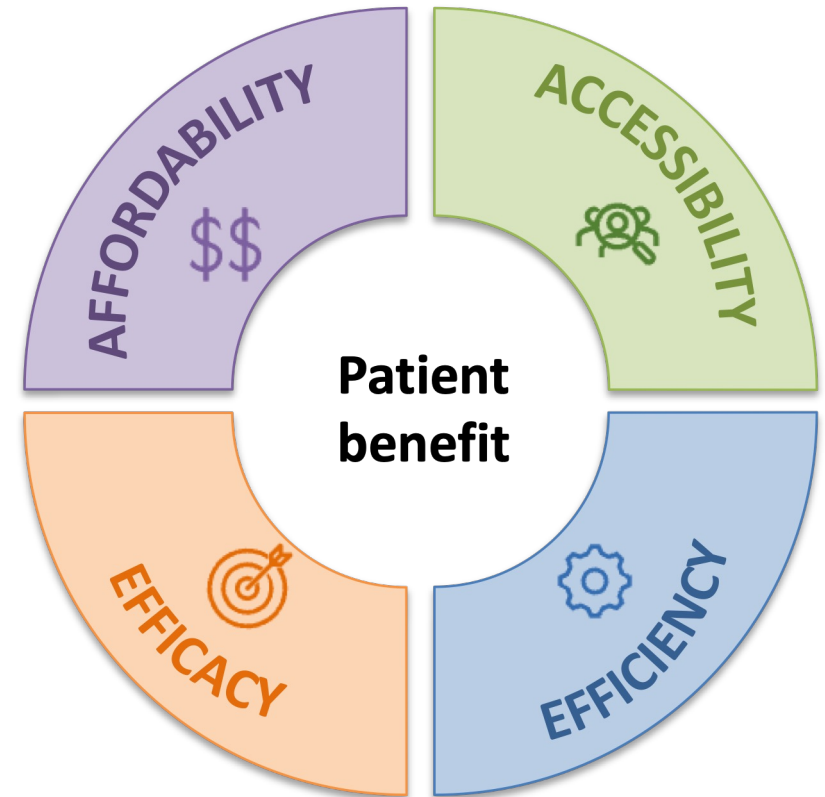


The Geneva Statement

Sustaining scientific progress,
patient benefit and equitable care
in oncology

Olivier Michielin, MD-PhD
HUG and University of Geneva

**Swiss Academy of Medical Sciences
ASSM / SAMW**

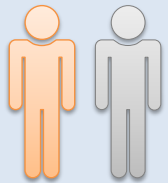


Geneva, June 2026
Manuscript submitted to Nature

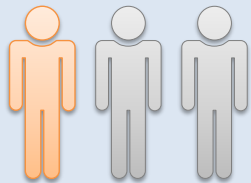
Cancer demand grows in volume, duration and complexity

Cumulative risk over a lifetime

1 in 2 men (2025)



1 in 3 women (2025)



Evolution of statistics

Evolution of incidence

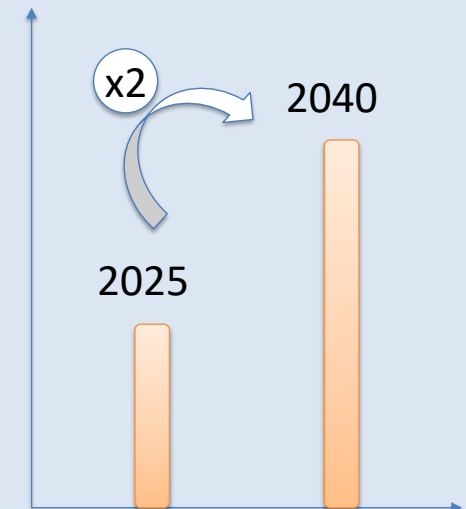
- Incidence on the rise, mainly due to population ageing

Increased survival

- Therapeutic advances increase 5-year survival¹
 - 2013: 64%
 - 2017: 67%

Projections for 2040

Increase in cases treated



A common direction across science, care and society

An international discussion

The meeting brought together cancer researchers, clinicians, economists, public-health experts and patient advocates at the Fondation Louis-Jeantet on 21–23 June 2026.

The question for 2035

How can society sustain high-quality, equitable cancer care and ambitious research as the patient population and costs grow?

What the Statement establishes

Ten recommendations span prevention, evidence generation, treatment, data, financing and the organisation of care.

What remains to be decided

The shared direction does not imply agreement on operational aspects, sequence or trade-offs. Implementation requires explicit choices.



We need to make choices!

ASSM supported the meeting and can help connect its scientific, ethical and health-system implications

Day 1 evening:

Opening Plenary: **Robert Weinberg**



Moderators: **Susan Gasser**
Jan Gerrit Schuurman

Day 2 Plenaries:

- A. Demographics and System Pressure**
- B. Economics and Cost Development**
- C. Regulation and Adoption**

Elisabete Weiderpass
Nils Wilking
Liselotte Hoejgaard

- **3 breakout rounds**
- **Plenary Synthesis**

David Hunter
Sarah Wordsworth
Claudia Habl

AI in Medicine:

Olivier Michielin
Charlotte Bunne
Moritz Gerstung

Day 3 Plenaries:

- D. Clinical Trials and Treatment Reform**
- E. Prevention and Early Detection**
- F. Infrastructures and Economic Sustainability**

Emile Voest
Julian Peto
Simon Oberst

- **3 breakout rounds**
- **Plenary Synthesis**

Liesbeth de Vries
Peter Sasieni
Otmar Wiestler

- **Sum-up:**

Anton Berns

ACKNOWLEDGEMENTS

“2035: Anticipating the Future of Cancer” was made possible by:

The generous support of many Swiss institutions and foundations

- ISREC Foundation, Lausanne;
- HUG Private Foundation, Geneva;
- Ludwig Institute for Cancer Research, New York and Lausanne;
- **SAMW/ASSM Swiss Academy of Medical Sciences, Bern;**
- Swiss Cancer League and Swiss Cancer Research Foundation, Bern;
- Martin Stoffel Fund of the UBS Philanthropy Foundation, Zürich;
- Mach-Gaensslen Foundation, Zürich;
- Fondation Solidar-Immun, Lausanne;
- HUG, University Hospitals of Geneva and UNIGE, University of Geneva;
- Fondation Philanthropia, Geneva;
- Fondation Michel Tossizza, Lausanne;
- Fondation Louis-Jeantet, Geneva

ASSM supported the meeting and can help connect its scientific, ethical and health-system implications

Four dimensions towards a sustainable cancer system



Affordability

Prices, value assessment and financing determine what the system can sustain.

Accessibility

Networks, workforce and patient participation determine who can benefit.

Efficacy

Prevention, early detection, research and trials determine what works.

Efficiency

AI, patient records, biomarkers and real-world evidence support better decisions.



We need to make choices!

The 10 recommendations of the Geneva Statement



- 01 Patient benefit guides resource allocation
- 02 AI across research and care
- 03 Meaningful trials that change standards of care
- 04 Prevention receives greater priority
- 05 Early detection and screening undergo evaluation
- 06 Networked comprehensive cancer infrastructures
- 07 Pricing and reimbursement reflect benefit
- 08 Proportionate regulation and less bureaucracy
- 09 A sustainable and rewarding workforce
- 10 Equity, access and patient involvement

The numbers refer to the order in the publication. Several recommendations contribute to more than one quadrant

The 10 recommendations of the Geneva Statement



Affordability

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Patient benefit is the basis for allocating resources



The full value of an intervention

- Overall survival and durable disease control
 - **Example: adjuvant anti-PD-1 in melanoma**
- Health-related quality of life and treatment toxicity
- Long-term care needs and patient time
- Rehabilitation, social participation and return to work

The decisions this changes

- Compare benefits with the resources required.
- Reassess low-value tests, surveillance and treatment.
- Fund care that delivers meaningful benefit.
- Link treatment price to the magnitude of benefit.
- Discuss less intensive and palliative options openly.

The Statement asks for a higher evidence bar, prices linked to benefit and continuous reassessment as longer-term outcomes become available.

Meaningful benefit should guide drugs, surgery, radiotherapy, diagnostics and supportive care alike



Prevention needs sustained public investment

Established priorities

Tobacco prevention and cessation
HPV and HBV vaccination
Healthier weight, activity and lower alcohol exposure
Protection from established carcinogenic exposures

New technology opportunities

Liquid biopsies, minimally invasive imaging and AI can improve detection.
Overall survival gains must be rigorously demonstrated.

Responsibility extends beyond individuals

Government policy can change the social, environmental and commercial conditions that shape risk.

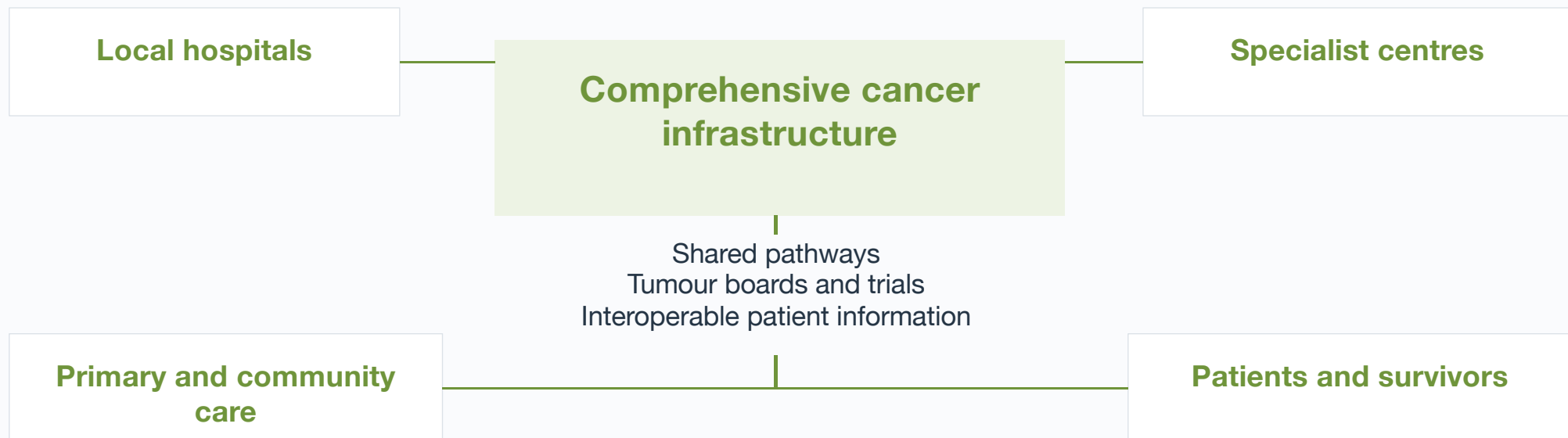
Accessible programmes and clear consumer information are essential to reach underserved populations.

The time horizon matters

Some benefits take 10–40 years to mature. Investment decisions must recognise benefits beyond the 2035 horizon.

Prevention reduces future burden, while today's patients continue to need effective care

Cancer networks connect specialist expertise to local care



The Statement proposes at least one centre per five million inhabitants across Europe, including Switzerland

Specialist capability and convenient local care should form a coordinated patient pathway

AI depends on a longitudinal, interoperable patient record



Clinical care

Diagnoses, stage, treatments, doses and adverse events

Diagnostics

Imaging, pathology and validated biomarker results

Molecular data

Genomics and linked biospecimens where appropriate

Patient outcomes

Survival, quality of life, late effects and experience

A secure record that follows the patient across care settings

Shared definitions and provenance

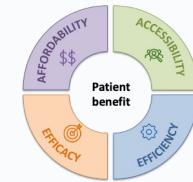
Representation, completeness and linkage

Governed reuse over time

Privacy, patient rights and maintained security

Data infrastructure needs recurrent funding for implementation, quality assurance and professional training

AI adoption needs clinical evidence and accountable oversight



01

Before deployment

Define the intended use and the responsible clinician.

Check data quality, representative validation and security.

Compare with the existing care pathway.

02

During clinical evaluation

Test effects on patient outcomes, safety and workload.

Assess performance across relevant groups.

Include implementation and verification costs.

03

After deployment

Monitor errors, performance changes and unintended demand.

Maintain human review and escalation.

Reassess, modify or stop tools that fail to add value.

A technically accurate model may still fail to improve the clinical pathway or the health system

Each recommendation needs an owner and a measurable result to implement the required changes

Workstream	Agents of change	Examples of measurable results
Benefit and financing Recommendations 1 and 7	Governments, payers, providers, health technology assessment (HTA) experts and industry	Survival and quality of life Treatment burden and net costs
Research and prevention Recommendations 3, 4, 5 and 8	Research funders, investigators, regulators, public-health agencies and patient groups	Time to trial activation Prevention uptake and screening harms
Care and participation Recommendations 6, 9 and 10	Cancer infrastructures, hospitals, educators, professional and patient organisations	Access and waiting-time gaps Staff retention and patient experience
Data and AI Recommendation 2	Hospitals, data and AI teams, funders, clinicians and patient representatives	Data completeness and linkage Clinical benefit and net staff time

Table 1 identifies agents of change. The proposed measures make implementation reviewable

A Swiss programme could start with shared evidence and pilots: Sequential implementation of the required changes

Phase	Proposed work	Deliverable for review
2026–2027 Agree on the foundations	Convene patients, care teams, researchers and payers. Define meaningful benefit and a common outcome set. Select care pathways with demonstrable unmet needs.	A joint work programme Named owners and baselines
2027–2030 Evaluate changes	Pilot linked patient records and selected AI uses. Support optimisation trials and network pathways. Test new professional roles and follow-up models.	Independent evaluation of benefit, equity, workload and cost
2030–2035 Scale on evidence	Expand interventions that demonstrate benefit. Reassess ineffective care and unsuccessful tools. Publish progress and maintain workforce investment.	A recurring review across all four dimensions, affordability, efficacy, efficiency, and accessibility

A proposed sequence for Switzerland, requiring partner agreement and funding

THANK YOU FOR YOUR ATTENTION!



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