Drawing attention to RSV and HMPV surveillance and testing in older adults across Europe

EHMA
European Health Management Association

Introduction:

Respiratory syncytial virus (RSV) and **human metapneumovirus (HMPV)** contribute substantially to the burden of lower respiratory tract infections in **older adults (60+)** and other high-risk groups, yet both pathogens remain under-diagnosed and under-reported across Europe. (1) Watson & Wilkinson. 2021. Respiratory viral infections in the elderly. Ther Adv Respir Dis.

Key messages

National health systems should conduct an evaluation of existing diagnostics and surveillance capacity and adopt a minimum interoperable dataset for RSV and hMPV.

Clinician and community readiness should be raised through focused education and outreach.

Prevention is not an expense. It is a cost-saving public health strategy. Improving Surveillance and Testing for RSV and hMPV in older adults today prevents respiratory complications tomorrow.

Methods

To illustrate the levels of fragmentation in surveillance across Europe, EHMA conducted a comprehensive literature review capturing how RSV and HMPV are tracked for older adults in France, Germany, Italy, Spain and the United Kingdom.

To complement the literature review and provide more context to the case for improving surveillance and testing for RSV and HMPV, EHMA also conducted a targeted cross-country expert survey (n=52) of clinicians, laboratorians, public health, and policy/administrative professionals.

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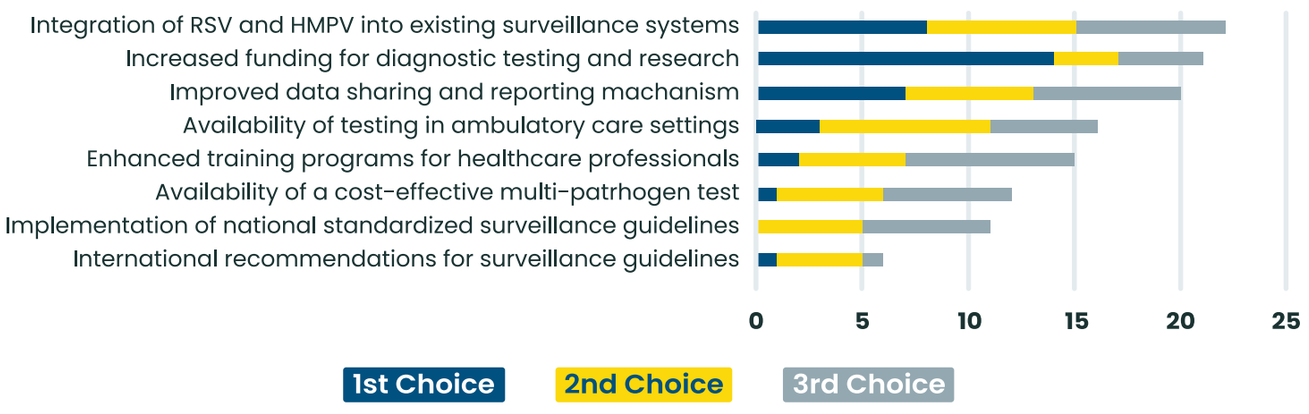
Results / Findings:

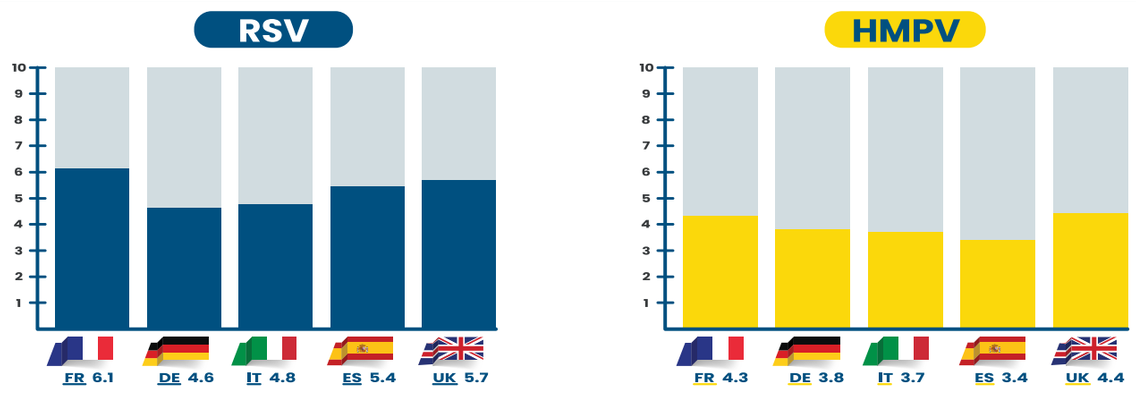
Respondent rankings: Best opportunities to improve for RSV

Respondents were asked to rank up to three opportunities for improving surveillance and testing, based on perceived impact.

Respondent rankings: Best opportunities to improve for HMPV



How receptive is your country's healthcare system to adopting new measures to improve testing, diagnosis, and surveillance for RSV in older and high-risk adults?



National health systems should:

1. Adopt a minimum interoperable dataset for RSV and hMPV and phase reporting to EU platforms.

A compact, standardised set of variables will make national data comparable, actionable and credible. Countries should begin by requiring these fields from sentinel sites and hospitals for RSV and then phase-in HMPV fields as laboratory capacity permits.

2. Conduct an evaluation of existing diagnostics and surveillance capacity.

Where possible, collect a minimal estimate for the capacity of the health system to rollout different RSV and HMPV testing and surveillance programmes for older adults. Coordinated evaluation will allow for more informed reimbursement, vaccination and prevention decisions into the future.

3. Raise clinician and community readiness with focused education and outreach.

Low clinician awareness and unclear testing algorithms suppress demand for diagnostics even where capacity exists. Rapid, low-cost interventions like brief CME-accredited training modules and one-page clinical decision aids will increase appropriate test use.

4. Implement pragmatic sentinel testing pilots within current resource constraints.

Instead of assuming immediate, universal year-round multiplex testing, start with realistic pilots that maximise existing assets: test residual samples from influenza/RSV sentinel streams and SARI hospitals, prioritise high-yield contexts, and use pooled testing or targeted NAAT panels for sentinel subsets.Run seasonal pilots in peak months and expand to year-round only where sustainable.

5. Remove immediate testing barriers by reforming reimbursement and specimen pathways.

Where testing is unaffordable or logistically impossible, surveillance will remain incomplete. Short-term, targeted measures, such as temporary reimbursement codes for specimen collection from older adults, would make testing feasible without requiring universal expansion of lab capacity.

(1) Watson & Wilkinson. 2021. Respiratory viral infections in the elderly. Ther Adv Respir Dis.

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