16th European Health Forum GASTEIN

2nd to 4th October 2013

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Building Resilient Healthcare Systems

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Opening Plenary

Resilient and Innovative Health Systems for Europe

Bailing out Healthcare through Innovation: What can we learn from one another?

By Uwe E. Reinhardt, James Madison Professor of Political Economy, Professor of Economics and Public Affairs, Woodrow Wilson School of Public and International Affairs, Princeton University, USA

On the back of growing prosperity in the industrialized countries during the post-WWII decades, health systems in most countries became complacent and lapsed into a "business as usual" *modus operandi*.

Several economic pressures on health care in recent years have awakened health sectors out of their slumber. The aging of populations very where actually is the least of these problems. More important has been a gradual but inexorable shift of global economic growth from the developed countries to the increasingly price- and quality competitive emerging markets. The more sluggish economic growth in the developed world cause by that shift has been amplified by outsourcing of labor in these countries to computers and by man-made problems, such as reckless fiscal policies in some countries, including the U.S., reckless policies in private banking and, in Europe, an ill-conceived and hence ill-structured common currency area, the Eurozone.

Jarred by the financial pressures these developments have brought to bear on health care, that sector can bail itself out only by embracing or at least accepting disruptive innovations that will redistribute economic privilege within health sectors and, we hope, control better the heath sector's claim on real and financial national resources.

In this presentation, I propose to examine the terrain in which innovations are required and are, indeed, already underway. There is much the developed nations can learn from one another in this regard and, indeed, also from, industrial-engineering advances in health care being developed in the emerging markets.

Parallel Forum 1

Mental Health. The Motor for a Healthy Economy

Preventing alcohol harm in the workplace through screening and brief interventions

By Don Shenker, Director, Alcohol Health Network

Across the EU, alcohol-related productivity losses of €59Bn account for nearly half of all the social cost of alcohol in Europe (Anderson 2010). According to a study in Finland, alcohol consumption measured by drinks per week was positively associated with the number of sickness absence days for both men and women (Johansson 2009).

The International Labour Organization recognises that up to 25% of staff in large workforces may be drinking in a way which puts their health at risk (ILO 2005), however significant barriers exist in trying to address this.

Staff drinking at increasing risk levels may be unaware of the health risks involved, companies may not offer opportunities to assess drinking levels and staff may under-report alcohol use in face-to-face interventions at work for fear their employment may be affected (Del Boca 2003)

Using standardised alcohol screening and brief intervention to identify risky drinking and reduce it through use of the AUDIT tool has been evidenced as highly effective and cost-efficient by the World Health Organization. Indeed a 2007 Cochrane review of face-to-face SBI in primary care found

significant reductions in alcohol consumption and brief interventions in primary care and other settings is recommended by NICE (Kaner 2009).

What is innovative is encouraging the use of these alcohol screening and brief interventions techniques in the workplace and with workforces per se to prevent alcohol harm. Currently, use of AUDIT among occupational health or EAP professionals tends to only occur once problem drinking (including dependency) has already been identified and disciplinary action is imminent.

Offering staff voluntary use of AUDIT as an awareness raising initiative at work, including use of online SBI acts to prevent drink problems from occurring at an earlier stage. SBI at work can also act to signpost staff to in-house or external services to support reduction to low-risk levels.

US research has shown that over a four-year period, for every $1 spent on implementing systems to screen staff with the AUDIT tool, providing brief interventions and referring on to specialist treatment, companies save $4 in sickness absence costs, absenteeism, presenteeism and recruitment (Quanbeck 2010).

Online alcohol interventions in the workplace offer advantages of anonymity, privacy and scalability over face-to-face interventions. A further advantage is ongoing open access to online interventions (Murray et al 2013).

Recommendations on developing systems for SBI at work are currently missing from EU or national strategies on reducing alcohol harm at work, where more emphasis is placed on ensuring alcohol policies are in place or on creating alcohol free zones with breath-testing.

The EU Commission should commission further research on offering SBI at work as a preventative measure and the EU Strategy on Alcohol needs to be renewed to emphasise the added importance of offering SBI in the workplace. This will encourage national governments to update their alcohol strategies accordingly.

Depression in the Workplace and out of it

By George Christodoulou, Professor, President, World Federation for Mental Health

Depression is one of the leading causes of disease burden globally, predicted to be THE leading cause soon, and a variety of situations in the workplace like absence from work, reduced productivity, loss of motivation, burnout, poor relationship with employers and colleagues may be due to depression. Mental health promotion programs in the workplace in addition to early detection, appropriate management and consistent prophylaxis can be rewarding in terms of both human suffering and investment.

However, in a Europe in the turmoil of a severe economic crisis it is the people who are **out of the workplace** who suffer more and especially the recent additions to the unemployment lists.

Unemployment is likely to produce or precipitate a variety of mental health problems, most notably depression, suicide and alcoholism. It is very strongly linked with suicide as every 1% increase in unemployment is associated with 0,79% rise in suicides at ages younger than 65 years. An increase in suicidality and actual suicide has recently been reported in Greece, a country that has shown considerable resilience until recently.

With reference to the reaction of the population to financial crises it is important to differentiate between normal sadness (an adaptive and potentially productive response) and depression (a disruptive psychopathological response). This is important as to the management of the mental health effects of crises.

In view of the association of unemployment with depression and suicide it would be prudent to select the lesser of two evils (i.e. cuts in salaries rather than dismissal from work) when saving money is a sine qua non necessity. It is also important to select culture-specific policies (e.g. support of the family in countries of the European South contrary to social protection schemes that are more relevant to Northern countries).

Although investing in Mental Health contributes to cost-effectiveness and increased productivity yet this investment has not been proportionate to the evidence. Not only government officials but also the public view mental health as low priority when confronted with the need for budget cuts. This calls for effective communication of mental health professionals and advocates with all stakeholders including policy makers and the public.

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Parallel Forum 4

Building Resilient Healthcare Systems

More health through systemic innovation

By Bernhard Bührlen, MetaForum Innovation for more health

With regard to financial issues, demographic change and other challenges to our health systems, it is obvious that fundamental change is necessary. Concepts are necessary that are innovative in the sense that outdated positions be left and obsolete technologies and procedures be abandoned in order to release resources for more adaptive methods. However, the impact of past health system reforms has been restricted. Health policy and health systems are highly complex and to a large extent intransparent, which leaves room to powerful stakeholder groups to pursuit their needs and interests and thus secure the status quo against change. Traditional, but also modern concepts of governance for health reach the limits of their ability to enforce the necessary changes. Implementing 'stand-alone' programmes for more transparency or for more user involvement or for more outcomes orientation is useful, but not able to bring about the need basic redirection.

Instead, it is the conviction of the think tank MetaForum 'Innovation for more Health', that for real systemic innovation towards more sustainable and resilient health care, synergies of different, inter-dependent approaches have to be enabled:

- A new understanding of health and well-being
- Equality of chances
- Active participation
- Ability to innovate, systemic change and sustainability
- Transparency and readability of the system
- Orientation towards benefits and outcomes
- A new comprehension of health economy
- Fundamentally new health policy making

Different policy interventions need to work together in a coordinated way: Transparency without health literacy cannot work, nor can user participation without outcome orientation. It is necessary to take into account whose of the different stakeholders' goals are met actually and whose are not, if the expert-based governance that we see now is sufficient, and how healthcare reform or innovation should be designed.

The presentation will give a short overview of the mentioned concepts and their mutual dependencies. This could help clarify some of the concepts and related goals to facilitate the further discussions.

Parallel Forum 5

mHealth. Health at your fingertips

Supporting LIFE in Malawi and building its mHealth Infrastructure

By John O'Donoghue, Health Information Systems Research Centre (HISRC), University College Cork, Ireland

Background: The vast majority of front line health care for children with acute illnesses in sub-Saharan African countries is provided by health care workers who have a basic level of training. In Malawi, these are known as Health Surveillance Assistants (or HSAs). They are a group of trained, outreach workers employed by the Malawian Ministry of Health who serve as frontline health care staff in the battle against largely preventable childhood diseases. Two major diseases include malaria and infantile diarrhoea. Malaria is a significant problem in Malawi with preschool children having the highest prevalence of malaria parasitaemia and 60.1% of preschool children had trophozoites present in their blood samples. Infantile diarrhoea is another health problem in Malawi as 22% of children under 5 years of age had infantile diarrhoea in the 2 weeks prior to a health survey in Malawi of whom only 36% were brought to a health facility for treatment and 18% received no treatment. If healthcare workers are unable to manage diseases at the individual level then attempting to apply disease management protocols at a national level will be very challenging if not futile.

Solution: To support HSAs at the patient point of care and larger epidemiological bodies to manage and control diseases, we propose to use low cost technologies through the development of the Supporting Low-cost Intervention For disease control (Supporting LIFE) project. Supporting LIFE, seeks to utilise established technology to circumvent the absent or limited healthcare infrastructure by exploiting the cellular telecommunications network, the utilisation of vital sign sensor technologies and point of care decision support systems. More specifically the Supporting LIFE project will develop an eHealth solution based on the WHOs Integrated Management of Childhood Illness (IMCI) namely an electronic-IMCI.

Successful Long term Partnerships (Malawi and Europe): The Supporting LIFE project is led by UCC (Dr John O'Donoghue and Dr Joe Gallagher) in partnership with Lund University (Sweden) and Oxford University (UK). However the real success of the Supporting LIFE project lies in the leadership provided by our Malawi partners, Mzuzu University, Luke International Norway (NGO), Ungweru (NGO) and the Malawian Ministry of Health. It is through this strong Malawian consortium that the Supporting LIFE project will succeed in its project objectives. In parallel it will greatly enhance the potential of meeting larger national mHealth Objective e.g. eHealth, mHealth, and Cloud Services within Malawi and other low resource settings. To build on this success and to develop a long term sustainable mHealth model between UCC and Malawi, UCC in partnership with Mzuzu University is establishing a fully dedicated eHealth facility christened the Supporting LIFE Institute within Mzuzu University campus.

Tags:

Application Perspective: (Recent Developments and Challenges)

Actor Perspective: (Improved Care and Added Value)

Security Perspective: (Privacy and Safety)

Evaluation of apps

By David Sainati, CEO, Medappcare, France

Mobile health is booming: there are a huge number of mHealth apps on app stores and it exists a lot of health connected objects (scales, tensiometers, watches, etc.). In front of this abundant offer, the issue of the quality of mobile health applications is pivotal. Today, there is no medical validation for mHealth apps and no guarantee of safety and quality is given to users... Medappcare has developed a leading medical and technical evaluation method for mHealth apps.

Parallel Forum 6

Non-Communicable Diseases. From research to action

Non-communicable diseases and the food environment

By Hannah Brinsden, Policy/Advocacy Researcher, International Association for the Study of Obesity, UK

The growing health burden of non-communicable diseases (NCDs) has been recognised by the World Health Organization (WHO) and the United nations (UN), with the adoption by member states of an 'omnibus' resolution to tackle NCDs which includes a overarching target to reduce NCDs by 25% by 2025. The 2013 Global Burden of Disease report showed that 14 of the top 20 health risk factors globally are diet related and there is widespread recognition that changing food environments are a major cause of the NCD epidemic. In particular, the rise in processed foods which are high in fat, sugar and salt, the marketing & promotions of these products by food corporations, as well as the increasing ease of access to fast food and the relative inaccessibility to fresh fruit, vegetables and meat. It is imperative that action be taken to address the food environment if we are to achieve the WHO target to reduce NCDs by 25%.

My brief presentation will

- Highlight some of the work being done to benchmark food environments as part of the INFORMAS project (International Network for Food and Obesity / Non-communicable Diseases Research, Monitoring and Action Support)
- Identify some examples of important food policies from around Europe
- Discuss the conflicts of interest that arise when addressing food environments, including questioning the role of the food industry in tackling NCDs
- Identify opportunities for public-interest and civil society advocacy so as to stimulate policy change, improve food environments and reduce the global NCD burden.

Tobacco industry interference in the policy–making process

By Stephanie Kumpunen, Research Officer, London School of Economics and Political Science, UK

Building on Gilmore's thesis from the NCD Forum at EHFG 2012, that corporations have responsibilities to maximise profits regardless of consequences to health, society or the environment, and to oppose policies that could reduce their profits, in this presentation I will argue that corporations use precise strategies to manipulate the policy making process.

The evidence discussed during the presentation will include recent examples of 'behind the scenes' industry interference on plain packaging in England, and more globally on the overt interference in public policy linked to Corporate Social Responsibility. Evidence from public meetings and private documents will be presented.

Workshop 3

Resilient Gx policy

Will generic use policy stand up to resiliency?

Introduction and basic consideration concerning the impact of generic policies

By Diana Brixner, Professor, Pharmacotherapy Outcomes Research, University of Utah, USA

A recent systematic review of has identified mixed evidence around outcomes versus cost. It revealed that scientific evidence on real world impact of generic substitution is scarce and that the assumption that generic substation is generating saving for the healthcare system is not always supported. In addition to the heterogeneity in cost-effectiveness of generic policies the definitions and market authorization regulations for generics vary considerably worldwide. A better understanding of the significance of bioequivalence or therapeutic equivalence and the potential limitations of current conventions in relation to interchange ability will be important to achieve more sustainable generic drug policies.

Variability in healthcare systems

By Nikos Maniadakis, Professor, National School of Public Health, Greece

A recent study comparing identified a high heterogeneity of definitions and market authorization conditions for generics or even a total lack of clear guidance in some countries. At the same time generic penetration is often cited as a key indicator of healthcare efficiency. The maximization of healthcare efficiency and supporting policies is pursued in order to better control the ever increasing demand and expenditure for health services. Often, pharmaceuticals (approximately 20% of total healthcare expenditure) are a primary target for achieving efficiencies. A study focusing on the efficiency of pharmaceutical control policies will be presented which is based on data of pharmaceutical policies and markets across 65 countries. The following domains were analyzed: pricing, reimbursement, dispensing, expenditure and demand control. In each domain, policies were classified and graded for the degree of regulation following a rating achieved through a multiple-country expert survey. Countries were clustered according to their policy mix. The study concludes that more regulation does not appear to increase efficiency or decrease expenditure on pharmaceuticals. Often more balanced approaches which allow freedom of choice, create incentives and foster competition may be more effective in meeting policy objectives and efficiency in pharmaceutical expenditure.

Access to drugs and drug availability

By Anke-Peggy Holtorf, Health Outcomes Strategies GmbH, Switzerland

Drug shortages worldwide and in Europe specifically were examined for the underlying causes and resulting consequences for health and cost. Common denominators of the increasing occurrence of drug shortages were aggressive price pressure leading to unsustainable profit levels with unintended negative impact on access to medicines or medicines quality. To ensure consistent access to safe, effective and consistently used medicines, more prudent decision making processes should allow the consideration of important endpoints beyond lowest price for pricing, listing, and purchasing decisions. It is strongly recommended to develop integrated solutions which consider all stakeholders and allow for reasonable incentives for those who are willing to invest in stable drug supply.

Value versus lowest price

By Zoltán Kalo, Professor, Eötvös Loránd University (ELTE), Hungary

After discussing the experiences with internal price referencing in countries with economic constraints, we will present the results of a retrospective real world analysis based on billing records of the Hungarian Health Insurance Fund, which shows on one hand that in chronic diseases switching to generic drugs after the patent expiry of original medicines may reduce health care costs. On the other hand, frequent switching among generic brands may result in negative health outcomes and increased health care costs. Suboptimal design and implementation of generic drug policies in chronic diseases may compromise expected benefits (i.e. same health gain at lower costs). Better evidence is needed to assess the compliance of patients and prescribers with cost-containment initiatives of payers.

What value can industry contribute to the public health care system?

By Jie Shen, Abbott Products Operations AG, Switzerland

Potential value dimensions from the industry perspective including proof of quality or bioequivalence, supply reliability, outcomes evidence, clinical improvement investments, outcomes improvement programs or other investments will be outlined. The objective of the discussion will be how these dimensions can be considered and rewarded in healthcare decision making.

Alternative funding sources: Universal coverage versus need for patient centricity and freedom of choice

By Helen Chung, Head of Health Policy Research, Swiss Re Services ltd., UK

This part of the discussion will focus on funding scenarios of healthcare, with emphasis on pharmaceuticals, that could strengthen resilience and sustainability of healthcare systems. Variations on the mix of public and private financing will be explored, with international examples.
Barriers to attaining an optimal mix will be considered, bearing in mind the trade-offs inherent in seeking equity and efficiency, but also to offer choice, satisfy preference, ensure quality and encourage advances.

The overarching debate for the session

How to improve standards and evidence to make appropriate, resilient and affordable policies for generics in the future. The case for a new approach to considering value, cost and prioritization of medicines will be discussed with the audience.

Workshop 4

Knowledge Translation

Research knowledge translation for policy development: barriers and facilitators?

Bridging the Research-Policy Gap within the WHO European Region - EVIPNet Europe

By Tanja Kuchenmüller, Evidence and Intelligence for Policy-making, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe

Despite considerable investment in global health research, health systems fail to deliver effective and cost effective services, leading to diminished health outcomes for populations and lost productivity (Lavis et al. 2003; Landry, et al., 2006; Pablos-Mendez, et al., 2005). For instance, evidence suggests that approximately 20-30 per cent of patients in the U.S. receive healthcare that is either not required or that could have harmful effects (Schuster et al. 1998). One of the key reasons why health systems fail to achieve better health outcomes is the "know-do-gap"—the difference between what is known (through research) and what is being done (applied in policy and practice)(Grimshaw et al. 2012).

The study of "knowledge translation" (KT) has emerged in the last two decades as the need to promote the influence of sound scientific evidence in the development of health policy and practice has gained increased international attention (Hanney et al. 2002).

KT is an iterative, dynamic and complex process. For conceptual purposes, Ian Graham and colleagues divide the process of knowledge translation into two phases: knowledge production and application (Graham et al. 2006). Other scholars, such as John Lavis, study the approaches of KT, distinguishing between four approaches: pull, push, exchange, and integrated (Lavis et al. 2006).

Building on the two frameworks above, WHO launched its Evidence-Informed Policy Network (EVIPNet) in 2005. While the frameworks support the analysis and development of KT interventions, it is equally important for EVIPNet to take findings related to barriers and facilitators of research utilization into consideration. For example, a prominent systematic review of this topic, which included 24 studies and 2,041 interviews with health policy-makers, concluded that the most commonly reported facilitators were personal contact, timely relevance and the inclusion of summaries with policy recommendations. In contrast, the most commonly cited barriers included the absence of interpersonal relationships, delayed or irrelevant research, mutual mistrust, and budget struggles (Innvaer et al. 2002).

The presentation concludes with a review of EVIPNets strategic plan and programme overview in Europe.

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The project Improvement in Postoperative PAIN OUTcome (PAIN OUT)

By Winfried Meissner, Department of Anaesthesiology and Intensive Care, Friedrich-Schiller University Hospital, Jena, Germany

Summary: The overall goal of the PAIN OUT project is to optimize pain—related outcomes of European citizens after surgery. To this end, postoperative pain management may serve as an example for other fields of medicine with high variability in care.

The project's main objective is to develop, validate and maintain an acute pain registry which includes a system for longitudinal measurement, feedback and benchmarking of patient reported outcomes. The registry allows comparison of quality indicators related to postoperative care between different countries and healthcare settings and to provide clinicians, hospitals and other stakeholders with treatment recommendations based on "real-life" data on patients' outcome. By end of the 4-year-funding period, the registry consisted of over 35,000 patient datasets and in addition to the original project partners, collaborators from over 60 hospitals, from all over the world, took part in PAIN OUT.

Research Knowledge Translation for Policy Development: Barriers and Facilitators

One of the main barriers in translating scientific knowledge into everyday clinical practice is the gap between evidence obtained from small-scale, selective prospective trials (=Randomized Controlled Studies, RCTs) as compared to the highly variable conditions patients experience in the real world. 'Real world' patients do not often match study settings. This results in non-transferability of evidence-based recommendations and guidelines (RCTs measure "efficacy" but not "effectiveness")

PAIN OUT offers both sides of the coin to clinicians and policy makers. On one hand, users receive feedback from 'real-world' patients and on the other hand, they are provided with contemporary, summarized recommendations from high-quality guidelines.

The primary target groups of PAIN OUT are policy makers at the local (hospital) and national levels. At the local level, PAIN OUT supports clinicians on the ward, ward and hospital directors with feedback of findings from their patients which allow them to identify deficits and areas with room for improvement. The standardized assessment of quality indicators facilitates rational discussion of strengths and weaknesses of care. It prevents discussions which are based on "gut feelings", and so can be appealing even to providers who do not give high priority to pain management.

PAIN OUT can help to change clinical practice and to monitor the effect of successful interventions on outcomes (e.g., introduction of a new drug). PAIN OUT allows identification of successful interventions, and thus, is an excellent tool to motivate and reward staff.

External comparison or 'benchmarking' allow identification of best practices in other institutions, and allow for 'learning from each other'. Audits performed on the basis of patient reported outcomes instead of structural and process criteria provide information based on direct indicators of quality rather than surrogate measures. By these means, PAIN OUT helps to allocate costly resources (e.g., Acute Pain Services) to those areas in a hospital with the largest benefit.

On a national level, PAIN OUT generates epidemiological data which support policy makers in scientific societies, professional organisations and the public health system to set up research and education agendas, normative regulations (e.g., accreditation/certification activities, obligatory quality assurance, pay for performance, public disclosure) and other activities aimed to provide better care to patients.

The project "Improvement in Postoperative PAIN OUTcome" (PAIN OUT) was funded by the European Commission's 7th Framework Programme (FP7) and included 17 participants from 9 countries.

Breakfast Workshop 1

Outcome Variation

Moving towards safer and more efficient health services – evidence from the ECHO project on systematic variations in healthcare delivery

Collective abstract

Enrique Bernal-Delgado, Aragon Health Sciences Institute (IACS)

Jeni Bremner, Director, European Health Management Association (EHMA)
Mark Pearson, Head of the Health Division, OECD
Paul Giepmans, Policy Analyst, European Health Management Association

Quality, access and efficiency of healthcare services are growing concerns in Europe and are at the heart of all debates in health policy-making and management. The healthcare agenda of European Member States is driven by the question how we can achieve better healthcare accessible to all, without threatening the sustainability of systems and services. The European Collaboration for Health Optimization (ECHO) project is an international effort to deliver unique insights on the unwarranted variation in the effectiveness, quality and safety, and efficiency of health systems and services. It shows, from a geographical perspective, whether populations are over or under exposed to healthcare, and from a hospital-provider perspective it allows for analyzing patients' exposure to high or low hospital care quality.

ECHO brings together comprehensive record-level patient data on virtually all patients treated in public hospitals from six European countries in order to compare health care performance across countries, and at detailed sub-national organizational and geographical levels. For that purpose, ECHO has built a comparable set of indicators able to portray systems performance in several areas of care.

This session brings the first results of the project, and shows how the output can result in better decision making in healthcare. Participants will be engaged in discussions around the best possible uptake of results and how different stakeholders can engage in turning evidence into good decision-making.

Lunch Workshop 3

Schizophrenia and Social Inclusion

Schizophrenia and social inclusion: perspectives, needs and solutions

Collective abstract

Kevin Jones, Secretary General, EUFAMI
Esko Hanninen, Health and Social Policy Advisor
John Bowis, Health Policy Advisor

Schizophrenia is a severe brain disorder characterised by fundamental disturbances in thinking, perception and emotions (1). Affecting approximately 1% of the world's population (2), it usually starts between the ages of 16 and 25; impacting people in the prime of their lives (3,4).

Schizophrenia has a major and multifaceted economic impact on society. The direct costs of providing care for people with schizophrenia account for 1.5 to 3% of national health budgets (5). The use of hospital beds is high amongst people with the condition, and the cost of in-patient care is the largest component of the direct healthcare costs of schizophrenia (33-66%) (6). The indirect costs encompass loss of productivity – approximately one fifth of people with schizophrenia who are of working age are employed (7) compared with 65% in the general population (8). Costs to other care organisations and public sector bodies, particularly social service (welfare) agencies, housing departments and the legal system, are also important but less readily observed (5).

A major contributing factor driving the cost burden of schizophrenia is social stigma; which can deter people from seeking diagnosis and thereby access to appropriate treatments and support (1,2,9). This can create a vicious cycle of discrimination leading to high levels of social exclusion and the rise of indirect societal costs, including unemployment (80%) (5), drug abuse (47%) (10), long-lasting institutionalisation (9.8%) (11) and homelessness (6%) (12). These factors can further impact

recovery, adding to the indirect cost on society, borne largely by the person with schizophrenia and their caregivers.

To address some of these issues, F. Hoffmann-La Roche is undertaking a global policy study which considers the impact schizophrenia has at every level of society.

The study aims to understand and identify:

- The level of social exclusion among those people affected by schizophrenia
- How social exclusion impacts everyday living for people affected by schizophrenia, including the wider family circle
- The benefits of social inclusion for people affected by schizophrenia – for individuals and for wider society
- The policy solutions to support the social inclusion of people affected by schizophrenia, and members of the enlarged family unit

At this year's European Health Forum Gastein your contribution through a live voting session will add to this study and together will help to inform discussion on the areas of real need, the challenges and the opportunities for policy change for social inclusion in schizophrenia.

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Workshop 7

State of Oncology 2013

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Great advances have been made in treating and curing cancer patients in recent decades, but there is still a long way to go. Collectively, we face significant future challenges in cancer management owing to growing inequalities both globally and nationally in access to diagnostics and treatment, an ageing population, rapidly increasing prevalence in the developing world and increasing incidence/survival rates bringing about their own burden to healthcare systems.

For policy makers, the importance of actively addressing these challenges in cancer cannot be under-estimated. The session, coordinated by the International Prevention Research Institute (iPRI), offered a forum for discussion to support policy makers in tackling the issues. The global cancer burden has doubled over the last 25 years and is set to double again before 2030, making prioritizing a robust and future focused management strategy essential to meet the demands of tomorrow. The session focused on joint-working and ideas exchange, including a networking session to interactively discuss the policy changes that could be made by political leadership to ensure successful developments in oncology in the decades ahead.

As well as ideas exchange, the audience considered how the four pillars of oncology continue to offer a useful blueprint to guide policy and prioritize action to be taken:

- **Prevent all Cancers that can be prevented**. Half of cancers have avoidable causes meaning prevention efforts are an important part of the puzzle, including tackling smoking, alcohol, excessive sunlight exposure, lack of physical activity, poor diet and obesity. In lower resource regions, the

majority of cancers are caused by chronic infections making the development and delivery of effective vaccines vital.

- **Treat all Cancers that can be treated.** Whilst cancer treatments have improved substantially, many patients do not have access to modern therapy regimes. Every cancer patient has a right to the best cancer treatments for their condition

- **Cure all cancers that can be cured.** Whilst therapies targeted at specific biological or genetic features of certain cancers are starting to be developed, there are many hurdles which will limit their introduction into all but the highest resource settings.

- **Provide Palliation whenever Palliation is needed.** Improvements in palliative care in the past decades have been slow to be rolled out in every high-resource country. Palliation is needed not only for pain control in the final moments of life, but should be available at every part of the cancer pathway. The situation in low-resource countries is appalling and must be addressed as a priority.

On top of these pillars however, it is clear that to solve the momentous global inequalities in cancer care and outcomes that exist, we need to go beyond current financial investment and move towards radical new ways of thinking, adopting innovative models and building effective and sustainable public-private partnerships. The sophisticated therapies in development offer great potential for progress to accelerate, but we cannot let cancer care become a luxury good, and so closing the access gap will become as important as innovation in the future fight against cancer.