine, they depend on the health status of the patient. Regarding close contacts in families, they are considered as suspected and have to self-isolate, but this does not apply to children.

The Chair reminded that the HSC is invited to consider the possibility of reaching a consensus for isolation and quarantine measures, in a similar fashion as it was done for the testing strategy. The Chair noted that there is no need to have the same measures in place but at least a similar justification for the implementation of these measures.

Follow-up:

- *The HSC will continue to provide updates on the matrix of isolation and quarantine measures.*
- *The Commission will share by Wednesday 7/10 an updated version of the matrix*
- *The HSC to consider the possibility to agree on a common approach to quarantine*

3. Follow-up to the Commission Communication on short-term preparedness for COVID-19

The Chair informed the HSC of the status of the progress report.

The Commission has produced a progress report of implementation of the Commission Communication on short-term EU preparedness. Based on countries feedback, we have been able to give a short overview of the status of preparedness in Member States. Unfortunately, as we have been sharing until now, the response rate is too low to be able to provide a full picture of the preparedness status in the EU. This report is in its final stages, and is now being consulted with DG services. The Commission will then be able to share the report with the HSC for review. With this report, it will therefore provide a snapshot of the status but the Commission would welcome in the future any update on some of the points raised in this Communication.

Follow-up:

- *The HSC to be consulted on the progress report, once finalised with DGs inputs.*
- *The HSC to provide continuous updates on some of the actions in the Communication.*

4. Cross-border treatment of patients

DG SANTE reminded of "Guidelines on EU Emergency Assistance on Cross-Border Cooperation in Healthcare related to the COVID-19 crisis"[1], presented to the HSC on 3 April. The guidelines lay out existing mechanisms to facilitate cooperation in cross-border healthcare, covering aspects including coordination of requests, transport, reimbursement and treatment. More specifically, the guidelines detail mechanisms to assist health authorities by:

- coordinating requested and offered intensive care places for patients and qualified medical personnel through the HSC and the EWRS;
- coordinating and co-funding the emergency transport of patients and qualified medical teams across borders through the EU Civil Protection Mechanism;
- encouraging Member States or non-governmental organisations to send qualified teams of medical personnel across borders; and
- providing clarity on the reimbursement of healthcare costs, transfer of patient records, continuity of care and the mutual recognition of prescriptions.

Any Member State or participating state can benefit from full- or partial-financing support through the European Union Civil Protection Mechanism for cross-border transport of patients and/or medical personnel. The Commission opened a dedicated notification on this in EWRS. Member States are invited, via the HSC contact points, to use the template for requests for intensive care places, assistance from medical staff, as well as make offers of assistance. DG SANTE will circulate an SOP breaking down the step-by-step process. MS were invited to raise specific questions at the next HSC.

Follow-up:

- *The Commission is working on a detailed SOP to be shared with the HSC.*

5. Remdesivir – joint procurement

The Commission updated on the joint procurement procedure, ongoing to ensure access to Veklury from October onwards; following the evaluation committee meetings, an agreement with Gilead has been reached, and the framework countract is being finalized. 36 countries participate in the joint procurement, including all EU MS, 2 EEA countries the UK and 6 candidate countries and potential candidates. This joint porcurement is the exclusive way to access Veklury for all JPA signatory countries.

Follow-up:

- *All participating countries have been invited by e-mail to their designated representatives in the Steering Committee for this joint procurement procedure to approve the contract.*

6. COVID-19 MEDEVAC

The Chair shared an update on the MEDEVAC requests that have been taking place since the beginning of the outbreak. More than 30 MEDEVAC requests have been received, most of which have been finalised with an EU Member State. Requests have been coming from the UN (UNICEF, UNV, MINUSCA, MONUSCO, UNESCO, UNAMA, UNDP, WFP, UNDSS and WHO staff) and from NGOs. The Chair thanked the responding countries for their availability

[1] https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=OJ%3AJOC_2020_111_I_0001

and support and informed the HSC that a new arrangement is in place with colleagues in DG ECHO for the MEDEVAC requests happening outside of office hours.

7. AOB ECDC's rapid risk assessment

The ECDC provided a presentation as a follow up to the latest 12th update of the ECDC's risk assessment and the list of questions circulated by the Commission, including on the classification of countries and trends at regional level, priority non-pharmaceutical interventions by risk level, and interventions amongst younger population.