1st EAPM Global Conference

‘Forward Together - Where we are now and the necessary next steps for a resilient healthcare System: effective ways of investing in healthcare in a COVID 19 and Post-COVID 19 world’

Tuesday, July 14th, 2020
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Executive Summary
This conference, a global stocktaking of healthcare in the pandemic, was also an exploration of how far improvements are continuing to be effected in the quality of life for citizens and patients, and as such was a bridge building conference in more ways than one. It brought together representatives of distinct disciplines and interests - public health decision makers, regional institutions, politicians, patient organisations, and associations engaged in personalised healthcare, and it attracted 440 participants from a broad health community across geographic divides as wide as China, Japan, Australia, New Zealand, Malaysia, Brazil, Peru, Cuba, Rwanda, South Africa and, of course, North America, and the EU. It explored the connections and parallels between tackling COVID-19 and developing personalised medicine. It considered how to bridge the gap between paying for innovation and keeping healthcare funding sustainable, and between short-term costs and long-term benefits. And it offered some pathways between many distinct - and sometimes contrasting – perspectives on healthcare.

During the pandemic, EAPM continues to promote the incorporation of personalised medicine into healthcare systems, with the aim of allowing the health of all citizens to benefit from the uptake of innovative medical interventions tailored to the specific needs of individual patients, providing better treatment, preventing undesirable adverse reactions, and fostering a more efficient and cost-effective healthcare system.

The underlying issue is how, both during and after the pandemic, innovation can best be supported and translated into healthcare systems, and the conference provided a forum for exploring whether the experience with COVID-19 has lessons that relate to personalised medicine – and vice versa. This can be broken down into specific sub-questions, such as how can we empower data to drive better health care decisions, providing evidence for clinicians, policymakers and decision makers; how can we facilitate dialogue among stakeholders - not just in the pharmaceutical sector and with diagnostics companies and technology companies, but also with physicians, academia, patients, regulators, payers and policymakers; how can we develop policy frameworks that respond to the urgency of the need for action – to tackle the pandemic and to create sustainable health systems; and how can the challenges be addressed through greater global and regional alignment among different stakeholders.
The evolving responses to the pandemic, including emergency-driven shifts of focus and resources, have highlighted obstacles to the implementation of personalised medicine. But they have also suggested opportunities to accelerate progress, not least in the impetus that COVID-19 has given to high-end medical research, to radical thinking about health systems, and to a new spirit of cooperation. But success in surmounting obstacles and in realising opportunities depends on meeting certain conditions. These include identifying and establishing the appropriate mechanisms and incentives at national, regional level and global level; building more effective and more inclusive forms of cooperation; and creating appropriate policy frameworks that go beyond EU Council Conclusions on personalised medicine, or the Precision Medicine Initiative in the US. The challenge now is to design and develop new frameworks that are inspired by the best examples of recent healthcare thinking, in order to build further bridges between stakeholders.

The form of the conference was two successive seminars, one in the morning covering Asia, the Middle East and the European Union, and one in the afternoon covering European Union, Latin America and North America. Each seminar reviewed the same broad issues: New science and new opportunities in a COVID-19 and Post COVID-19 world; Propelling Health Care into the Twenties: Futureproofing the Global Policy Landscape; and Grasping the chance: transforming healthcare through public-private cooperation. The detailed programme and list of speakers appear as an annex to this report.

The conference delivered numerous recommendations, which appear throughout this report. EAPM will be setting up an expert panel to discuss them, and to consider actions to promote the most appropriate links between global experience and the approach for the EU. There is a pressing need for closer alignment between distinct approaches to healthcare, while still respecting the principle that healthcare is delivered locally. Precedent already exists for this, in, for example, the agreement by member states to share data as inspired through EAPM’s MEGA project, or in the current efforts to create interoperability, or - most compellingly right now - in the joint work underway to counter the COVID-19 pandemic, the plans for a European pharmaceutical strategy, and incentivisation of research into unmet need. EAPM is committed to a continued contribution to this evolution.

Denis Horgan
Executive Director, European Alliance for Personalised Medicine
Reccomendations

• Better links in the access chain and between funding bodies, industry and technology platforms.

• More integration of data systems and elimination of silos that divide healthcare stakeholders.

• Closer collaboration between basic researchers and clinicians in multidisciplinary teams on discovery and implementation of reliable diagnostics.

• Closer partnership and collaboration across the health system, with public and private engagement.

• A public health vision, mission, and strategy and a smart implementation plan for new ways of innovating in healthcare systems.

• Sustainable long-term funding for critical healthcare resources and infrastructures.

• Recognition of the connection between public health and personalised healthcare.

• Greater emphasis on prevention, wellbeing, and better public health to create a value-based environment.

• Relevant training of the health workforce and increased institutional health literacy

• Health equality and rational allocation of resources to ensure better quality of life for patients and citizens.
In his opening remarks to the conference, Denis Horgan drew attention to the striking parallels in the questions posed by the COVID-19 pandemic and by the implementation of precision medicine. The theme was echoed by panellists throughout the day.

Recent decades have seen a dramatic increase in collecting, analyzing and visualising data, based on growing knowledge of genomics and more sophisticated screening and testing technologies and strategies. These have provided the base for the development of personalised medicine. At the same time, many weaknesses and gaps remain in healthcare systems, which are often reluctant to adapt to new challenges and new opportunities. This encapsulates the challenge facing the implementation of personalised medicine. It also encapsulates the challenges thrown up by the pandemic. COVID-19 has given new prominence to the issues of understanding disease and searching for remedies – and at the same time it has highlighted the risks of systemic inertia or weaknesses in public health strategy. But there are grounds for hope that the sheer scale and urgency of the pandemic, and the unprecedented international resonance it has lent to the need for solutions, is generating a new dynamic in cooperation and radical thinking.

Central to success in relation both to COVID-19 and to personalised medicine is the need for a comprehensive vision. The immediate challenge in each is the elucidation of pathology, but the implementation of effective measures – to control and combat COVID-19 or to integrate personalised care – depends in each case on an all-embracing approach. COVID-19 cannot be defeated by looking at only part of the population or part of the world. Personalised medicine cannot be put into effect without taking account of the broadest sweep of healthcare. Both of them require a shift in the structures and priorities of health systems, to take account of the collective as well as of the individual. And both of them depend heavily on collaboration and on a degree of personal engagement: the collaboration of researchers and innovators and policymakers and professionals in delivering care, and the responsibility of the individual – for risk avoidance in social distancing and the wearing of masks to minimise transmission of coronavirus pathogens, or for contributing to personal health through lifestyle choices.

The obvious question that arose was how to capitalize on this to develop policy frameworks in Europe, in North America, in Latin America, in Asia, Australia, or in Africa. Because new policy frameworks will, it was widely agreed, be necessary both to avert or resist further pandemics, and to build more responsive and sustainable healthcare systems that exploit the possibilities of innovation.
Introduction

The meeting reflected the widespread conviction that the pandemic requires detailed study of long-term responses in the health domain, as well as assessment of its economic impact and the consequences for healthcare funding. Cooperation, co-development and alignment – along with investment in public health - were the constant refrain of panellists from around the world.

On the form that the cooperative responses should take, positions were more nuanced, with advocacy for a focus on themes as distinct as preparing preventive measures, managing future uncertainty, or protecting vulnerable populations. Workforce development issues, more extensive health infrastructure and quality of medicines also featured prominently. But the essence of the debate was the recognition that while healthcare is influenced by numerous distinct factors, it is vital to maintain links along the entire chain, and recognize the interaction among all the different elements if the right policy options are to be chosen.
The objective of better and more patient-centric healthcare is neatly characterised by the four Ps - as Maude Elvira Phipps, Professor of Human Genetics at the Monash University Malaysia, remarked early in the day: a constellation in which increasingly sophisticated technology permits medicine to be more predictive, preventive, personalized and participatory, and to move care from the obsolescent approach of one-size-fits-all into the domain of the individual.

It is predictive in its capacity to identify high-risk individuals with specific (and often hereditary) causative mutations – such as Crohn’s disease, before the manifestation of disease onset, possibly permitting early intervention.

It is preventive with individuals with diseases or conditions that are more strongly influenced by environment and lifestyle than by heredity, such as type 2 diabetes.

It is personalized in providing the right dose for the best outcome, guided by information on population genetics. Phipps illustrated the point with her experience among populations across Asia with different and specific genetic clusters (central European, African, Asian). “Personalization based on genetic testing requires clues about the population that individual comes from,” she said. She cited the value of this approach in permitting the avoidance of a trial and error approach with warfarin among Malays, Chinese and Indian populations displaying variations in vitamin K receptors.

For optimum personalisation, genotyping is necessary. Patients with similar phenotypes may have biologically distinct disease profiles related to differences among endophenotypes, and this requires deep phenotyping – which also provides valuable volumes of big data, she added.

And it is participatory, since it requires confidence and trust among patients and practitioners in the reliability of healthcare systems, in health policies, and in healthcare service providers.

As one participant remarked, without the right structures and links, aiming at something a refined as personalised care can be seen as tantamount to looking for a needle in a haystack. However, there is a fifth P which might be seen as one of the key outcomes of the conference - the public aspect of personalised healthcare. This constitutes a bridge from the individual to population-based health care, with epidemiology guiding an approach which is not only personalised but also stratified. This is the mechanism, it was argued, that can make it possible to target the best individual care on the basis of informed foresight – a much more effective approach than assessing each individual against an almost limitless range of options.

**Personalised medicine**
Covid-19 The disruptor

Ample evidence was presented of the negative disruption that coronavirus was inflicting – obviously in terms of direct mortality and morbidity, but also in the adverse consequences in delayed diagnosis or treatment of other conditions, from cancer surgery to vaccination. As one cancer patient representative said, “COVID-19 global pandemic has quite literally wrought havoc”, citing also the increased risks of infection, and interruptions to follow-up, support and palliative care. The point was echoed by cancer specialists from Australia, Japan, India and Brazil, with examples ranging across productivity loss, surveillance, primary prevention and screening.

The pandemic also starkly exposed the underlying inequalities both between and within countries and communities, with higher rates of incidence evident in the most disadvantaged populations.

However, COVID’s 19 impact has also instigated some positive responses. The conference heard numerous examples of how health services had reacted with corresponding disruptions to mitigate the negative impacts. At the simplest level, developments cited in the digital virtual telehealth space included the steep increase in the use of telemedicine: Dan Grant, Managing Director, MTP Connect, Australia, said that he had seen consultations by phone or video rise to 80% of the total, and Maarten added that the practice had been reinforced by new payment arrangements that for the first time compensate doctors. Similarly, clinical research organisations are now accepting electronic signatures on legal documents – after years of fruitless advocacy for it to happen. Contact tracing apps are being developed at speed in many countries, wearables include identifying bracelets or tokens, and drones are being trialled to retrieve testing samples from isolated indigenous communities in Malaysia to avoid risks of contamination populations sequestered in the jungle.

The sudden growth in health infrastructure and digitalisation of health as health systems react to the challenge has gone wide and deep. Examples offered included the rapid build-up of critical care capacity in many countries, the rescheduling of routine care in a bid to compensate for disruptions, the wide scale use in modelling for predictive analysis, and novel initiatives for data collection, analysis and sharing – including India’s national digital health mission, and the leap in the number of testing laboratories in the Balkans from two to 36.

The positive impacts of disruption have also been seen in the rapid changes in mindset. COVID 19 has been a catalyst in accelerating reflection and rethinking. As Mary Harney, former Irish Tanaiste, pointed out, the pandemic demonstrated not only that health systems were unprepared,
but also obliged politicians at last to recognise the direct link between health and the economy. There are numerous signs of health systems reacted with unprecedented alacrity to the new situation. Etienne Richer, Associate Director of the Canadian CIHR Institute of Genetics, reported how his institute had launched a dedicated research funding opportunity in early February and announced its first round of funding decision before the end of March “thanks to the dedication and all the work that researchers provided.” Mark Ferguson of the Science Foundation Ireland reported a similar experience in relation to funding of a contact tracing app, noting at the same time the many accounts from around Europe and beyond that funders “have been reviewing programmes much faster... there’s been international peer reviews to turn things around and we’ve still kept the quality.”

But the most remarkable shift has been the new readiness among distinct stakeholders to work across what previously were often only slightly porous frontiers, and that in many cases were rigidly-observed barriers. The clearest example is – as many panellists observed – the numerous collaborative drives to develop vaccines and therapies, and the trend towards large international clinical trials. As one panellist remarked, “It is truly breath-taking when you look at therapeutics and the amount of international collaboration and speed of sharing of data.” Not only has the pandemic spurred medical research. As Joanne Hackett, General Partner Healthcare Practice, IZY Capital, UK, added “this is where we’ve seen the pandemic highlight the importance of being open and receptive to sharing data.”
Improvements needed

The catalytic effect of the pandemic did not, however, induce complacency among the panellists. They were eloquent in identifying the need for improvements, both in the immediate present, and also longer term, to combat coronavirus and to establish personalised medicine more firmly as a guiding principle of health systems.

Overcoming fragmentation was a dominant theme: “No country is isolated in 21st century and that means there has to be a common approach,” as one panellist expressed it. There were repeated calls for the development of a genuinely global joint strategy to cope with the pandemic, and for closer integration in work together across the healthcare spectrum. It is essential “to share data and best practices and work together, whether it’s in the supply chain or education or empowering citizens,” said one. Overall, the pressing need is for a greater degree of global alignment on health system priorities and management.

Faster data access was another priority, with calls for corresponding improvements in data governance, so that, for instance, data moves directly from hospitals and laboratories to databases. Better use of data too needed encouragement: Mary Harney pointed out that 97% of hospital data is never exploited fully in personalised medicine, and Joanne Hackett queried the lack of policy for combining cancer test data from around the world: “Why can’t we be doing that?” Lillian I. Siu, Senior medical oncologist at the Princess Margaret Cancer Centre in Toronto, underlined the need for the development of real-world evidence as a new vision emerges of clinical trials leveraging a lot of data, with sharing initiatives around the world for rare diseases.

Pierre Meulen, executive director of IMI, argued for “a lot more integration”, and foresaw that the next phase of the public-private partnership model would overcome current silos and “build collective value and a seamless transition between the technology pushers and the innovation pullers in health systems.”

The building of greater trust and confidence had to be tackled head-on insisted many panellists – and this would require greater honesty and transparency among all stakeholders, along with sensitivity to legitimate concerns over privacy. Trust also demanded commitment to follow the evidence, and greater attention to literacy. This must be more than simply information and injunctions to patients and the public (even healthcare professionals needed reminding of the importance of washing their hands): real literacy implies a broad approach to education, to inculcating and reinforcing a sense of individual responsibility for health, and to adapting training and workforce skills.
Improvements needed

It also requires, as one panellist reminded the conference, with an oblique reference to recent high-profile withdrawals of scientific articles, a degree of humility, “because there’s an awful lot that we don’t know, and it’s important that we are very clear that the evidence may change”.

The importance of combating inequality was emphasised by Bogi Eliasen, Director, Head of Health/Head of Denmark Unit UNESCO Chair in Bioethics, who foresaw a risk that the evolution of high-end technology in more sophisticated testing would be focused on the richest 10% of the world, leaving the rest out of the picture. “We have to find a way to connect the disconnected people if we want to have resilient health systems. We must avoid creating another digital divide, and one that will be much more complicated to solve in the future.” Tikki Pangestu, former Director, Research Policy & Cooperation, WHO, Geneva, shared the view, wanting to see respect for the UN sustainable development goals with a corresponding focus on investment in universal health coverage with an emphasis on primary care and preventive approaches.

The overwhelming consensus from the meeting was that the coronavirus crisis should not be wasted, and that the progress it has promised and prompted should not be neglected as and when the crisis eases. While the immediate challenge is overcoming COVID 19, the key aim should be to maintain the momentum for more durable adaptations of healthcare systems, so that they become more resilient and sustainable – and able to mobilise those new capacities to exploit the full benefits of personalised medicine. “We must make sure that we don’t go backwards after we come out of the pandemic, but rather that we continue to move forward and take advantage of the changes that happen”, said one. “The pandemic is going to ensure that people understand without a good health system you cannot have a successful economy,” said another. As Mark Ferguson put it, “After any major disruption you very rarely go back to where you were before, so can we go forward to something better?”

Bogi Eliasen speculated on getting a better outcome in a different way - “maybe a new definition of personal health, not focused on specific treatments but with a lifespan as good as possible.” Others took a similar line: “Not necessarily just doing more of the same or trying to connect different dots, but starting to think differently about the outcomes.”

There was wide support for the view that the health sector has been lazy about innovation, slower than many other sectors in adopting change, and that after years of complacency over success in treating disease, it is time to re-focus on the possibilities of more preventive, predictive and personalised medicine. Joanne Hackett emphasised just how wide the scope of change should be.
“It sometimes has nothing to do with actual medical treatment, but with issues as basic as how to get food to hospitals, so there’s more to it than just thinking about new medications or different medications, but rather how are we going to accelerate and integrate that whole supply chain.”

But the question remains about how to achieve that progress, and how to persuade decisionmakers to accept its merits. Tikki Pangestu was guardedly optimistic, perceiving a strong dynamic of reform towards “more resilient and equitable and sustainable health systems.” But he acknowledged “We can’t make this happen without strong political will”. That can be secured, he suggested, only by persuading decisionmakers of the importance of collaborations and partnerships at national as well as global level. It will need a strategic pitch to emphasise the benefits to public health and the social and economic benefits of reducing inequality.

For Chai Chuah, Former Director General of Health at New Zealand Health Ministry, “Precision healthcare is where we have to go. But how we fund that in the short term before we see the long term savings is another question.” And he cautioned against underestimating “the gravitational pull of the conventional vested interests to frustrate what we are now seeing in some very early progress.” The adaptations must be coherent: they must cover service delivery, the funding environment, the business environment and the adoption of technology change. Progress towards personalised healthcare will not come about by accident, and still less for citizens everywhere. For Chai Chuah, it will require a clear purpose, a vision and a strategy.

Sadakatsu Ikeda, Associate Professor in Medical Oncology at Tokyo Medical University, said it had been possible to build a personalised approach in oncology in Japan through a combination of convincing leaders government leaders and key influencers in academia and industry, and wide collaboration among academia, industry, government, and patients– underpinned by adequate arrangements on technology and on reimbursement.

But the difficult issue of payment preoccupied many panellists. Stanimir Hasurdjiev, Chairperson of the National Patients’ Organization of Bulgaria, expressed some scepticism about “how to make all this research money work for society and patients.” And according to Sarah Garner, Acting Program Manager for Health Products and Pharmaceuticals at WHO EUROPE, “There’s no point in all this investment in research and development only for it to come screeching to a halt as the healthcare systems figure out how they’re going to pay for the products.” The access to high cost medicines is massive challenge, she said, urging “a new set of roles and responsibilities between industry and the healthcare systems to bridge that current gap where healthcare systems are saying it’s too expensive and industry is saying that we need this investment to maintain innovation.”

**Improvements needed**
Making it happen

If politicians are to support healthcare system transformation, they will have to be convinced of its benefits.

She added that WHO is examining how high-income countries can be supported, to find a way to bridge the gap on expensive therapies and how to encourage further, widespread innovation. Marcus Guardian, Chief Operating Officer of EUnetHTA, noted that “patients’ needs are very different from those of the CEO of a smaller company that has an amazing product,” and some form of collaboration will be needed to ensure that these needs are matched. In his view, administered pricing systems “are probably a barrier to adoption of these medicines”, and he urged broadening the concept of value for personalised medicine to incorporate the value of reducing uncertainty.

Carla Bedard Pfeiffer, Senior Health Systems Strategy Leader – Personalised Healthcare at La Roche AG, offered her own stocktaking of where we are now and of effective ways of investing in healthcare in a COVID 19 and post-COVID 19 world for more resilient health systems. For her, success would lie in greater integration of big data and digital solutions, and in better translating of research from basic to clinical and beyond. From her perspective, the central issue was how to foster a policy environment that promotes more resilient and adaptive health systems which are public health centered through a multi-stakeholder approach.

And amid all the diverse views expressed during the conference, there was general agreement that the opportunity of the moment is that innovation that is currently seen as disruptive could be transformed into innovation that is sustainable.
Reccomendations

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- Health equality and rational allocation of resources to ensure better quality of life for patients and citizens.
Session 1: New science, new opportunities in a COVID-19 and Post COVID-19 world

The potential is undeniable. New understanding of epidemiology, precision medicine, and pharmacogenomics, the deployment of technologies such as genomics, single-cell sequencing, microbiome analysis and transcriptomics, and the opportunities arising from bioinformatics and digital innovations can be transformative for individual patients. But policy frameworks and regulatory and legislative bodies have often struggled to react quickly enough, and healthcare professional training exhibits clear gaps. So the full benefits of better care, prediction of risk, promotion of healthy lifestyles, adaptations in healthcare organisation, and cross-fertilisation and collaboration between disciplines and professions, remain unrealised.

Maarten Ijzerman, VCCC professor and head of Cancer Health Services Research in the University of Melbourne, Australia

Maude Elvira Phipps, Professor of Human Genetics at the Monash University Malaysia

Bettina Borisch, Professor of Social and Preventive Medicine at the University of Geneva, and Director of the Secretariat of the World Federation of Public Health Associations

Jayesh Ranjan, Principal Secretary for Industries & Commerce to the Government of Telangana, India

Sadakatsu Ikeda, Associate Professor in Medical Oncology at Tokyo Medical University, Japan
Session 2: Propelling Health Care into the Twenties: Futureproofing the Global Policy Landscape

Even before the pandemic, policymakers were acknowledging the need for readjustments – and even for radical rethinking – of their approaches to health and health care. COVID-19 has imparted a new sense of urgency, which opens up the prospect of greater focus on the benefits of integrating personalised health care and personalised medicine into revised health care systems.

Bogi Eliasen, Director, Head of Health/Head of Denmark Unit UNESCO Chair in Bioethics
Joanne Hackett, General Partner Healthcare Practice, IZY Capital, UK
Tikki Pangestu, former Director, Research Policy & Cooperation, WHO, Geneva
Sarah Garner, Acting Program Manager - Health Products and Pharmaceuticals, WHO EUROPE
Mary Harney, Former Tánaiste and Former Minister for Health, Ireland

Session 3: Grasping the chance: transforming healthcare through public-private cooperation

Healthcare systems are not always ready to respond to new opportunities. A policy discussion is urgently needed to realise the potential of personalised healthcare globally and empower scientific enterprise that can benefit the population of the entire planet.

Pierre Meulien, Executive Director, Innovative Medicines Initiative (IMI)
Chai Chuah, Former Director General of Health at New Zealand Health Ministry
Dan Grant, Managing Director, MTP Connect, Australia
Nares Damrongchai, CEO, Thailand Center of Excellence for Life Sciences, Thailand
Carla Bedard Pfeiffer, Senior Health Systems Strategy Leader - Personalised Healthcare, La Roche AG
Seminar 2:
European Union, Latin America and North America

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Antoni Montserrat, Senior Expert on Cancer and rare Disease, DG Public Health, European Commission
Lars G. Hemkens, Deputy Director Basel Institute for Clinical Epidemiology and Biostatistics; Senior Scientist, Department of Clinical Research, University Hospital Basel
Etienne Richer, Associate Director, CIHR Institute of Genetics, Canada
Mark Ferguson, Chief Scientific Adviser to Government of Ireland

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Stanimir Hasurdjieiev, Chairperson, National Patients’ Organization Bulgaria
Marianna De Camargo Cancela, Senior Researcher, National Cancer Institute, Rio de Janeiro, Brazil
Lillian L. Siu, Senior medical oncologist, Princess Margaret Cancer Centre, Toronto, Canada
Marcelo D’Agostino, Senior Advisor for Information Systems and Digital Health, Department of Evidence and Intelligence for Action in Health at the Pan American Health Organization
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Alastair Kent, Formerly Director of Genetic Alliance UK
Lou Garrison, Professor Emeritus in The Comparative Health Outcomes, Policy, and Economics Institute in the School of Pharmacy, USA
Marcus Guardian, Chief Operating Officer, EUnetHTA
Du Wenmin, Shanghai Drug Monitoring and Evaluative System
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European Cancer Patient Coalition

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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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Next EAPM events

18 September, 2020:  
ESMO High Level Roundtable ‘Seeking innovation solutions at for cancer patients and citizens’

13-14 October, 2020:  
German Presidency Conference: “Building a decentralised, data-rich biomarker space to speed better care and quality of life for citizens and patients”

November 2020:  
2nd EAPM Global Conference: “Providing a global forum to ensure Public Trust in empowering Digital Data for health Science in a Covid and Post Covid World”