Osakidetza

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OSASUN SAILA DEPARTAMENTO DE SALUD

Basque Country Comprehensive Cancer Plan 2025-2030

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List of Acronyms

AI	Artificial Intelligence
ALL	Acute Lymphoblastic Leukaemia
AYA	Adolescent and Young Adult
BCCP	Basque Country Comprehensive Cancer Plan
BCP	Basque Cancer Plan
BIOEF	Basque Foundation for Health Innovation and Research
CCC	Comprehensive Cancer Centre
CNS	Central Nervous System
CROMs	Clinician-Reported Outcome Measures
CT	Clinical Trials
ECAC	European Code Against Cancer
ESCAV	Basque Country Health Survey
EU	European Union
HBV	Hepatitis B Virus
HL	Hodgkin Lymphoma
HPV	Human Papilloma Virus
HR	Human Resources
ICP	Individual Care Plan
IHO	Integrated Health Organisation
PAGS	Physical Activity Guidance Services
PCTI	Science, Technology and Innovation Plan
NHS	National Health System
PNS	Peripheral Nervous System
PPM	Personalised Precision Medicine
PREMs	Patient-Reported Experience Measures
PROMs	Patient-Reported Outcome Measures
EHU	University of the Basque Country

Executive Summary

Executive Summary

Introduction and background

The Basque Country Comprehensive Cancer Plan 2025–2030 (BCCP) is the strategic instrument of the Basque healthcare system to comprehensively address cancer, one of the leading causes of morbidity and mortality in the community. This disease was responsible for **28% of deaths in the Basque Country in 2023, making it the leading cause of death among men (33.8%) and the second leading cause of death among women (22.3%).** This impact also translates into a high burden of potential years of life lost, , especially among middle-aged and older people.

The demographic transition, an ageing population and increased life expectancy have contributed to a higher incidence of cancer, calling for a comprehensive approach that combines prevention, early diagnosis, personalised care, therapeutic innovation and continuous care.

Between 2015 and 2019, more than 71,000 new cases of cancer were diagnosed in the Basque Country, an annual average of 14,327. The most common forms were breast cancer in women and prostate cancer in men, followed by colorectal and lung cancer. The overall incidence has been declining since 2012, especially in men, thanks to screening programmes such as those for colorectal cancer.

The five-year relative survival rate has improved for most tumours, particularly breast cancer (88%) and prostate cancer (90%). However, significant challenges remain in tumours such as lung (20%) and pancreatic cancer, where mortality rates remain high. In the case of **childhood cancer,** although it accounts for less than 1% of all cancers, **it is the leading cause of death by disease in children under 15,** with an overall five-year survival rate of 80.4%.

The Basque Country Cancer Plan (BCP) 2018-2023 was the first comprehensive strategic framework in this area, structured around **6 challenges and 39 objectives.** Its implementation enabled progress to be made in standardising care, creating a common healthcare model and improving coordination between different levels of care.

Notable achievements include:

- The consolidation of Tumour Boards as the cornerstone of the healthcare model.
- The implementation of rapid diagnostic circuits (Minbizi).
- The creation of the Regional Coordination Committee for Childhood Cancer.
- The roll-out of the cervical cancer screening programme.
- The development of Onkobide, a corporate system for pharmacotherapeutic management.

The evaluation of the BCP in 2023 concluded that more than 80% of the objectives were achieved. Although some areas for improvement were identified, such as:

- The need to strengthen care for specific groups (children, the elderly, long-term survivors).
- Review of governance and the coordinating role of the BCP.
- The lack of a dashboard for monitoring the plan.
- The lack of visibility of the plan among professionals who are not directly involved.

The new BCCP not only continues the path set out in the 2018–2023 BCP, but also expands and transforms it, introducing a more ambitious, equitable and people-centred vision. It takes these lessons learned and **broadens the scope of the term 'comprehensive', prioritising health promotion, disease prevention and equity in all phases of the oncological process. It also strengthens inter-institutional coordination** and is committed to a transformative leadership that will enable progress towards a more humane, efficient and sustainable model.

The BCCP development process has been highly participatory, with over 250 professionals from different fields involved through various forums covering: healthcare personnel, managers, patients, associations and representatives from other healthcare-related sectors. This participation has enabled us to develop a plan with a solid technical and social foundation.

In addition to incorporating the lessons learned from the previous BCP, the new BCCP **has been designed in close alignment with the main European, national and regional strategic frameworks,** thereby reinforcing its consistency, legitimacy and capacity for impact.

At European level, the BCCP is inspired by the European Union's **Cancer Mission**, which aims to save at least 3 million lives over the next decade through a comprehensive approach based on five pillars: (1) to better understand the disease, (2) to prevent what can be prevented, (3) to optimise diagnosis and treatment, (4) to improve quality of life, and (5) to ensure equitable access to all treatments. This mission is complemented by the **Europe's Beating Cancer Plan,** which addresses all stages of the oncological process and promotes equity across Europe.

At the regional level, the BCCP is aligned with the **Basque Country Health Plan 2030,** which establishes the following strategic priorities: (1) promoting health in childhood and adolescence, (2) promoting active ageing, (3) reducing avoidable morbidity and mortality, and (4) reducing health inequalities. This plan is the roadmap for Basque health policy and provides the overall planning framework for the BCCP.

Furthermore, other **key strategies** have been taken into account in the development of the BCCP, such as the **National Health System Cancer Strategy, the Osakidetza Strategic Plan 2023–2025,** and cross-cutting and intersectoral plans in areas such as palliative care, mental health, patient safety, humanisation, addiction, the environment, occupational health and social determinants of health. The current regulatory framework and the 2030 Agenda have also been considered to ensure the plan's consistency and sustainability in the medium and long term.

With this solid and aligned foundation, the BCCP stands as a key tool for dynamically tackling the present and future challenges of cancer in the Basque Country between now and 2030, from a comprehensive, innovative and people-centred perspective.

Strategic formulation

The strategic formulation of the Basque Country Comprehensive Cancer Plan 2025–2030 (BCCP) defines the conceptual framework that guides all the actions of the plan. It comprises the mission, vision, guiding principles and priority areas for action.

MISSION

> *"Establish a* ***comprehensive, participatory, sustainable and dynamic strategy*** *to guide cancer actions based on* ***excellence, scientific evidence and equity,*** *generating* ***value for Basque citizens*** *in terms of* ***better health outcomes****"*

VISION

With this BCCP, the Basque Country hopes to achieve the following:

- Improve the **survival rate of people with cancer.**
- Reduce the **potential years of life lost due to cancer**.
- Improve the **quality of life** of people, cancer patients and survivors, their families and carers.
- Maintain and enhance the commitment to **equity.**
- Improve the **public's perception** of how the System addresses cancer.

To this end, the BCCP will prioritise its efforts in the following areas:

- An **integrated, comprehensive approach** to cancer at all stages, with advanced oncology care and a healthcare model which makes this possible.
- The promotion of **education/prevention programmes** to achieve the participation of **all citizens.**
- **Progress in prevention and early diagnosis.**
- **Access to personalised care and advanced treatments.**
- Information systems that provide data in epidemiology, in the clinical field, in management and in research.
- **Universal, equitable, and humane access** to all resources of the system, both healthcare and non-healthcare.
- The ability to dynamically implement innovative advances.

GUIDING PRINCIPLES OF THE BCCP

The guiding principles underpin the formulation, design and roll-out of all strategies, programmes and interventions. The BCCP is based on the following principles:

1. People-centredness and humanisation

- People playing an active role in their health and cancer treatment.
- Community involvement, patient experience, and humanisation as key elements.
- Reducing social inequalities and ensuring equal access.
- Incorporation of the gender perspective and attention to diversity.

2. Prevention and early detection

- Health promotion and primary prevention.
- Early detection and population screening for tumours with scientific recommendation.
- Agile and effective diagnosis in cases of clinical suspicion.

3. Comprehensive care and continuity of care

- Comprehensive, continuous and personalised care model throughout all stages of the process.
- Promote cross-sectoral collaboration.

4. Organisation, coordination and networking

- Recognition and promotion of collaboration between professionals and teams.
- Organisational model based on strategic specialisation.
- Flexibility to adapt the plan to local contexts and future changes.

5. Quality, innovation and evidence-based decisions

- Continuous improvement, sustainability and efficiency as pillars.
- Use of up-to-date information and evidence-based decision-making.
- Stimulation of the plan based on advances in R&D&I.

6. Leadership and governance

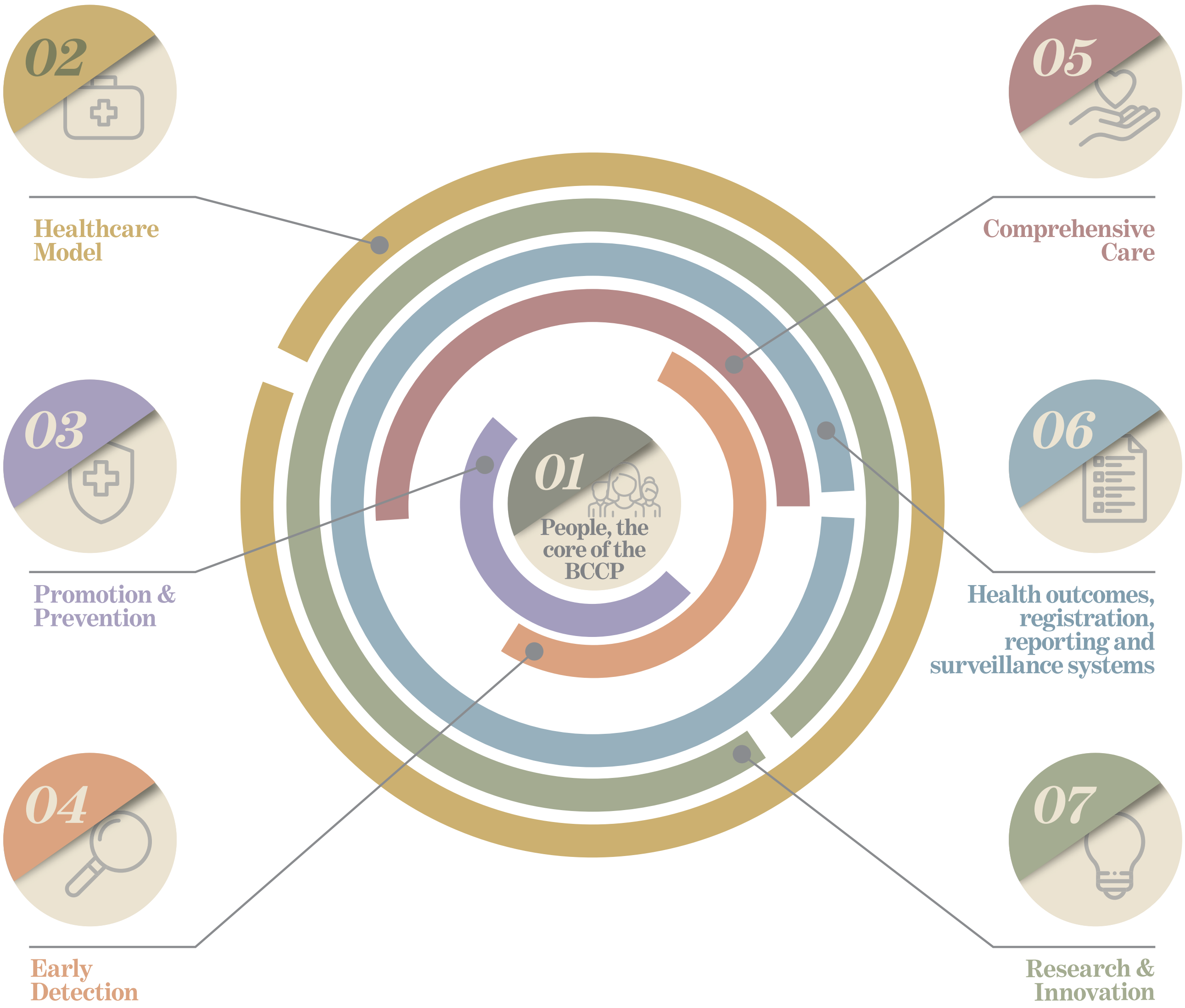
- Transformative leadership that drives system adaptation.
- Shared vision among all stakeholders.
- Active participation of citizens, patients and professionals.
- Consider implementation as a key focus from the outset.
- Continuous assessment based on results.

Priority Areas for Action

The definition of priority areas is a key element of the BCCP, as it guides the policies and actions that will be rolled out in the Basque Country to combat cancer in the coming years. The proposal is based on the evaluation of the 2018–2023 BCP, the six-pillar structure of which has been updated following a benchmarking exercise with national and international cancer plans.

The new BCCP adapts this structure to the Basque reality and organises it into **seven Priority Areas** (Outline of the seven priority areas of the Basque Country Comprehensive Cancer Plan 2025-2030, each with its own conceptual framework, specific objectives, concrete actions and monitoring indicators).

Outline of the seven priority areas of the Basque Country Comprehensive Cancer Plan 2025-2030.



Outline of the seven priority areas of the Basque Country Comprehensive Cancer Plan 2025-2030.

These **7 priority** areas are broken down into a total of **35 objectives and 142 actions.**

7 Priority Areas
35 Objectives
142 Actions

PRIORITY AREAS	NO. OF OBJECTIVES	NO. OF ACTIONS
1. People, the core of the BCCP	5	14
2. Healthcare model	4	19
3. Health promotion and cancer prevention	3	14
4. Early detection	4	11
5. Comprehensive care	9	41
6. Health outcomes, registration, reporting and surveillance systems	3	16
7. Research and innovation	7	27
TOTAL	35	142

Furthermore, special attention has been paid to groups with different needs during the development of the BCCP: **children, adolescents and young adults (AYAs), elderly and long-term survivors.** With this in mind, the plan includes 20 specific actions aimed at these groups and encourages all general actions to consider their suitability for these populations.

1. People, the core of the BCCP

This area establishes the ethical and operational foundation of the BCCP: people-centred oncology care. It is based on the premise that every individual (whether they are a patient, caregiver, professional, or member of the community) **must be at the central focus of all actions within the system.** This approach goes beyond just the clinical aspects to **include emotional, social, cultural, and spiritual ones.**

The model is aligned with the Osakidetza Humanisation Model, which sees humanisation as a shared responsibility between organisations, professionals and citizens.

Holistic, empathetic, and personalised care is promoted, guaranteeing dignity and comprehensive well-being for those undergoing the oncological process.

This priority area includes the following **5 objectives, comprising a total of 14 actions:**

OBJECTIVES	NO. OF ACTIONS
1.1 Promote an **organisational culture focused on the humanisation of care,** encouraging leadership in personalised and empathetic care at all levels of healthcare.	1
1.2 Encourage the **active and meaningful involvement of patients and their companions in shared decision-making processes** regarding their care.	3
1.3 Offer **comprehensive, personalised care** that respects the dignity, needs, values and preferences of each patient, ensuring empathetic and clear communication at all stages of the oncological process with accessible resources adapted to their circumstances.	4
1.4 Create **physical and care environments that promote the emotional and physical well-being of patients, companions and professionals,** and adapt them to the specific needs of each group, especially in paediatrics.	3
1.5 **Encourage the emotional and physical well-being of professionals,** and ensure that they have a healthy working environment and the tools they need to provide quality care.	3
TOTAL	14

2. Healthcare model

The BCCP healthcare model is the **organisational structure that coordinates cancer care in the Basque Country.** Its objective is to guarantee comprehensive, equitable and quality **care based on the effective coordination between all levels of care**, specialities and professionals involved in the cancer process.

This model is based on a **multidisciplinary approach,** in which different healthcare professionals collaborate in a structured manner. It is aligned with European strategies such as the Cancer Mission and the Europe´s Beating Cancer Plan, with the aim of making the Basque Country part of the European network of Comprehensive Cancer Centres (EUnetCCC). Furthermore, **communication** is recognised as a **cross-cutting theme of the model;** it reinforces the need for fluid communication **between institutions, professionals and citizens,** both to improve internal coordination and to raise awareness and inform the population about prevention, early diagnosis and comprehensive support.

Overall, this model represents a step forward towards a **more integrated, innovative and people-centred system, aimed at maximising health outcomes,** reducing inequalities and ensuring **excellent cancer care throughout the Basque Country.**

This priority area is structured around **4 objectives and a total of 19 actions.**

OBJECTIVES	NO. OF ACTIONS
2.1 Guarantee an equitable and efficient Healthcare Model that pursues quality and integrated care for cancer patients in the Basque Country.	9
2.2 Provide **specific Care Pathways** in place to ensure rapid, efficient and consistent responses tailored to patients’ changing needs.	4
2.3 Integrate cancer research into the healthcare model to drive innovation and continuous improvement in care.	3
2.4 Commit to the **European accreditations and standards.**	3
TOTAL GENERAL	**19**

3. Health promotion and cancer prevention

Health promotion and primary prevention are core strategies of the BCCP to reduce the incidence of cancer in a sustainable manner. This priority area **seeks to empower citizens and transform environments to reduce exposure to risk factors and promote healthy lifestyles.**

Action is taken at two levels, based on a comprehensive approach: (i) **individual,** promoting self-responsibility in healthcare throughout life, and, (ii) **cross-sectoral,** promoting public policies that integrate health into areas such as education, urban planning and the environment.

The interventions are based on scientific evidence and aim to reduce risk factors, using the European Code Against Cancer (ECAC) as a reference. This strategy places prevention at the heart of the BCCP, with a **proactive, evidence-based approach aimed at improving quality of life, reducing inequalities and guaranteeing the sustainability** of the health system.

The priority area of Health Promotion and Cancer Prevention is structured around **3 objectives and 14 actions.**

OBJECTIVES	NO. OF ACTIONS
3.1 **Implement policies to promote healthy environments** to encourage the adoption of **healthy lifestyles, reduce exposure to environmental and social risks associated with cancer,** and reinforce **preventive interventions.**	5
3.2 **Promote healthy lifestyles in relation to the risk factors associated with cancer,** taking into account: life stages, health inequalities and the gender perspective.	7
3.3 **Protect the health of workers** by reducing **exposure to occupational carcinogens and promoting healthy working environments.**	2
TOTAL	14

4. Early detection of cancer

Early detection is one of the key pillars in the fight against cancer, as it allows the disease to be identified in its early stages, reducing the aggressiveness of treatments and improving survival rates and quality of life.

The BCCP structures this priority area around the following lines of action: **evidence-based population screening programmes for asymptomatic individuals,** in accordance with the recommendations of the Council of the European Union for high-prevalence tumours such as breast, colorectal and cervical cancer, and surveillance programmes for individuals with a high genetic risk.

In sum, this area promotes a modern, equitable and evidence-based approach to early detection, which is key to reducing mortality and moving towards a more proactive and people-centred oncology system.

This priority area has 4 objectives and a total of 11 actions.

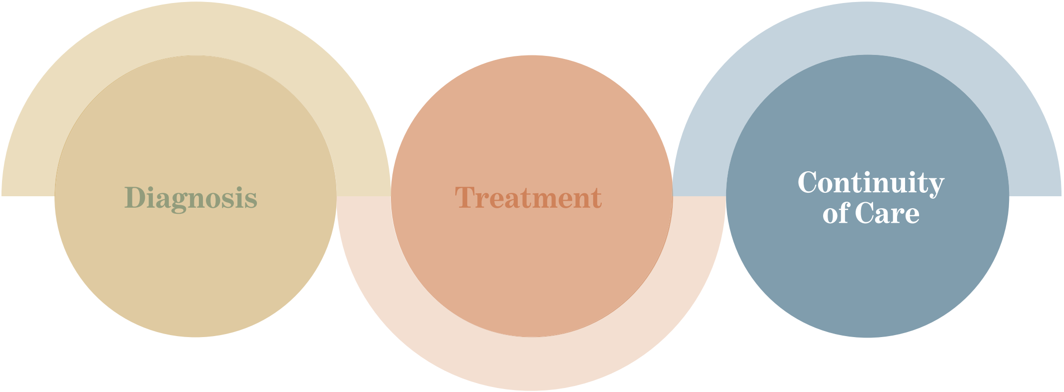
OBJECTIVES	NO. OF ACTIONS
4.1 Adapt the approach to secondary prevention in line with European recommendations and scientific evidence.	2
4.2 Increase participation in population-based screening and reduce inequalities.	4
4.3 Understand the results of screening in terms of impact on incidence and mortality, as well as benefits and adverse effects.	2
4.4 Ensure access to surveillance and monitoring programmes **for people with increased risk criteria:** hereditary cancer, family history and occupational exposure.	3
TOTAL	**11**

5. Comprehensive care

The BCCP promotes a **comprehensive and integrated model of cancer care,** accompanying patients **from diagnosis through to monitoring and end-of-life care.** This model focuses on the individual and their environment, ensuring continuous, coordinated, and high-quality care.

Comprehensive care **encompasses both health and non-health aspects** and requires **effective coordination between professionals and different levels of care.** It includes early diagnosis, innovative and personalised therapies, and the incorporation of advances such as Precision Medicine, Artificial Intelligence and telemedicine.

As shown in the diagram, comprehensive care is structured in the following phases:



This priority area has **9 objectives and a total of 41 actions.**

I. Diagnosis

Detecting cancer in its early stages is key to improving the chances of cure. The aim is to **reduce the time between suspicion and the start of treatment to a minimum, as well as to improve the accuracy of the diagnosis.** With this objective in mind, the new BCCP is committed to strengthening tools such as **biological and radiological diagnosis and Precision Medicine, and to expanding and standardising rapid diagnosis circuits, such as the Minbizi model.**

OBJECTIVES	NO. OF ACTIONS
5.1 **Reduce waiting times for cancer diagnosis** by using specialised staff and advanced technologies, ensuring rapid detection and accurate diagnosis of disease.	8
5.2 **Consolidate the implementation of Personalised Precision Medicine** as standard in cancer diagnosis, based on genomic data, biomarkers and updated guidelines.	3
TOTAL	11

II. Treatment

Improving the prognosis requires **constant innovation in surgical, medical and radiotherapy treatments.** The **inclusion of advanced treatments** (such as cell therapies, biological therapies, and proton therapy) **in the Service Portfolio** is promoted, as this ensures that all patients have equal access to them and that they are administered by highly specialised teams.

OBJECTIVES	NO. OF ACTIONS
5.3 **Ensure equitable, effective and sustainable access** to treatments and medication available in the public health system, thus avoiding unjustified variability and ensuring that therapeutic decisions are based on clinical value, scientific evidence and the consensus of multidisciplinary teams, in order to improve health outcomes and the quality of life of patients.	7
5.4 **Optimise effective, equitable and sustainable access to innovative treatments.**	3
5.5 **Improve patient health outcomes** by concentrating on high complexity, low prevalence surgical procedures, in accordance with recognised standards.	2
TOTAL	12

III. Continuity of care

Caring for someone with cancer does not end with treatment. It is essential to identify and **address their needs** (and those of their support network) **at all stages: from diagnosis to chronicity or end-of-life.** This includes aspects such as surgical preparation, nutrition, physical exercise, psychosocial support and palliative care. **Coordinated efforts between healthcare professionals and social services are essential to ensure this continuity.** Furthermore, **special attention is given to survivors** who, after completing treatment, may face physical and emotional consequences that affect their quality of life.

OBJECTIVES	NO. OF ACTIONS
5.6 **Ensure that the patient is provided with the necessary care and resources** based on a **functional assessment** carried out at each stage (diagnosis, treatment, rehabilitation, chronicity, end of life) to cope with the disease and clinical decision-making.	8
5.7 **Optimise palliative care support within the cancer care process.**	3
5.8 **Improve coordination between the different levels of care** involved in the oncological process through agile, two-way communication between professionals in the health, social and educational fields, adapting digital tools as necessary.	5
5.9 **Provide specific training in the field of care** to Osakidetza professionals, patients, their support network and the community, with a focus on improving quality of life at all stages of the process.	2
TOTAL	18

6. Health outcomes, registration, reporting and surveillance systems

The Basque Country Comprehensive Cancer Plan (BCCP) proposes a cancer care model that goes beyond clinical treatment that is committed to a comprehensive and integrated approach that accompanies the person from diagnosis to long-term monitoring or end-of-life care. This approach seeks not only to cure, but also to care for, support and improve the quality of life of people affected by cancer.

In this context, the BCCP places improving health outcomes at the centre of its strategy, with these being understood as positive changes in health status attributable to health interventions. With this in mind, an assessment based on five key areas is proposed:

- **Epidemiological results,** which make it possible to analyse incidence, mortality, survival and equity in access to services.
- **Clinical results,** focusing on the patient's medical progress and the effectiveness of the treatments received.
- **Healthcare management,** which assesses the quality of care and the performance of services and the system as a whole.
- **Value,** understood as the efficiency in the use of resources in relation to the health benefits obtained.
- **Results in humanisation,** which include aspects such as quality of life, patient satisfaction and respect for their preferences.

In order to make this assessment possible, **the plan focuses on strengthening information and registration systems,** as well as **promoting clear and effective data governance** to ensure the quality, traceability and usefulness of the information collected.

All of this is aligned with the development of the European Health Data Space (EHDS). This initiative aims to improve equitable access to quality healthcare throughout the European Union, promote therapeutic and digital innovation, and move towards a more efficient and ethical use of health data.

The priority area comprises a total of **3 objectives and 16 actions:**

OBJECTIVES	NO. OF ACTIONS
6.1 Create a Management Model based on providing value to cancer patients and the population in general, focused on **improving health and overall well-being and promoting prevention, safety, efficiency and the sustainability** of the health system.	4
6.2 Use a robust Cancer Information System, which complies with the **standards set by the European Data Space.**	8
6.3 Establish a decision-making model to assess the **health impact** of different interventions **at macro, meso and micro levels,** as well as accountability to society. This model will assist in the use of objective data for service portfolio management, and promote value-based funding and payment, facilitating sustainable access to new medical treatments and healthcare technologies.	4
TOTAL	**16**

7. Research and innovation

Research and innovation are strategic elements of the BCCP, **and are essential for translating scientific advances into clinical practice and improving prevention, diagnosis, treatment and quality of life for people with cancer**. In the Basque Country, this commitment is channelled through a consolidated network of Health Research Institutes (Bioaraba, Biobizkaia, Biogipuzkoa and Biosistemak), coordinated by BIOEF, which lead a significant proportion of the health system's cancer research.

The plan promotes a translational approach, with a **special emphasis on Personalised Precision Medicine and Advanced Therapies,** which are priority areas in both the Health Research and Innovation Strategy and the PCTI2030. Furthermore, it recognises the importance of **promoting research from other fields** that respond to the real needs of patients throughout the entire oncological process.

During the term of the BCCP, significant progress is expected in the field of cancer research at European and international level. The plan will therefore serve as a reference framework for prioritising lines of research and innovation, ensuring that the Basque Country remains aligned with cutting-edge scientific developments and capable of being a leader in the global context.

The priority area for research and innovation has **7 objectives and a total of 27 actions.**

OBJECTIVES	NO. OF ACTIONS
7.1 Promote and reinforce cancer research and innovation, with a **comprehensive and collaborative approach,** drawing on the strengths of the Basque health ecosystem and enhancing the position of the Basque Country and its capabilities on the international arena with a clear commitment to improving care for patients and the general public.	3
7.2 Promote the integration of clinical practice, research and innovation, highlighting translational research and the effective implementation of solutions to optimise health outcomes.	2
7.3 Draw on the full potential of the cancer research and innovation ecosystem, including all actors involved in cancer R&D&I, both public and private, governmental and non-governmental, promoting the position of the Basque Country at international level.	3
7.4 Encourage citizen participation in research, innovation and evaluation.	4
7.5 Enhance the value of research activity, integrating it as an essential part of the development of the health profession.	4
7.6 Optimise access, development and participation in clinical trials, guaranteeing accessibility for patients and professionals.	7
7.7 Facilitate the comprehensive, ethical and efficient management of data and samples for cancer research.	4
TOTAL	27

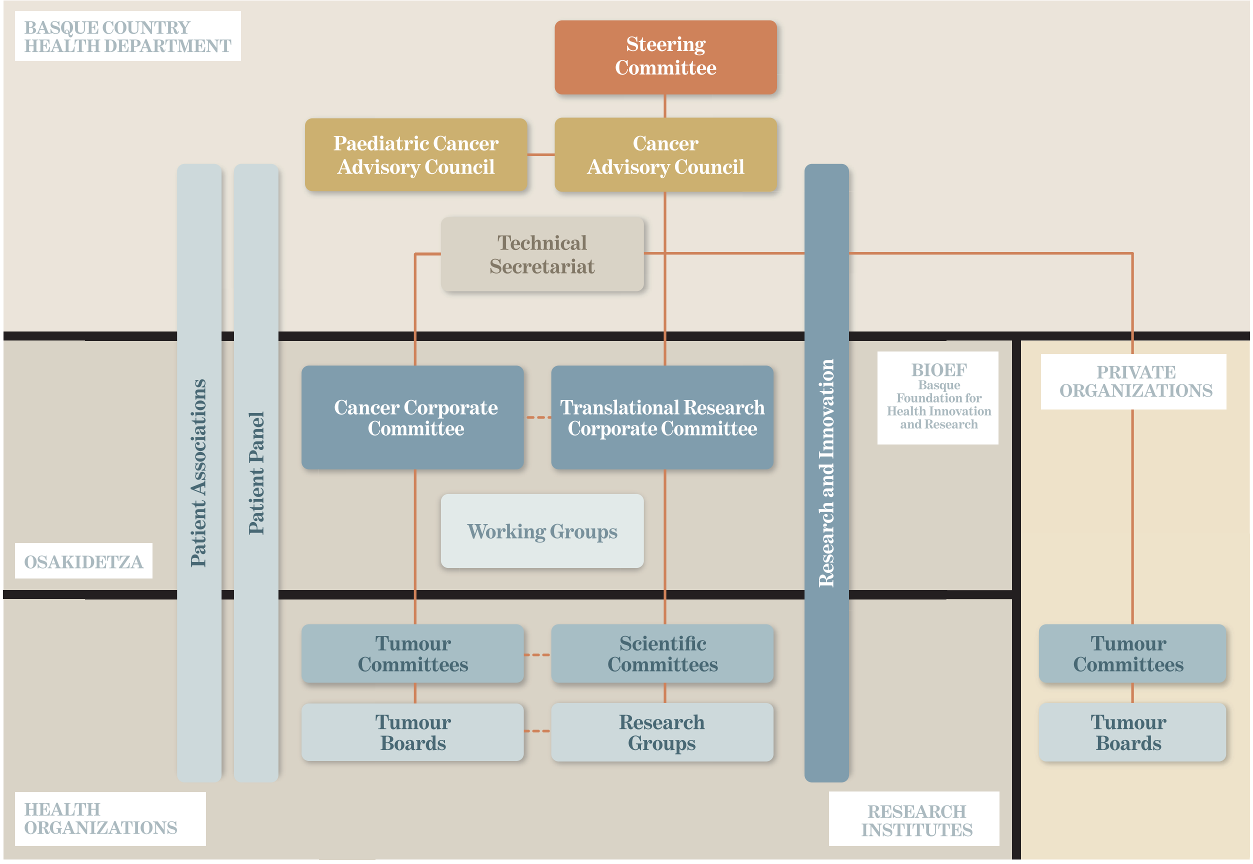
Governance of the BCCP

Organisational structure

The governance of the BCCP forms the organisational and functional framework that guarantees its implementation, monitoring and evaluation. It is conceived as a structured, participatory and dynamic system, aligned with the guiding principles of the plan and aimed at ensuring its effective implementation throughout the territory. The BCCP governance model is based on the following pillars:

- Solid and committed **institutional leadership.**
- **Active participation** of all stakeholders: professionals, patients, citizens, institutions, and healthcare organisations.
- **Interinstitutional and interdepartmental coordination,** under the principle of "Health in All Policies".
- **Transparency and accountability** through continuous monitoring and evaluation mechanisms.
- **Flexibility and adaptability** to respond to emerging challenges in the oncology system.

The governance structure is divided into different bodies with clearly defined roles, enabling effective and collaborative management of the plan. Figure 2 shows the organisational chart with the main elements of the BCCP governance structure. The main components are described below:



Organisational chart showing the main elements of the governance structure of the BCCP 2025-2030.

Main components:

- **Steering Committee:**

  Hhighest-level body responsible for leading the implementation of the BCCP, ensuring institutional commitment and validating results.

- **Cancer Advisory Council:**

  Responsible for managing the implementation of the BCCP, as well as its monitoring and continuous evaluation, proposing changes and/or improvements, if necessary.

- **Paediatric Cancer Advisory Council:**

  Ensures quality criteria for the optimal organisation and management of care for all cases of cancer in children and adolescents. It has a direct relationship with the Cancer Advisory Council.

- **Technical Secretariat**

  Operational core of the BCCP. Provides support for governance bodies, coordinates working groups and leads the evaluation of the plan.

- **Cancer Corporate Committee:**

  Among its various functions, it aims to implement the plan in the clinical and healthcare setting, gather the needs of healthcare organisations, and promote the integration of research into clinical practice.

- **Translational Research Corporate Committee:**

  Responsible for designing and supervising the Cancer Research and Innovation Strategy, and ensuring compliance with the objectives and actions related to Research and Innovation.

- **Tumour Committee:**

  Responsible for communicating the decisions of the Cancer Corporate Committee and their implementation within its organisation, and for maintaining two-way communication.

- **Tumour Boards:**

  Multidisciplinary teams that lead clinical management and therapeutic decision-making. They also aim to integrate research into clinical practice and facilitate synergies and coordinated work.

- **Working Groups:**

  Specific working groups will be set up to be responsible for implementing the BCCP's actions.

- **Patient and citizen participation:**

  It will be necessary to define the model for patient/citizen/association participation in the organisational model, care processes and research.

Dashboard

The dashboard is the tool that makes it possible to evaluate both the impact and the degree of implementation of the BCCP, as well as facilitate decision-making. In this case, a dashboard has been defined and structured on two levels:

- A plan with seven **General Indicators** linked to the achievement of the defined VISION and, therefore, more focused on achieving results and impact.

GENERAL INDICATORS
0.1. Cancer incidence rates in the Basque Country by type of cancer.
0.2. Cancer mortality rate in the Basque Country by type of cancer.
0.3. Overall survival and relative survival at 1, 3 and 5 years of people diagnosed with cancer in the Basque Country, by type of cancer.
0.4. Potential years of life lost by people who died of cancer in the Basque Country.
0.5. Years of life adjusted for quality of life.
0.6. Quality of life of cancer patients and survivors and their carers.
0.7. Public satisfaction on how the system deals with cancer.

- A set of 74 **Specific Indicators for each of the Priority Areas,** which aim to guide the level of achievement of the objectives and the degree of implementation of the BCCP.

PRIORITY AREAS	NUMBER OF SPECIFIC INDICATORS
1 People, the core of the BCCP	2
2 Healthcare model	10
3 Health promotion and cancer prevention	12
4 Early detection	9
5 Comprehensive care	18
6 Health outcomes, registration, reporting and surveillance systems	7
7 Research and innovation	13
TOTAL	**74**

01

Introduction and context

Introduction and context

The Basque Country Comprehensive Cancer Plan (BCCP) is the planning and programming tool used by the Basque health system in the field of cancer. It is a strategic plan that aims to improve health outcomes for this disease, which is currently the leading cause of death in men and the second cause of death in women, but which also has a direct impact on the quality of life of the patient and their relatives. The new BCCP has therefore been established as a reference framework to guide and promote the design of policies that contribute to improving the quality of life for patients, survivors and their relatives, through a comprehensive and coordinated approach to the disease.

In Europe, 2.7 million new cases and 1.3 million deaths were recorded in 2022, 2.3% and 2.4% more than in 2020, respectively [1]. It is estimated that by 2040, 31% of men and 25% of women in the EU will be diagnosed with cancer before the age of 75 [2]. In this context, the EU and the Cancer Mission [3], propose an overarching goal to achieve progress over the next decade that will save at least 3 million lives in Europe. In general terms, the aim is to extend the life expectancy of cancer patients, to achieve a better quality of life - also for survivors and their families - and to consolidate mechanisms to prevent or delay the onset of the disease.

The most important of the Europe´s Beating Cancer Plan initiatives is number 5, which aims to ensure high quality care through the European Network of Comprehensive Cancer Centres (EUnetCCC) [4]. To meet this goal, different joint actions are in place to reduce inequalities in prevention, diagnosis, treatment, rehabilitation and research, with a harmonised, high-quality approach to cancer care, as well as fostering collaboration between centres for sharing best practices, resources and knowledge. Specifically, this Plan covers a number of actions aimed at ensuring quality in the comprehensive approach to cancer in the Basque Country, based on the European standards established for CCCs.

The Basque Country Health Plan 2030 sets out the healthcare policy [5], defines the priorities for its period of validity, and aims to achieve a healthier regional population. One of its key goals is its General Objective: To improve health and reduce avoidable morbidity and mortality, taking into account that the main causes of the burden of disease and mortality are non-communicable diseases (NCDs), cancer being one of the most relevant.

As a result, the Basque Department of Health has been working on its second cancer plan, as a continuation of the Basque Cancer Plan (BCP) 2018-2023, which helped lay the foundations for the approach to the disease, and which has provided important lessons learned during its implementation [6]. In this regard, it was considered necessary to give continuity to the BCP 2018-2023 and to keep progressing towards a more comprehensive approach to cancer care. This new Cancer Plan aims to increase the scope of the term “comprehensive” by prioritising health promotion and disease prevention, addressing the needs of people with cancer and their relatives equally at all stages of the process, improving inter-institutional coordination and with transformational leadership.

The process of drafting the BCCP 2025-2030 was highly collaborative, involving more than 160 professionals from the different groups of interest, mainly health professionals and managers, but also patients, associations etc. from the health sector and other related areas.

The result is the BCCP 2025-2030, with its own firm Mission. It also set out a Vision to defines its aspirations, Guiding Principles for the whole process, and Priority Areas with their respective Goals and Actions. A Dashboard to enable follow-up, assessment and monitoring, all within the framework of a Governance model defined for the Basque Country.

02

Current cancer situation in the Basque Country

Current cancer situation in the Basque Country

2.1 Health status in the Basque Country

Cancer has become consolidated as a public health problem in the Basque Country, accounting for 28% of all deaths in 2023. Among men, it is the leading cause of death (33.8%) while among women it is the second leading cause of death (22.3%) after cardiovascular diseases (26.3%). This impact is reflected not only in mortality figures, but also in potential years of life lost, as stated in the Report on Mortality in the Basque Country 2023 [7].

The demographic and epidemiological transition, characterised by an ageing population and an increase in life expectancy, has had a significant impact on these figures. This situation calls for a comprehensive approach combining preventive strategies, early diagnosis programmes and therapeutic advances to reduce incidence and improve survival and quality of life.

The report Cancer in the Basque Country 2001-2023 details the evolution of the incidence and mortality rates of cancer over the period in question, as well as cancer mortality for the period 2019-2023, as detailed in the sections below[8].

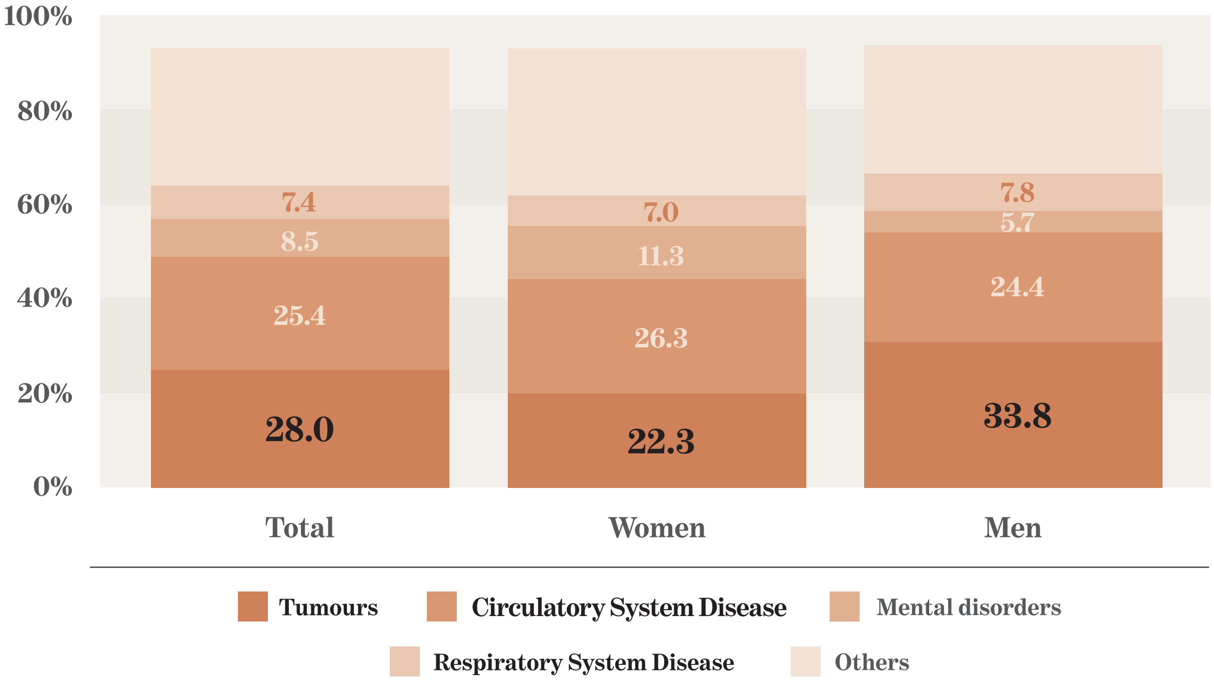


Figure 1. Distribution of the main causes of mortality in the Basque Country over the period 2019-2023, by sex.

2.2 Evolution of cancer incidence for the period 2001-2019

Between 2015 and 2019, 71,634 cases of cancer were diagnosed in the Basque Country, equivalent to an average of 14,327 new cases per year (8,251 in men and 6,076 in women).

The gross incidence rate was 780.1 per 100,000 in men and 542.4 per 100,000 in women, with age-adjusted rates higher in men, obtaining a male/female ratio of 1.7.

50% of cancer incidence is due to the four most common types.

- In women: breast cancer stands out for its incidence, followed by colorectal and lung cancer, with uterine cancer in fourth place.
- In men: prostate cancer is the most frequent, followed by lung, colorectal and bladder cancer.

The evolution of incidence rates for all malignant tumours in the period 2001-2019 did not show significant differences until 2012 and then decreased by 1.7% per year over the period 2012-2019. This inflexion point is attributed to the drop in colorectal cancer cases due to the implementation of the population-based colorectal cancer screening programme in 2009. For the incidence of colorectal cancer in particular, a significant decrease of 10.5% per year was seen in the period between 2013 and 2016, followed by a slower, less significant decrease of 3.8% from 2016 onwards.

In women, there was a significant annual increase of 1.8% until 2013 (from 372.2 per 100,000 in 2001 to 462.1 in 2013). It then continued without significant changes until 2019 (462.1). Key points include a 5.8% annual increase in lung cancer (from 12.9 in 2001 to 40.2 in 2019), a 2.2% annual increase (from 8.0 to 12.8) in kidney cancer and a 2.1% increase (from 13.0 to 16.3) in pancreatic cancer.

In men, incidence increased by 0.3% per year until 2012 (from 816.7 per 100,000 in 2001 to 857.8 in 2012) and then fell significantly by 1.7% per year until 2019 (755.7). In the period 2001-2019, the incidence of thyroid cancer increased significantly by 5.8 per cent per year (from 1.7 to 7.2) and testicular cancer by 2.9 per cent per year (from 3.2 to 6.7). However, laryngeal cancer also decreased significantly, by 3.3% per year (from 28.7 to 15.3) and oral and pharyngeal cancer by 2.5% per year (from 39.4 to 25.6).

Although the most commonly-occurring cancers are breast cancer in women and prostate cancer in men, lung cancer in women and pancreatic cancer in both sexes require special attention. For breast cancer, screening programmes and therapeutic advances have improved survival rates, while pancreatic cancer remains one of the most lethal cancers due to late diagnosis.

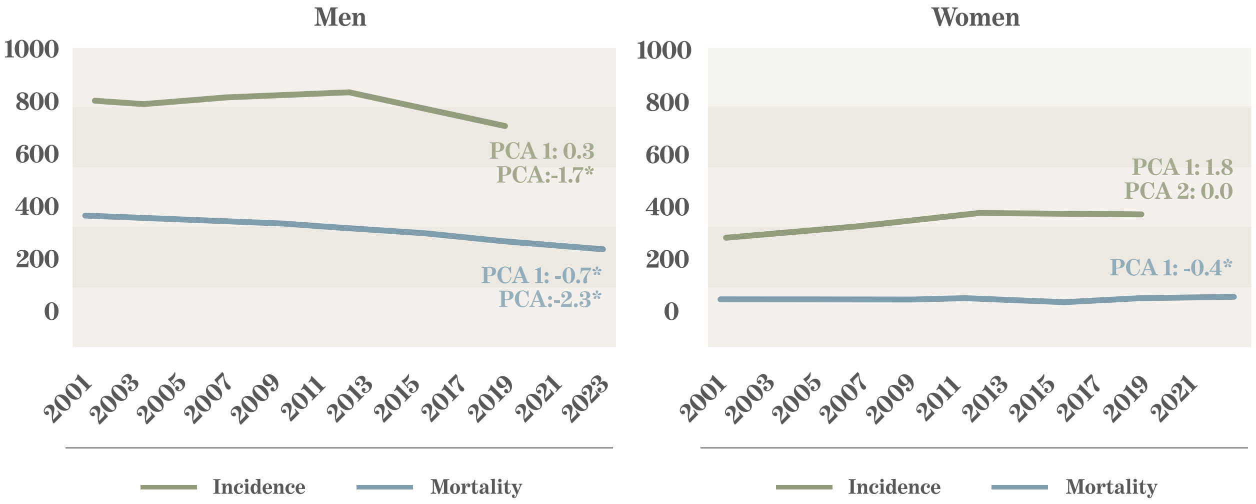


Figure 2. Evolution of incidence (2001-2019) and mortality rates (2001-2023) of malignant tumours (ICD-10: C00-C97) by sex

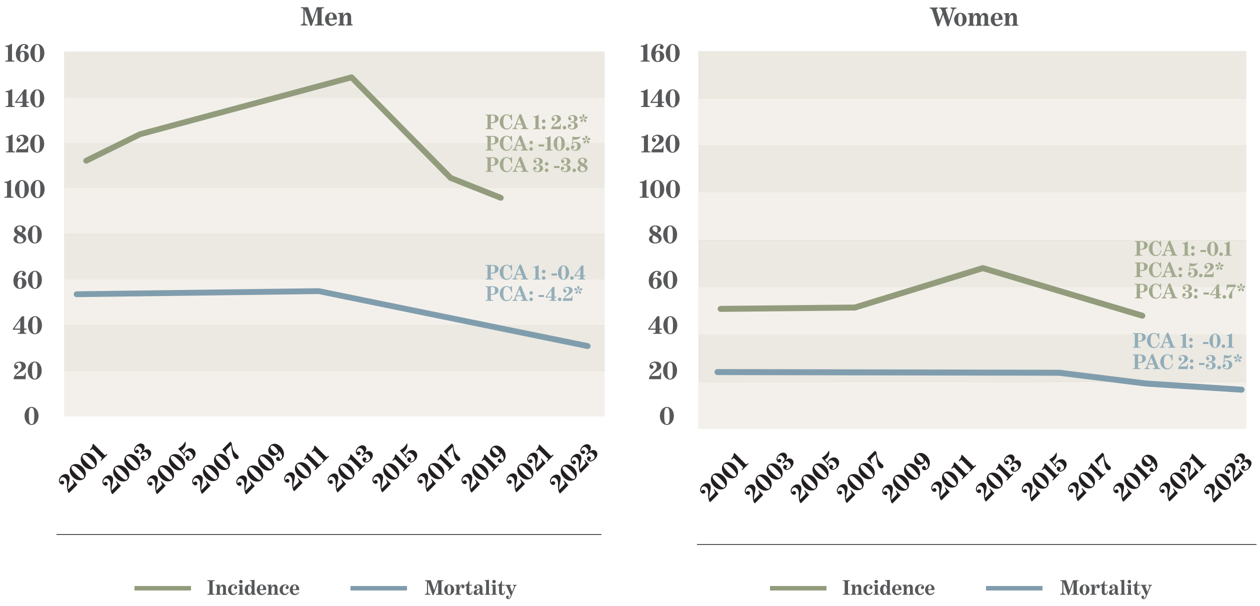


Figure 3. Evolution of incidence (2001-2019) and mortality rates (2001-2023) of malignant colorectal tumours (ICD-10: C18-C21) by sex.

2.3 Relative survival at 5 years

It is estimated that patients diagnosed with malignant tumours in the period 2013-2017 had a 5-year survival rate 39% lower than the general population by age and sex. However, there has been a significant improvement compared to those diagnosed in the period 2008-2012, when this value reached 42%.

Relative survival has improved in all age groups studied under 75, and especially in cases diagnosed at advanced stages (III and IV).

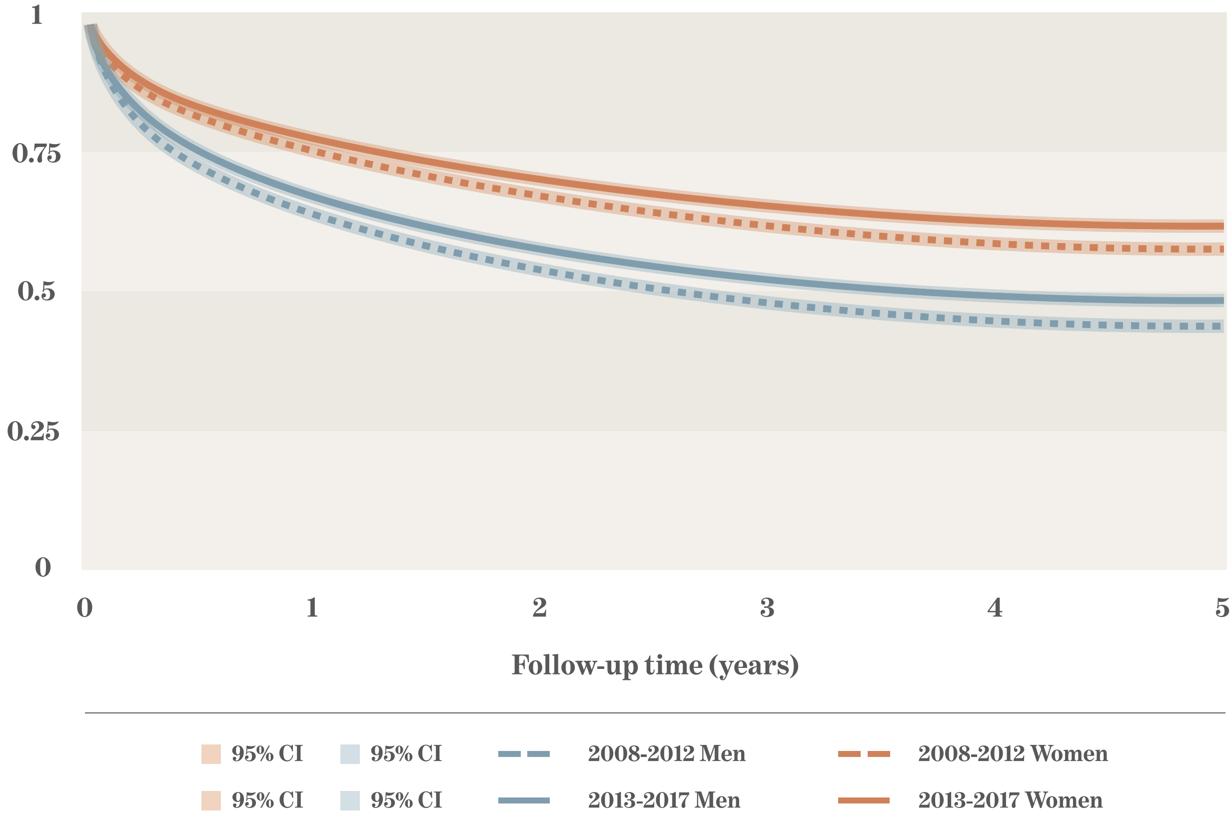


Figure 4. Survival curve for people diagnosed with cancer in the periods 2008-2012 and 2013-2017 by sex.

For cancers diagnosed in the Basque Country during the period 2013-2017, 5-year relative survival shows major advances in some types of cancer, although there are still significant challenges in others. The detailed data are as follows:

- **Breast cancer:** The median 5-year survival of diagnosed women is 12% lower than that of the general population (5-year SR: 0.88 [0.86; 0.89]).

  Breast cancer has made significant progress through population-based screening programmes and personalised treatments, resulting in a 5-year relative survival rate of 88%, improving both clinical outcomes and quality of life for these patients.

- **Prostate cancer:** The median 5-year survival of diagnosed men is 10% lower than in the general population (5-year SR): 0.90 [0.88; 0.92]).

  Opportunistic screening for prostate cancer has been carried out in the Basque Country for many years, and the relative survival rate is currently similar to that of breast cancer. However, there is more still work to be done on equitable access to this screening.

- **Colorectal cancer:** The median 5-year survival of those diagnosed is 31% lower than the general population (5-year SR: 0.69 [0.68; 0.70]). No significant differences in 5-year relative survival were observed between men and women.

  In the case of colorectal cancer, improvements have been observed due to the implementation of the early detection scheme launched in 2009, as tumours are identified at earlier stages. In fact, relative survival of those diagnosed has improved significantly compared to those diagnosed in the period 2008-2012. However, this type of cancer still poses a significant challenge due to the complexity of its management in advanced stages. Specifically, cases diagnosed at stage III and IV have a relative survival of 74% and 14% respectively, compared to 96% and 87% for those diagnosed at stages I and II. This is similar for men and women.

- **Lung cancer:** The median 5-year survival of those diagnosed is 80% lower than the general population (5-year SR: 0.20 [0.19; 0.21]). This is 81% for men and 77% for women, which are statistically significant differences.

  The 5-year relative survival rate, even for people diagnosed early in stage I, is 35% lower (39% in men and 24% in women) than that of the general population, and 58% lower (58% in men and 54% in women) for stage II. This highlights the need to reinforce primary prevention programmes with the aim of reducing the incidence of this cancer, as well as working on its early diagnosis.

  Nevertheless, the survival rate has improved significantly compared to that of people diagnosed in 2008-2012, when the 5-year relative survival was 13%, compared to 20% today. This improvement has been considerable for both men and women, and especially in those diagnosed at stage III, probably due to the introduction of new treatments.

- **Cervical cancer:** The median 5-year survival of diagnosed women is 35% lower than that of the general population (5-year SR: 0.65 [0.58; 0.71]).

  In the case of cervical cancer, improvements are also expected in the near future as a result of primary prevention strategies, such as vaccination against human papillomavirus (HPV), and the implementation of a more effective and accessible population-based screening programme.

These data demonstrate the need to continue reinforcing policies for prevention, early detection and equitable access to innovative treatments, adapting strategies to the specific characteristics of each type of cancer in order to continue improving survival rates.

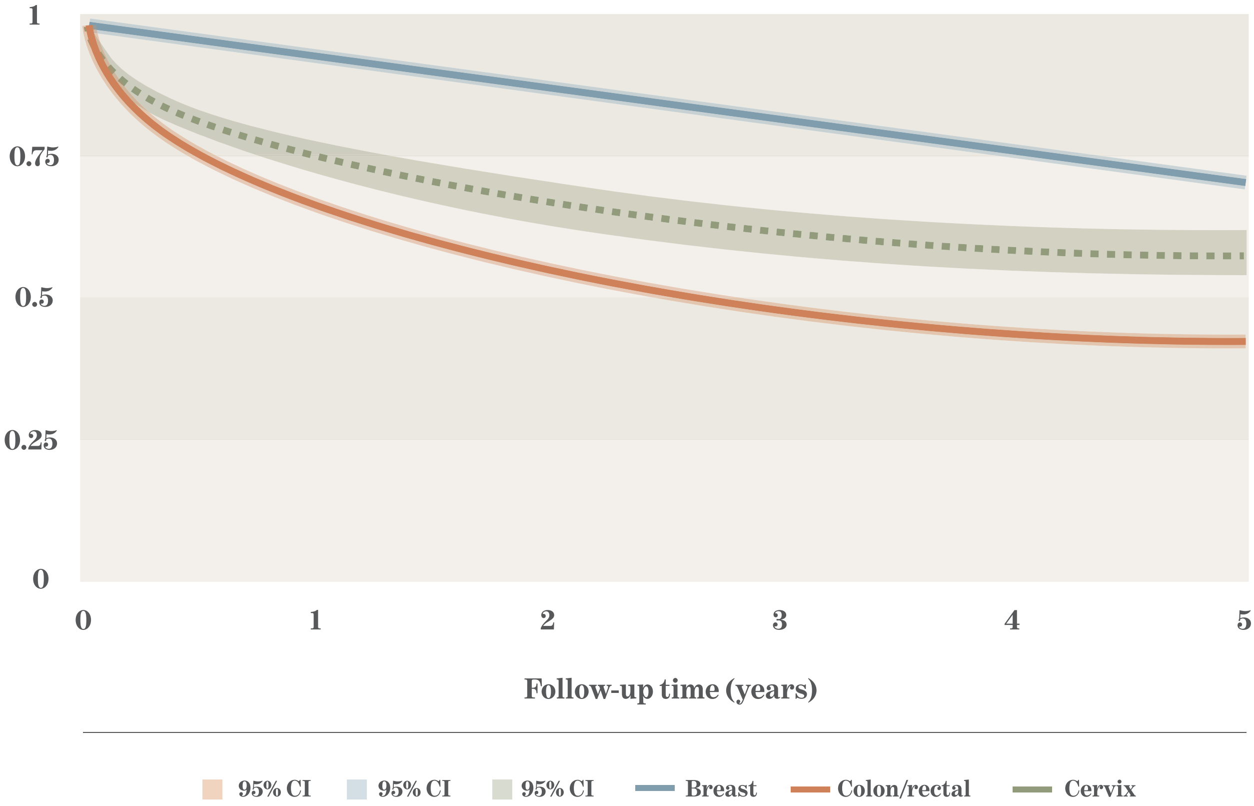


Figure 5. Survival curve for people diagnosed with breast, colorectal or cervical cancer in the period 2008-2017.

2.4 Cancer mortality 2019-2023

During the period 2019-2023, there was an annual average of 6,146 deaths (3,655 men and 2,491 women) from cancer per year, which means a crude cancer mortality rate in the Basque Country of 343.6 per 100,000 inhabitants in men and 220.6 in women; there is a significant difference between the two sexes. These differences are partly due to the higher incidence of cancers with a poorer prognosis such as lung cancer, and prostate cancer in men.

The age-adjusted rate shows a marked decline in both sexes over the period 2001-2023, especially in men, where it fell from 438.9 per 100,000 inhabitants in 2001 to 322.0 in 2023, with a sharper annual decline from 2013 onwards (-2.2% per year). In women, there was a more moderate drop (-0.4% per year), from 177.3 in 2001 to 154.2 in 2023. In both sexes, five tumour sites accounted for 51% of cancer deaths: lung, colorectal, pancreas, prostate and bladder. By sex, in men, the cancer that causes the most deaths is lung cancer (24.3% of cancer mortality), followed by colorectal (11.9%), prostate (9.4%), bladder (7.2%), liver (6.2%) and pancreas (6.0%). In women, the most frequent cancer is lung cancer (14.1 %), followed by breast cancer (12.8 %), colorectal cancer (12.7 %), and then pancreatic (8.6 %), stomach (5.0 %) and leukaemia (4.9 %).

Notably, lung cancer has moved from being the third leading cause of death in the five-year period 2016-2020 to the top cause in the five-year period 2018-2023. Between 2018 and 2023, lung cancer became the leading cause of death from cancer in women, overtaking breast cancer. This is related to birth cohorts where increased smoking in women was observed. Despite advances in early detection, more effective treatments and the adoption of healthier lifestyles, the increase in lung cancer in women underlines the need to evaluate specific prevention and treatment strategies for these tumour sites, following European Council recommendations

To assess the impact of premature mortality, Potential Years of Life Lost (PYLL) were calculated. In women, the causes of death resulting in the most potential years of life lost were tumours (57%), followed by diseases of the circulatory system (12%). In men, tumours also occupy the first place (39 %) followed by external causes (20 %) and diseases of the circulatory system (19 %). The specific causes resulting in the greatest loss of potential years of life in women are malignant breast tumour (12 %), and malignant tumour of the trachea, bronchus and lung (11 %). In men, the highest premature mortality is due to malignant tumours of the trachea, bronchus and lung with 10 %.

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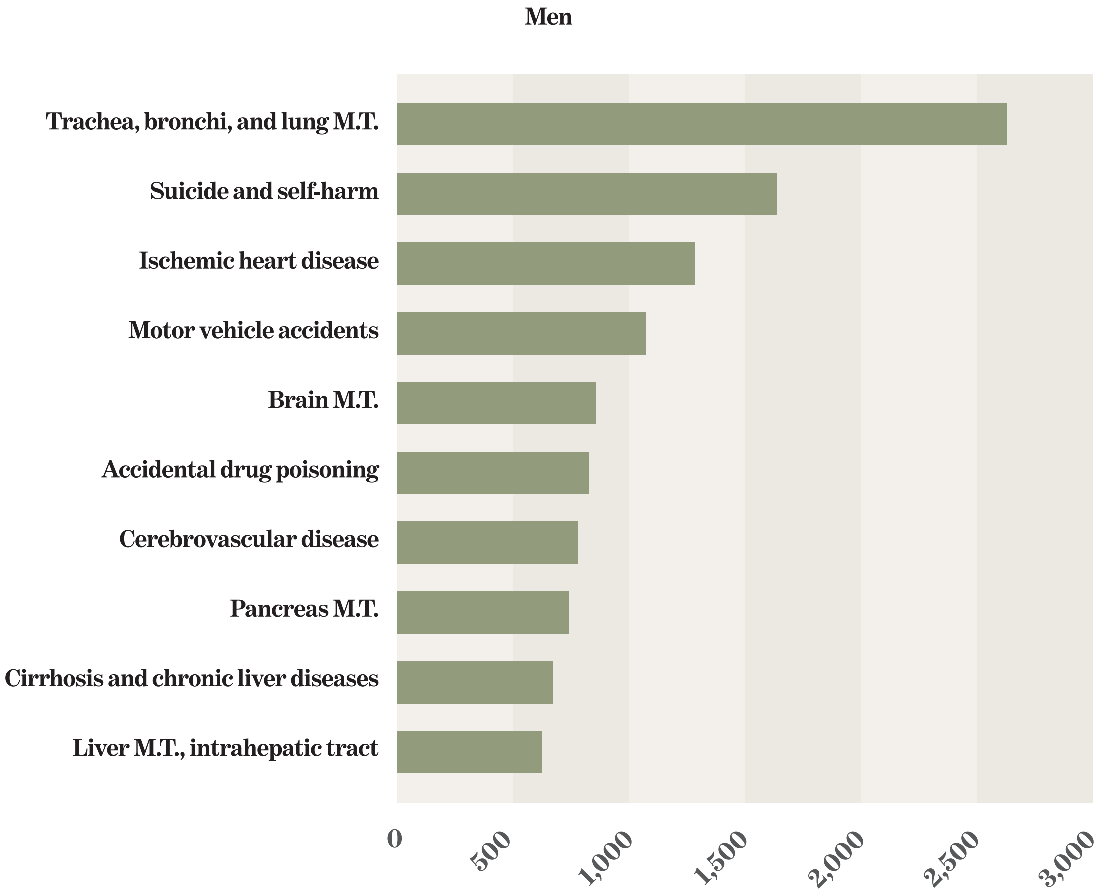


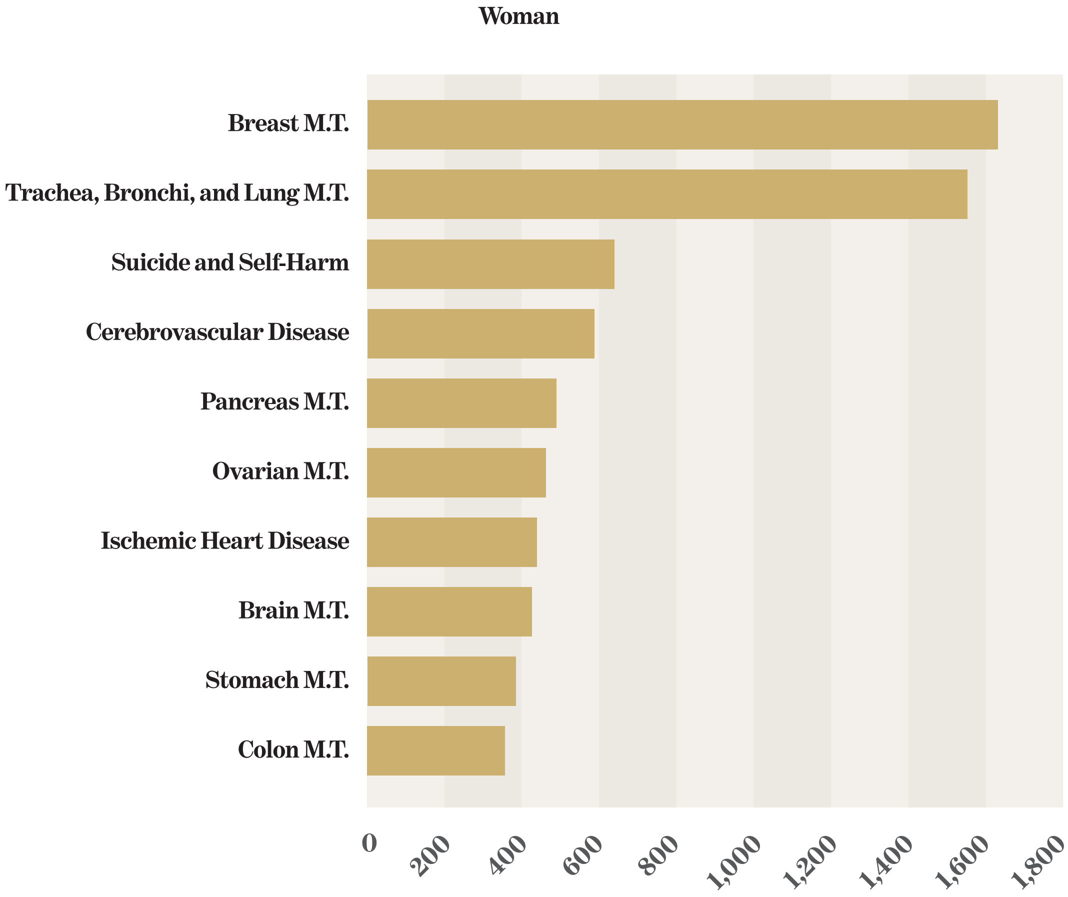


Figure 6. Number of potential years of life lost by sex in the Basque Country in 2023.

2.5 Childhood cancer 1990-2018

Detailed data, figures and tables are available in the document Childhood cancer in the Basque Country 1990-2018 [9].

Malignant tumours represent the leading cause of disease-related mortality in children aged 1-14 years, even though cases diagnosed in childhood constitute less than 1 per cent of all cancers in the population. Between 1990 and 2018, 1,338 cases of cancer were registered in children under 15 years of age, with a rate of 159.88 cases per million people per year. The incidence of childhood cancer is highest in children under one year of age, decreasing steadily until the age of 9 and then continuously increasing until the age of 14. Girls are most affected in the first year, after which boys are more affected at virtually all ages. Although its incidence is low, childhood cancer has a significant impact on families and represents a major public health challenge.

Distribution by age group

- Under 1 year of age: Peripheral nervous system (PNS) tumours accounted for 36% of cases, neuroblastoma being the most frequent (89% of cases in this category).
- From 1 to 4 years: Leukaemia was the most common cancer (43%), followed by malignant tumours of the central nervous system (CNS) at 16%.
- From 5 to 9 years: Leukaemia remained predominant (35%), followed by CNS tumours (22%) and lymphomas (17%).
- From 10 to 14 years: In this group, leukaemia and lymphomas accounted for 48% of cases. This age range also showed a higher incidence of bone tumours (15%) and soft tissue sarcomas (11%), while epithelial tumours were more frequent in girls, at 16% of cases.

Between 1990 and 2018, 58% of tumours detected were in boys, and 42% in girls. In the overall ranking, leukaemia is the most frequent cancer in both sexes. Girls show a higher incidence of epithelial tumours, germ cell tumours and renal tumours. PNS tumours show similar rates in both sexes, and the rest are more frequent in children.

Over the period analysed, there was a stable increase in the adjusted incidence rate in children. In the case of girls, the evolution was similar until 2013, when an increase in incidence was observed, although this was not statistically significant.

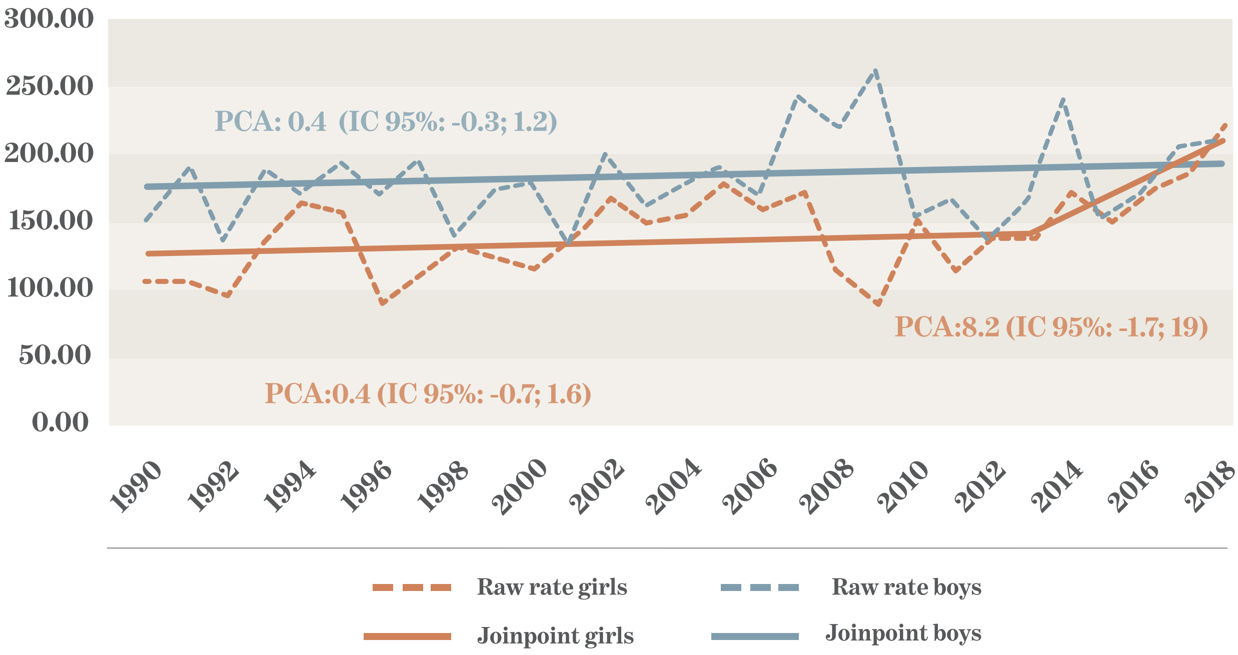


Figure 7. Crude rates of childhood cancer (0-14 years) per million and joinpoint adjustment by year of diagnosis and sex in the period 1990-2018 in the Basque Country.

Regarding mortality, for the period 1999-2018, childhood cancer was responsible for:

- 1.4% of deaths in children under one year of age, ranking seventh among causes of death in this group.
- 26% of deaths in children aged 1-14 years, becoming the leading cause of disease-related mortality, with 1 in 4 deaths attributed to cancer.

Despite its impact, the evolution of mortality showed a downward trend during the period analysed, with a reduction of -1.7% per year, although this decrease was not statistically significant.

Childhood cancer survival, however, has seen significant gains. For the period 2007-2016, the survival rates were:

- 90.6% 1 year after diagnosis.
- 82.5% 3 years after diagnosis.
- 80.4% 5 years after diagnosis.

No statistically significant differences by sex were observed. By groups of tumours, 5 years after diagnosis, the highest survival after retinoblastoma (100%) and epithelial cell tumours (100%) is for lymphomas (98.4%) specifically Hodgkin's Lymphoma (HL) (100%), renal (86.4%) and leukaemia (85.2%) especially Acute Lymphoblastic Leukaemia (ALL) (87.6%). The worst survival rate, less than 80%, is for CNS tumours (41.7%), bone tumours (72.4%) and PNS tumours (75.0%).

These data highlight the importance of continuing to reinforce research, early diagnosis and specialised treatment strategies in the field of childhood cancer, to improve outcomes and reduce the impact of the disease on children and their families.

The paediatric cancer research carried out in the Basque Country is also of note. In May 2022, the Joint Clinical Research Unit on Childhood Cancer in the Basque Country was created as part of the Basque Public Health System. As a result, the paediatric oncology units of Bizkaia and Gipuzkoa act as a network in the field of clinical research. This has encouraged collaboration and facilitates both units being involved in a clinical study/trial on cancer in children, thus allowing the possibility, where appropriate, of all paediatric cancer patients in the Basque Country who are treated in Osakidetza.

In 2023, 41 research projects and 22 clinical studies were conducted in the paediatric population, the majority of which were run by international non-profit organisations. These projects are mainly focused on gaining a better understanding of paediatric cancer through genomic techniques, leading to improved clinical management and more accurate diagnosis and prognosis. These studies focus mainly on medulloblastomas, neuroblastomas, leukaemias, lymphomas and rare tumours. This research also makes it easier for patients to access clinical trials. In addition, initiatives are being carried out to improve care and promote physical activity, with the aim of improving the quality of life among children with cancer.

2.6 Population-based early detection programmes

Cancer screening programmes in the Basque Country have been fundamental in preventing and reducing cancer mortality. These programmes, aimed at the early detection of initial stage tumours, and in some cases pre-malignant lesions, have proven to have a positive impact on public health, improving survival rates and reducing the burden of disease in the population.

The following is an overview of the three population-based cancer screening programmes currently in place in the Basque Country.

Breast cancer

The breast cancer screening programme in the Basque Country, started in 1996, is aimed at all women between 50 and 69 years of age, and at women between 40 and 49 years of age with a first-degree family history of breast cancer. In 2023, the participation rate returned to pre-pandemic levels, reaching 79.3%. This is considered an optimal level of participation as, according to European recommendations, a rate of over 70% is considered acceptable and a rate of over 75% is desirable [10]. This high participation reflects the population's acceptance and trust in the programme, which is crucial for early detection and facilitates the application of less invasive treatments, with a direct impact on patients' quality of life.

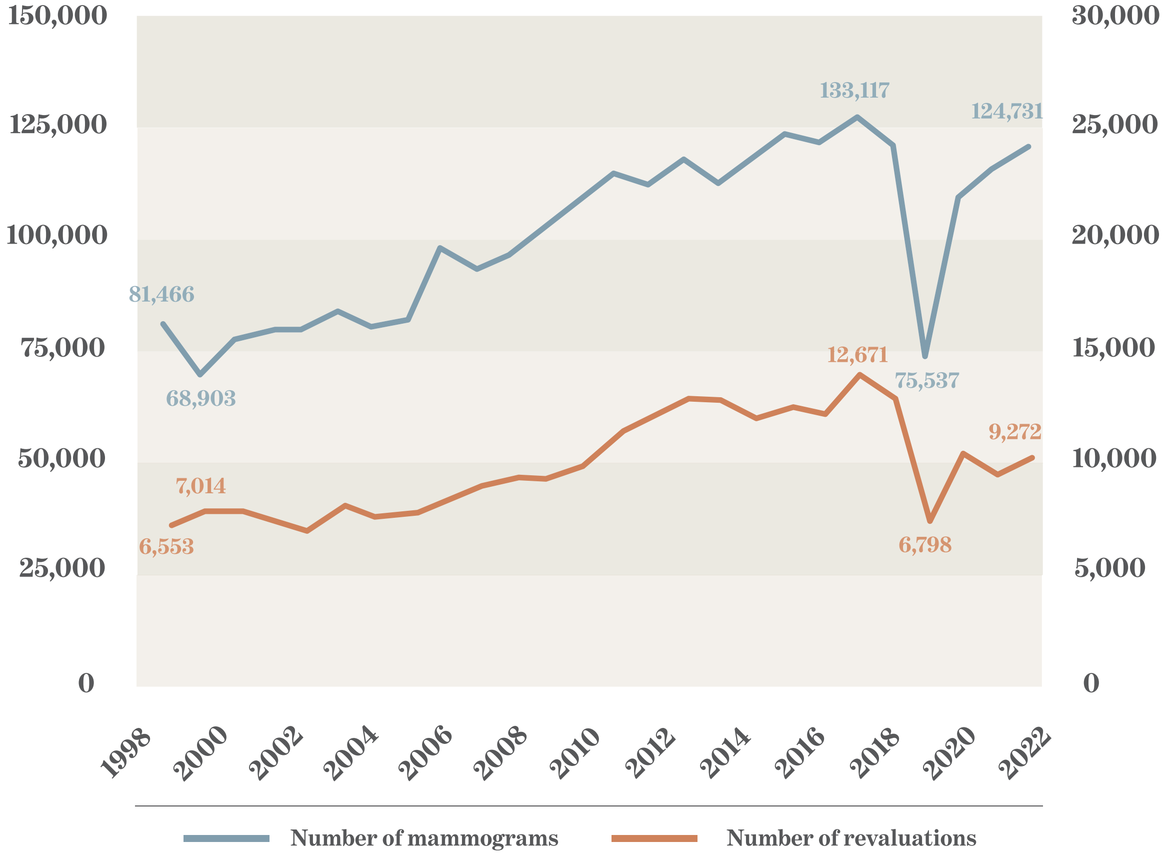


Figure 8. Evolution of the participation rate in the Breast Cancer Screening Programme in the Basque Country over the period 1998-2023.

The following table shows the most relevant results of the Programme since its inception:

Table 1. Indicators of positivity, re-evaluations and detection rates of the Early Detection of Breast Cancer Programme in the Basque Country for the period 1996-2024 (to June).

RATES BASQUE COUNTRY 1996-2024 (to june)	FEMALES	%	EUROPEAN GUIDE
Women invited	3,333,510	-	-
Scans performed (Participation rate)	2,633,515	79.0%	>70%
Re-assessments performed	227,700	8.7%	-
Women referred to Hospital (3 HR, 4, 5)	28,655	1.1%	-
Rate of cancers detected x 1,000 women screened	-	4.98%	5.0%

Colorectal cancer

Colorectal cancer screening is aimed at people aged 50-69, who are invited to undergo a quantitative faecal immunochemical test (FIT) every two years. In March 2024, the programme was extended to include people up to the age of 74, in line with the European Recommendations and the National Health System Public Health Position [11,12]. The extension of the age range to people aged up to 74 was an important step, as this group has a higher risk of developing colorectal cancer. Early detection of this disease increases the chances of successful treatment and helps to reduce associated mortality.

In 2013, the programme reached 100% of the target population. However, the COVID-19 pandemic delayed invitations to a significant percentage of the population, reaching only 48% of people by the end of 2020. This backlog has gradually been reduced, with full recovery of coverage in the first half of 2023.

The following table shows the most relevant results of the programme since its inception:

Table 2. Indicators of positivity, acceptance of colonoscopy and detection rates of the Early Detection of Colon Cancer Programme in the Basque Country for the period 2009-2023

RATES BASQUE COUNTRY 2009-2023	MEN	FEMALES	BOTH SEXES	EUROPEAN GUIDE
Participation rate x 100 valid invitations	67.78%	72.85%	70.40%	>65%
Positive rate x 100 participants	6.34%	4.10%	5.14%	4-11%
Adherence to confirmatory colonoscopy with definitive diagnosis	94.55%	94.82%	94.66%	90-95
Low-risk adenoma detection rate x 1,000 participants	11.54%	7.17%	9.20%	-
Invasive cancer (CRC) detection rate x 1,000 participants	2.84%	1.43%	2.09%	1.3-9.5%
Advanced lesion (AL) detection rate x 1,000 participants	27.06%	10.87%	18.39%	-
Advanced malignancy (AM) detection rate x 1,000 participants	29.90%	12.30%	20.47%	-
Positive predictive value CRC	4.49%	3.51%	4.07%	4.5-8.6%
Positive predictive value AL	42.67%	26.5%	35.76%	-
Positive predictive value AMA	42.74%	26.35%	35.77%	-

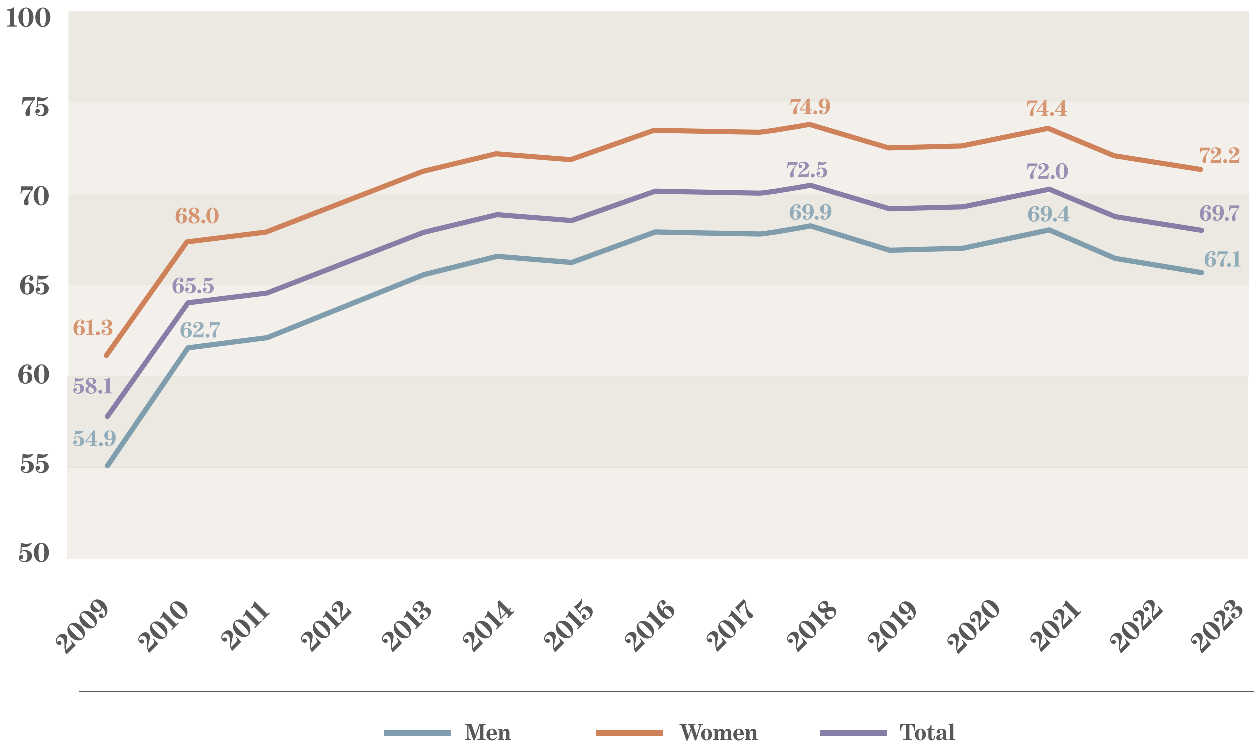


Figure 9. Evolution of participation in the Colorectal Cancer Screening Programme in the Basque Country over the period 2009-2023.

Cervical cancer

The cervical cancer screening programme currently targets women aged 25-65 years, with a deferred strategy by age:

- From 25 to 34 years: Pap test every 3 years as primary test.
- From 35 to 65 years: HPV screening with genotyping every 5 years.

The screening programme started in 2018, reaching 100% coverage in the invitation for women aged 25-34 by December 2022 and by December 2024 for the population aged 35-65. The implementation of HPV screening is a paradigm shift in the fight against cervical cancer. The inclusion of HPV genotyping is another significant advance in this programme, as it allows for more specific detection of the virus that causes cervical cancer, improving the effectiveness of screening and prevention.

Over the years, approximately 600,000 invitations to participate in the programme have been sent out to women aged 25-65 who had no record of having been screened within the recommended interval. In 2023, six out of ten women accepted the invitation to participate and in 2024 alone, 118,352 women were invited and 89,705 samples were analysed at the screening unit at Donostia University Hospital.

In general, no more than 7% of women screened will require further investigation for diagnostic confirmation; the rest will have a low-risk result and will be invited back in 3 to 5 years depending on the test performed.

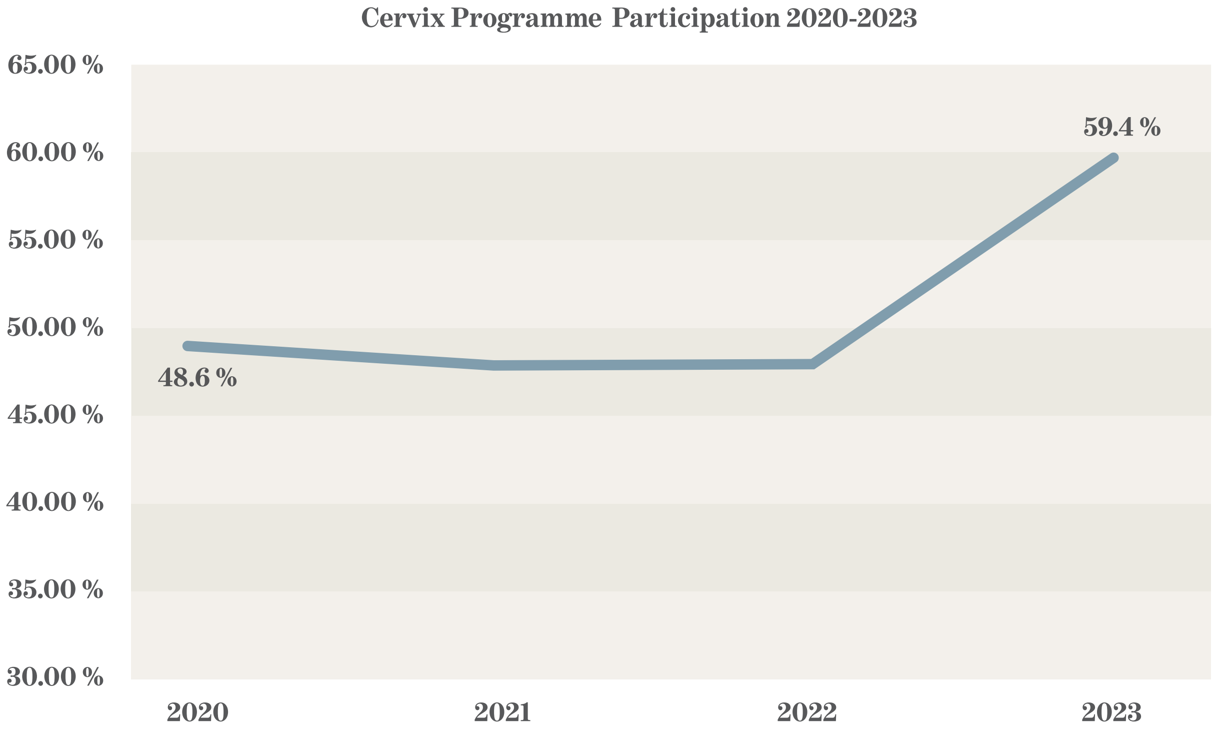


Figure 10. Evolution of participation in the Cervical Cancer Screening Programme in the Basque Country over the period 2020-2023.

The following table shows the most relevant results of the Programme since its inception:

Table 3. Indicators of positivity, biopsy acceptance and detection rates of the Basque Country Cervical Cancer Early Detection Programme 2019-2023

RATES BASQUE COUNTRY 2019-2023	FEMALES	%	EUROPEAN GUIDE
Valid invitations sent	544,028	-	-
Participants x 100 valid invitations	277,530	51.0%	> 70%
Opportunistic tests performed (at appropriate interval)	169,129	-	-
Rate of CIN2/3 detected x 1,000 women screened	1,580	5.69	-
Rate of cancers detected x 1,000 women screened	23	0.08	-

2.7 Healthcare data

The healthcare data related to cancer treatment in the Basque Country reflect an evolving panorama, with an increase in demand for care due to the growing incidence of the disease, which also has an impact on the demand for diagnostic and patient care services.

The referral hospitals for oncological care in Osakidetza have different Tumour Boards at which cases are discussed, for decisions to be made by a multidisciplinary group on the most appropriate treatment for each patient. In 2024, the Tumour Boards discussed approximately 16,500 cases. The breast and lung boards are the two most active boards in the Basque Country, with more than 2,000 cases evaluated each year.

The following table shows the number of unique patients assessed in each of the Tumour Boards in Osakidetza.

Table 4. Number of patients evaluated by each Tumour Board in Osakidetza in 2024.

TUMOUR BOARDS	NO. OF PEOPLE
TOTAL*	**16,636**
Breast	3,389
Lung	2,280
Hepato-biliary-pancreatic	1,480
Urological	1,437
Colorectal	1,157
Gynaecological	1,149
Esophageal-gastric	906
Head and neck	882
Neurological	631
Dermatological	629
Bone tumours and soft tissues	592
Endocrine	586
Haematological	461
Molecular	390
Haematopoietic Transplant	195
Paediatric	137
Radiosurgery	103
Peritoneal carcinomatosis	103
CAR-T therapy	62
Spinal metastasis	59
Neuroendocrine and adrenal tumours	8

*The total may include repeated individuals

The treatment plans designated for these people are mostly given on an outpatient basis, at the clinics of the different specialities, depending on the pathology, or in the medical day hospital.

Outpatient clinics

In recent years, there has been a notable increase in demand for outpatient services. Successive outpatient consultations in Medical Oncology and Radiation Oncology increased by 56-58%, reflecting not only the rising incidence of cancer, but also progress in treatments and the need for continued follow-up of long-term survivors benefiting from new therapies.

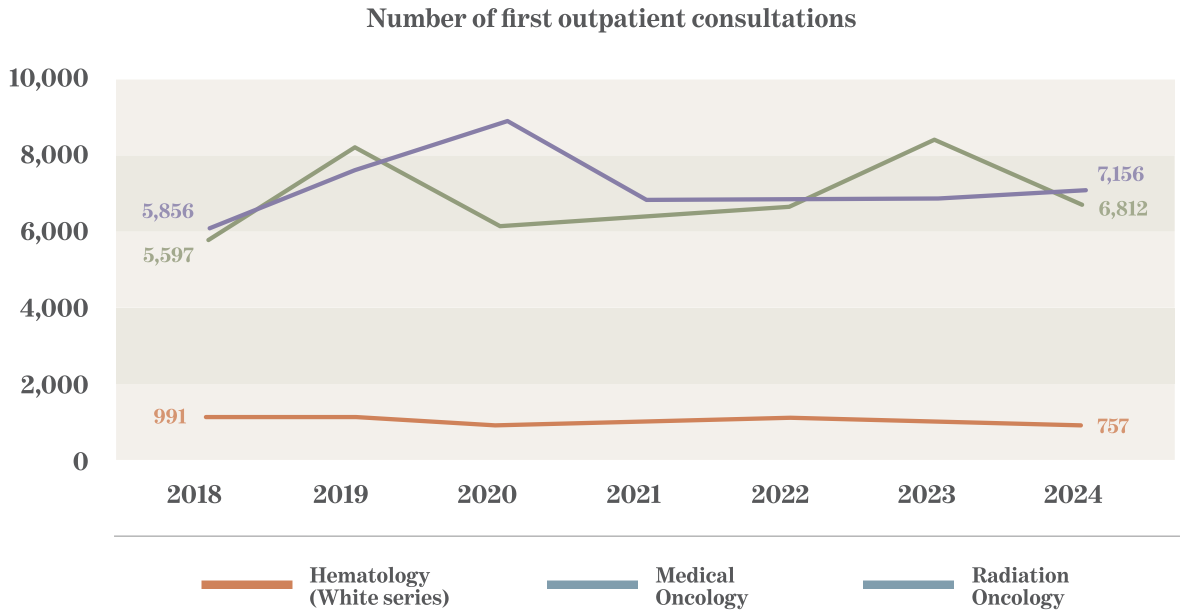


Figure 11. Number of first outpatient consultations in Medical Oncology, Radiation Oncology and White Blood Cell Haematology in Osakidetza over the period 2018-2024.

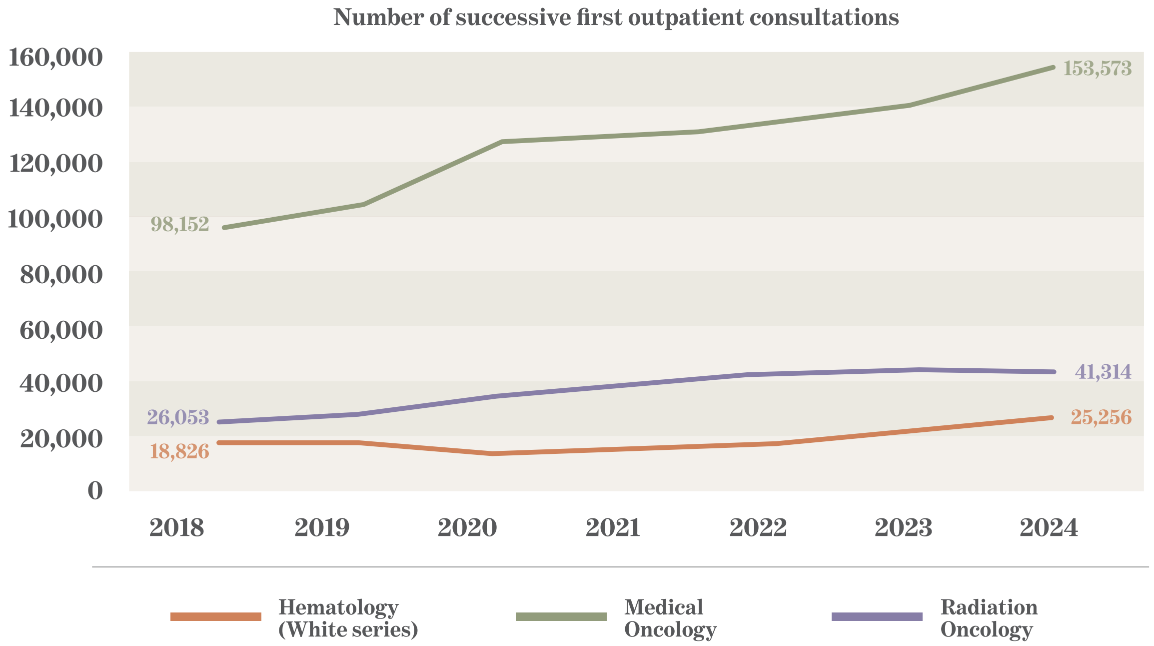


Figure 12. Number of successive outpatient consultations in Medical Oncology, Radiation Oncology and White Blood Cell Haematology in Osakidetza over the period 2018-2024.

Medical Day Hospital

Medical day hospital activity for Medical Oncology in Osakidetza has also increased significantly over the last two years, from 74,147 procedures in 2022 to 85,685, an increase of 15.6%, in 2024. Proportionally, the 65-75 age group undergo the highest number of day hospital procedures.

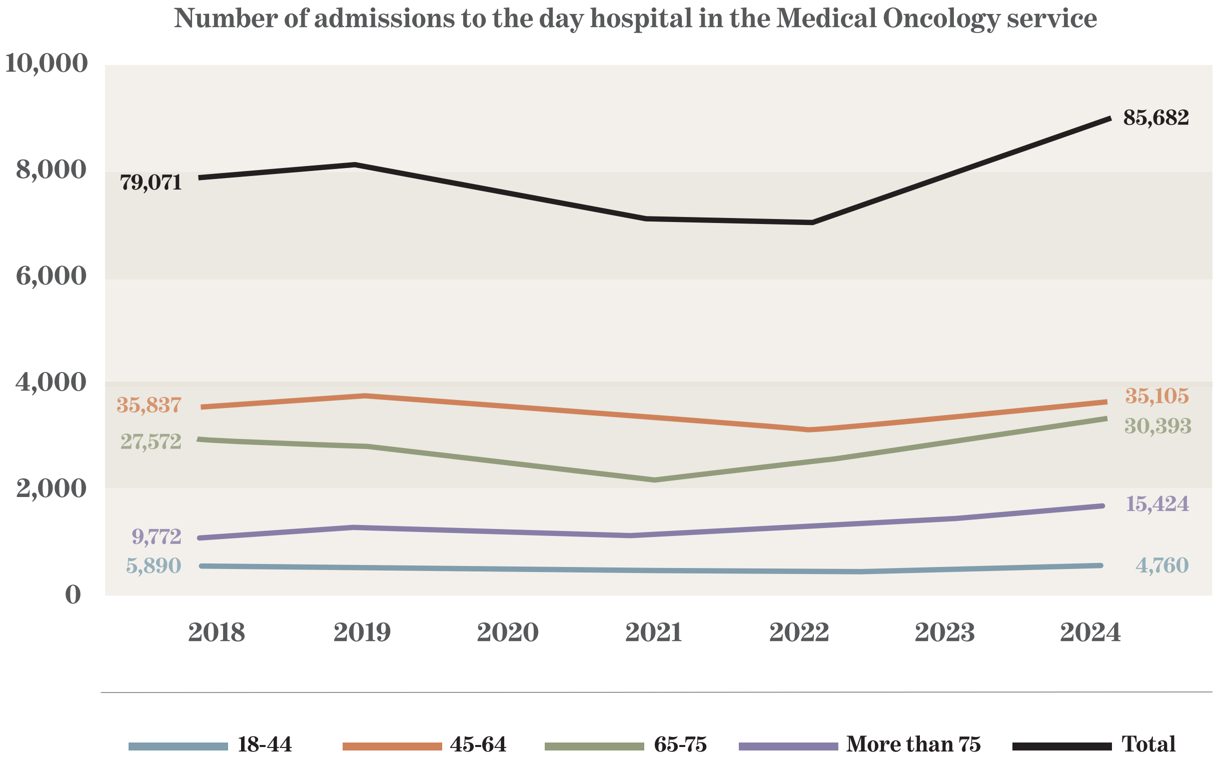
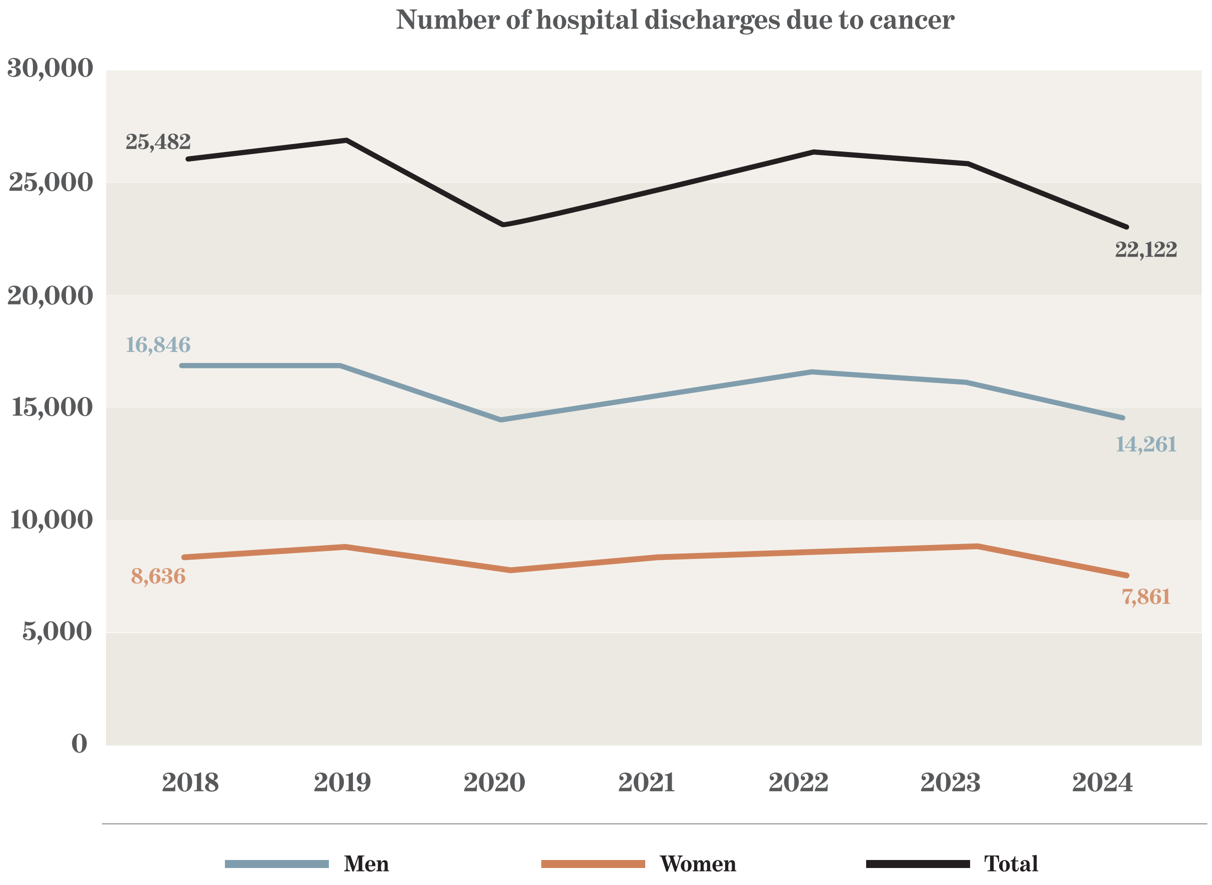


Figure 13. Number of procedures performed at the Medical Day Hospital in the Medical Oncology Service by age group for the period 2018-2024.

Hospitalisations

In the period 2018-2024 in Osakidetza there were 170,674 admissions with cancer as the main diagnosis, 64.8% in men. In 2024, there were 22,122 hospitalisations, mostly related to colorectal cancer, breast cancer and lung cancer, taking both sexes into account. However, prostate cancer or bladder cancer are among those resulting in more hospital admissions in men and breast cancer was responsible for more than 1,500 hospitalisations in women.

In general, of the cancers with the highest number of hospitalisations, leukaemia, colorectal cancer and pancreatic cancer result in hospital stays of more than 10 days on average. There is no significant difference in the average length of stay between men and women.



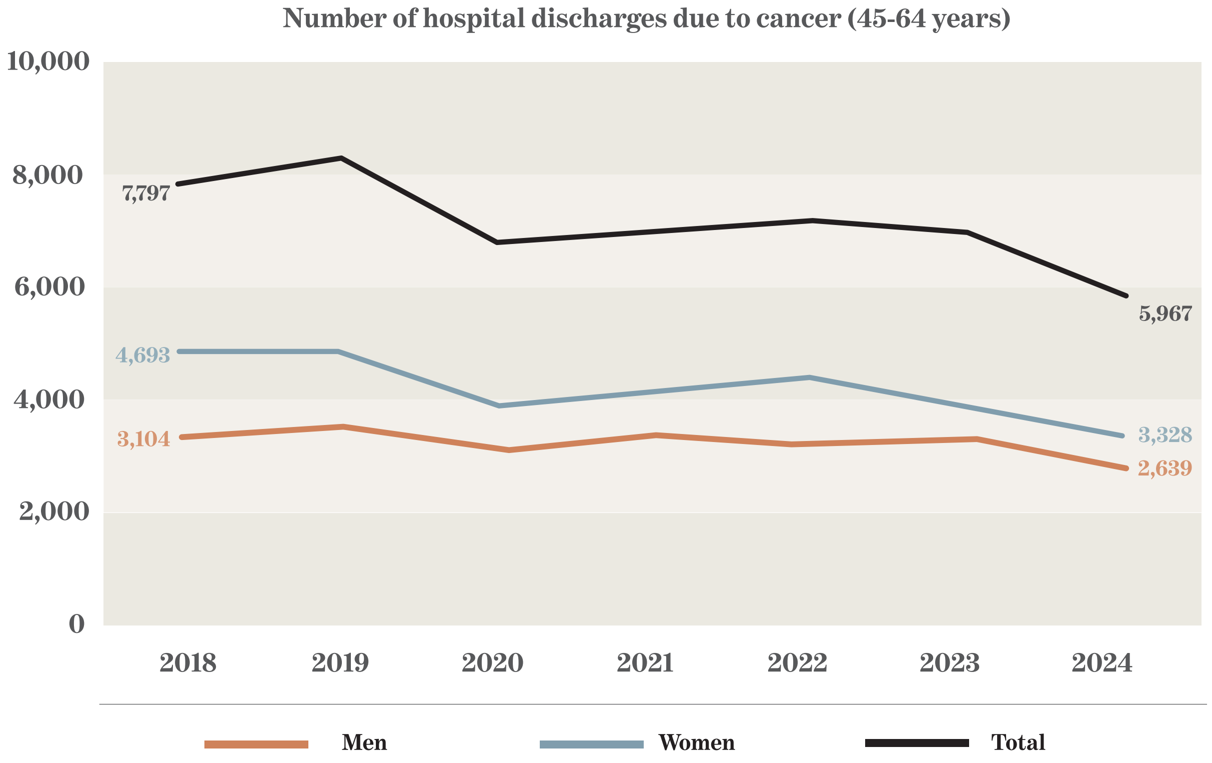


Figure 14. Evolution of the total number of hospital admissions and in the 45-65 age group in Osakidetza by sex.

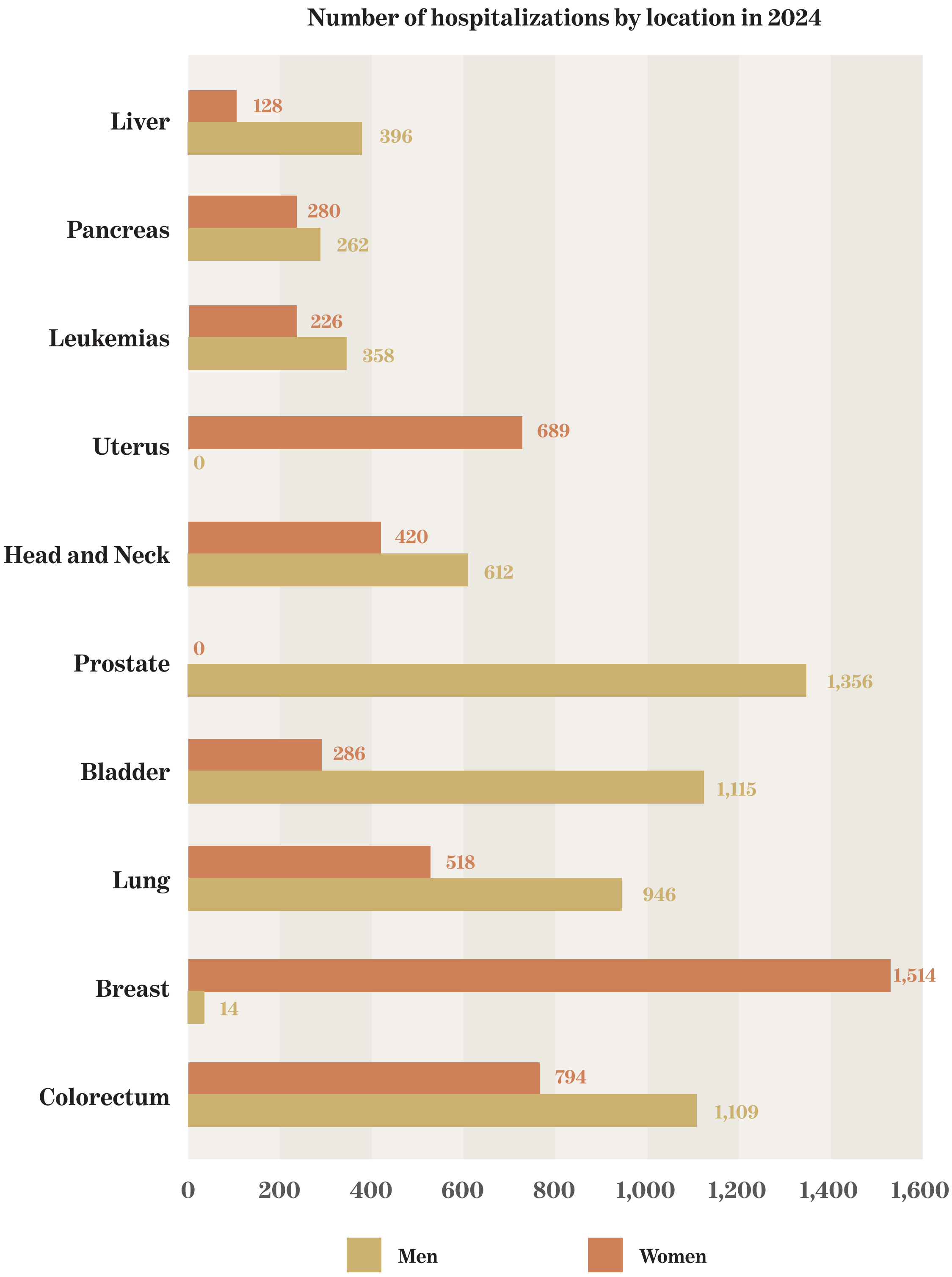


Figure 15. Number of hospital admissions in Osakidetza by sex and tumour location for those with more than 500 hospitalisations in 2024.

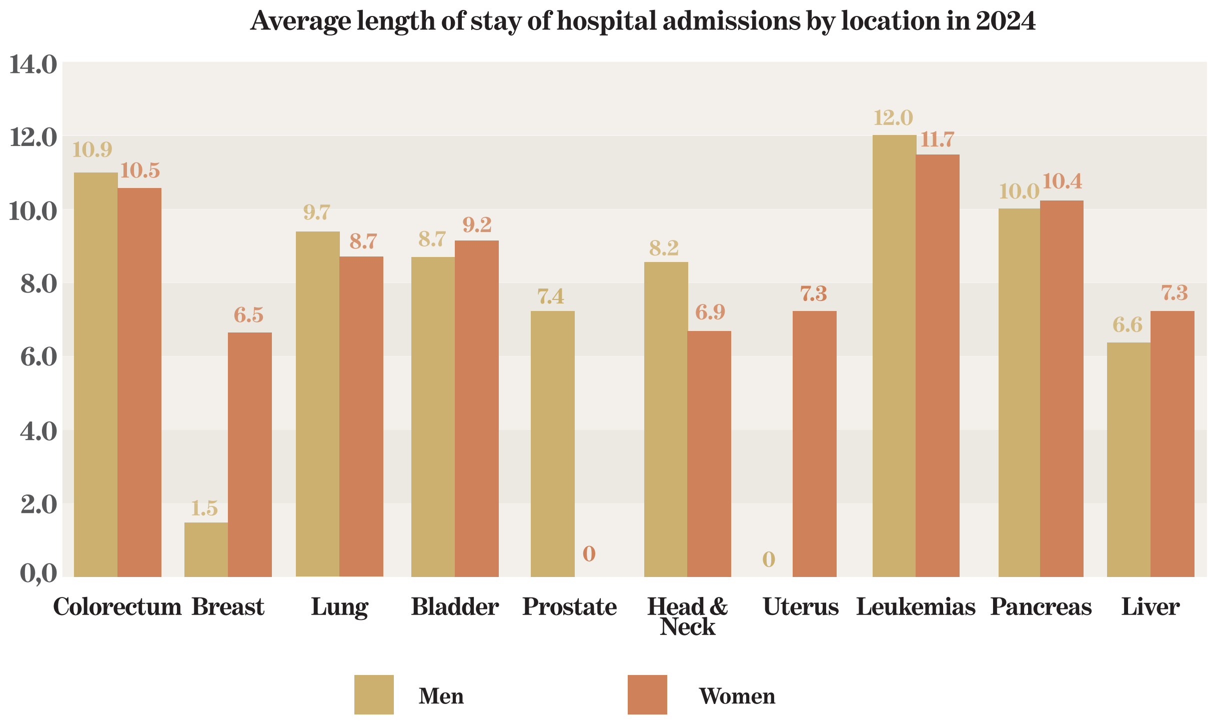


Figure 16. Average length of stay of hospital admissions in Osakidetza in 2024 by sex and tumour location.

Between 2018 and 2024, children under the age of 18 were admitted to Osakidetza due to cancer on 1,380 occasions, 56.4% of cases in males. In 2024 there were a total of 177 hospitalisations, mostly related to leukaemia. Hospital admissions in children for oncological reasons average 5.8 days compared to 8.9 days in adults, but admissions for acute leukaemia, the most common in children, have an average stay of 10.8 days. In 2023, approximately 60 paediatric patients diagnosed with cancer in the Basque Country were included in first-line clinical trials for their treatment.

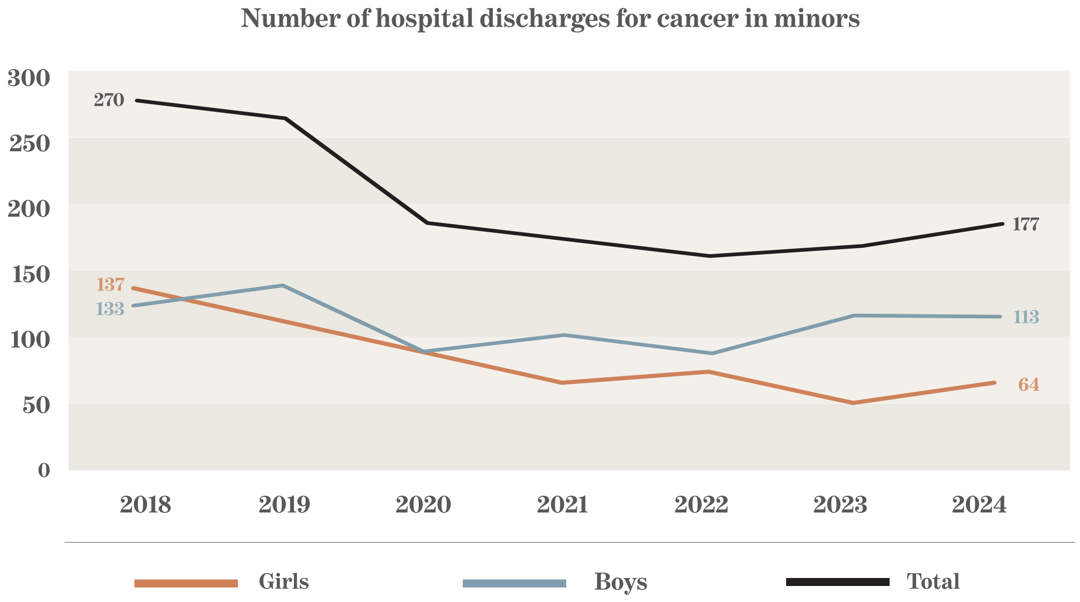


Figure 17. Evolution of the number of paediatric hospital discharges in Osakidetza with cancer as the main diagnosis by sex.

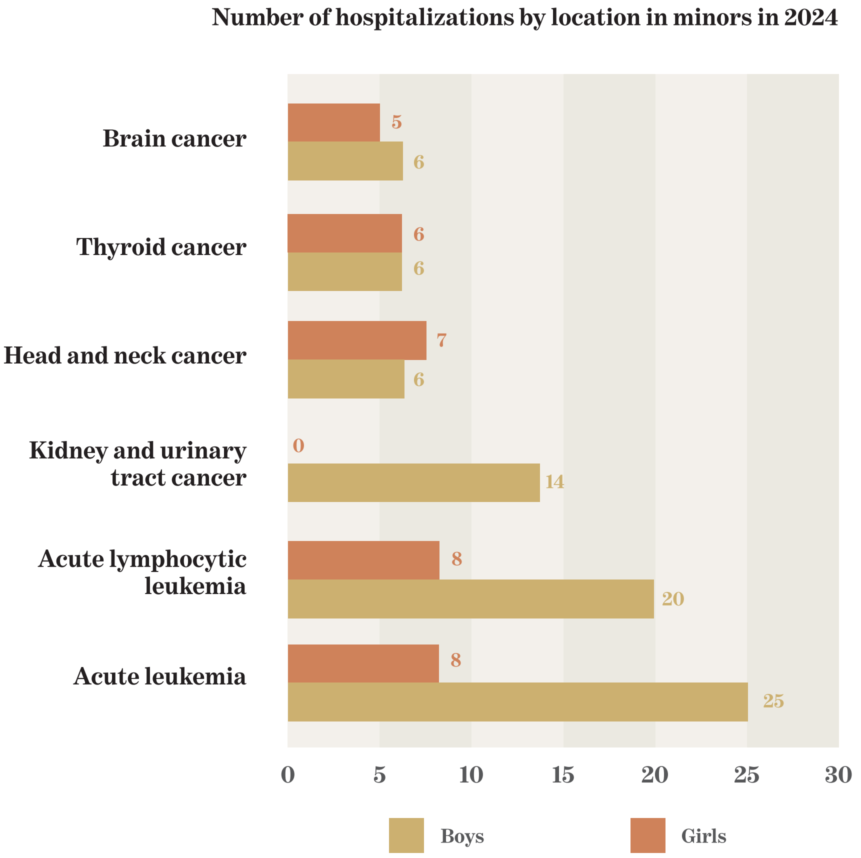


Figure 18. Number of paediatric cancer patient hospital discharges in Osakidetza in 2024 by sex and tumour location.

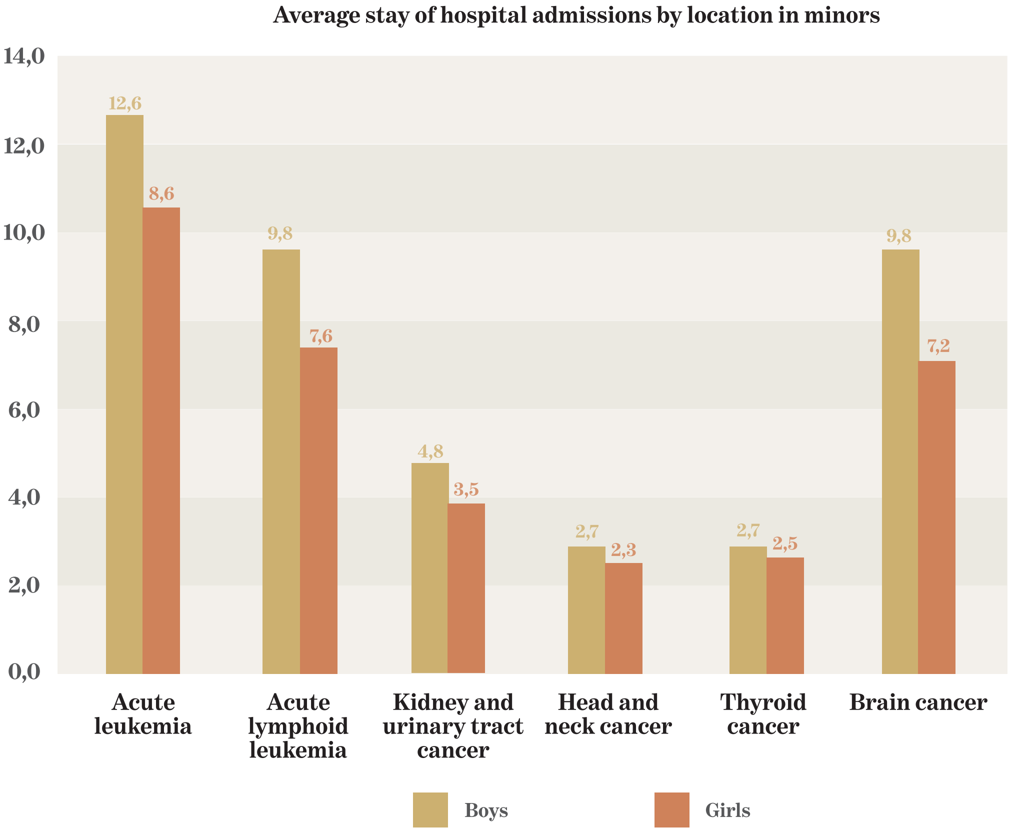


Figure 19. Average length of stay for paediatric hospital admissions in Osakidetza in 2024 by sex and tumour location.

Hospital-at-home

In addition to hospital admissions, between 2018 and 2024 cancer resulted in almost 11,000 home admissions, 55% in male patients. Forty percent of these admissions were requested by Medical Oncology, compared to 22% requested by Haematology.

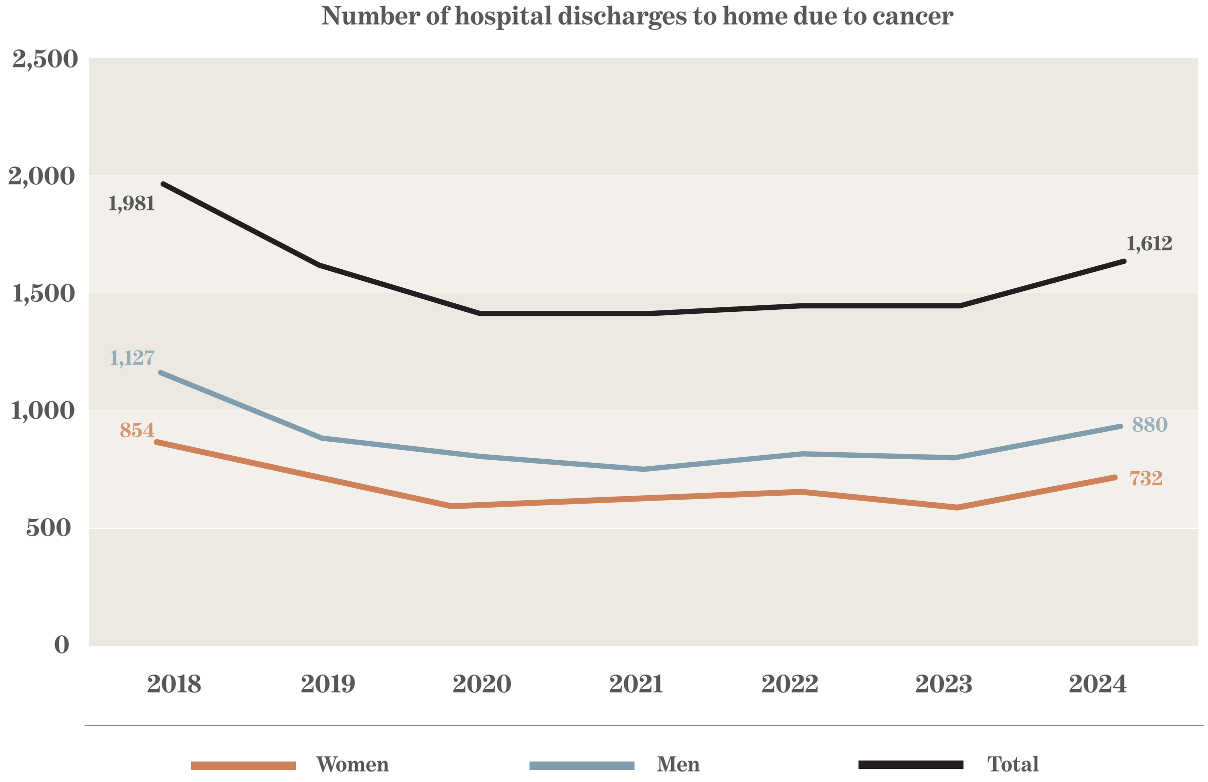


Figure 20. Evolution of the number of hospital-at-home admissions for cancer in Osakidetza for the period 2018-2024 by sex.

Primary care

Although the specific treatment phase of the patients is mainly carried out by medical specialist departments, the ongoing follow-up of these patients under primary care is important. In 2023, patients diagnosed with cancer in the previous years made an average of 11 visits to the primary care doctor or nurse in Osakidetza. Forty per cent of the visits were with doctors and 60 per cent with nurses. In addition, 20% of all visits were home visits, and in 9 out of 10 cases it was a nurse who attended. A further 20% were telephone appointments, while the remaining 60% took place in person at the relevant medical centre.

Antineoplastic treatment

Pharmacological treatments represent a significant part of Osakidetza's budget. Specifically in the case of cancer, treatment innovation has benefited patients by generally increasing their survival. However, these new treatments have led to a significant increase in the cost of antineoplastic therapies. In 2024, Osakidetza invested more than 125 million euros in these treatments.

2.8 Cancer research

Cancer research in the Basque Country is one of the priority areas of the Basque health system, supported by the Bioaraba, Biobizkaia, Biogipuzkoa and Biosistemak Health Research Institutes, coordinated by the Basque Foundation for Health Innovation and Research (BIOEF). The Basque ecosystem of healthcare research and innovation also has other research centres and universities working in the field of oncology. This research covers the entire cancer spectrum, from prevention and diagnosis to prognosis, treatment and improving patients' quality of life. Advances in these areas are aimed not only at combating the disease, but also at improving long-term outcomes for patients.

In 2023, the public sector in the Basque Country registered a total of 577 research projects and clinical studies focused on cancer, which represents approximately 28% of all healthcare research projects. This reflects the region's robust and multidisciplinary approach to the fight against cancer. Public cancer research in the Basque Country is supported by more than 300 researchers, distributed across 33 research groups, who develop innovative projects of high scientific quality. These focus mainly on colorectal cancer, breast cancer and tumours of the lymphatic and blood tissues, followed by brain and lung cancers. One of the main lines of work is the focus on Personalised Precision Medicine and Advanced Therapies, which has been included as a strategic area within the Personalised Health priority of the Basque Country's Plan for Science, Technology and Innovation 2030 (PCTI2030) [13]. This momentum has been instrumental in the development of treatments tailored to the specific characteristics of each patient, allowing greater effectiveness and fewer side effects. The implementation of advanced technologies, such as genomics, artificial intelligence and targeted therapies, is becoming an essential part of cancer research in the region.

In terms of scientific production, researchers at the Basque Health Research Institutes have achieved more than 800 publications in high impact scientific journals in the last five years, demonstrating the high level of research carried out in the Basque Country. This publication rate is a reflection of the ongoing effort to contribute to global knowledge in oncology, positioning the region as a reference point in the field of biomedical research. Cancer research in the Basque Country also has strong financial backing. In 2023, external funding for research projects exceeded 15 million euros, underlining the support obtained from institutions, industry and international organisations for projects taking place at the Health Research Institutes. This funding supports not only cutting-edge clinical trials, but also the implementation of innovative technologies in cancer treatment.

Similarly, the Basque Country has 4 more cancer researchers in existing private health organisations who took part in 4 research projects and clinical trials during 2023 with 3 publications in high-impact scientific journals.

Although cancer research in the Basque Country covers relevant areas and is making significant progress, challenges and areas for improvement still remain in certain clinical research areas. One of the main challenges is to improve clinical trials, where the Basque Country's activity is below the corresponding level for its population. There is a need to increase the number of sites and patients taking part in clinical trials. In comparison with the current national and international trend, today the Basque Country stands out in studies on breast, lung, bladder and sarcoma cancer; however, studies on colorectal cancer and haematological cancers are at significantly low levels. For example, although colorectal and pancreatic cancer are the second and third leading causes of mortality, in both cases only 1.4% of clinical trials focus on these diseases. Further progress is also needed in the development of clinical trials focusing on rare cancers and advanced therapies [14]. In terms of the distribution of clinical trials, they are mainly concentrated in phase III, with a higher percentage than the national average. However, early-stage trials (I and II) are considerably below average in both commercial and non-commercial studies, limiting patient access to innovative early-stage treatments [13, 14].

Another crucial challenge is the situation of the physician-researcher community, which faces difficulties in balancing clinical and research work [14]. Although progress has been made in some key areas of clinical research in the Basque Country, strategies are needed to boost participation in clinical trials, strengthen translational research and to ensure a supportive framework for professionals in the sector. This will help to consolidate clinical research in the Basque Country and improve its competitiveness at national and international level.

Cancer research in the Basque Country is currently in a phase of growth and consolidation, with a clear focus on Personalised Precision Medicine and Advanced and Innovative Therapies. The Basque research system continues to make strong progress, and institutional, financial and scientific support ensures that progress in this field continues to contribute to improving the care and treatments available to cancer patients, with the ultimate goal of improving patients' quality of life and reducing cancer incidence and mortality.

2.9 Social impact of cancer

A cancer diagnosis is not only a threat to one's health, but also profoundly transforms the personal, social and economic lives of cancer sufferers and their relatives. Beyond biological factors, social inequalities play a key role in the development of the disease, access to treatment and quality of life during and after the cancer process. The incidence and prognosis of cancer are strongly impacted by the so-called social determinants of health, such as socio-economic status, level of education, gender, age, ethnicity, place of residence, etc.

The most socially vulnerable people - those living with poverty, unstable employment, exclusion or loneliness - not only have a higher risk of developing cancer and later diagnosis, but also face greater barriers to accessing adequate treatment and quality care [16] . These barriers perpetuate and exacerbate inequalities at all stages of the cancer process, from prevention and early diagnosis to treatment, survival and palliative care.

There is strong scientific evidence for risk factors associated with cancer, such as smoking, alcohol consumption, obesity and sedentary lifestyles, and the prevalence of these factors varies significantly by social class. The latest data from the Basque Health Survey (ESCAV, 2023) show that there is a clear social and educational gradient with regard to dietary habits, sedentary lifestyles and/or exposure to tobacco smoke [17]. People from lower socio-economic groups or with lower levels of education show worse results in this regard. In the case of regular alcohol consumption, the social gradient is the inverse of the other risk factors mentioned; higher in the more advantaged social classes.

Early detection is another key tool in the fight against cancer, and social inequalities are also evident here. Participation in screening programmes varies significantly by social class and level of education. Wealthier women with a higher level of education participate more in breast and cervical cancer screening programmes. In the case of colorectal cancer screening, the difference observed in men from lower social classes and with a lower level of education is significant, with notably lower participation [17]. These data are a clear example of how social determinants affect exposure to risk factors, the adoption of a healthy lifestyle and access to prevention resources and timely medical care.

On the other hand, advanced age, in general, is the most relevant risk factor associated with cancer. In this regard, the ageing population, coupled with increasing life expectancy, poses new challenges for cancer care. This situation is aggravated when a diagnosis is received in a context of social isolation or unwanted loneliness, a phenomenon that is increasingly common in our societies due to demographic changes. In the Basque Country, for example, it is estimated that more than 2,500 people diagnosed with cancer each year live alone, and there are many other diagnoses in couples aged over 65 [18].

Cancer also has a strong impact on finances and employment. Many people's professional situation is affected by their diagnosis, as some are forced to give up work, reduce their working hours or change their activity, which in turn has an impact on their income and financial stability. Undoubtedly, the socio-occupational situation at the time of diagnosis clearly conditions the consequences of the disease on different aspects of life; this diagnosis may be a cause and/or aggravating factor of socio-economic risk for the subsistence of the person and their relatives. The economic toxicity of cancer refers to the direct and indirect economic costs associated with a cancer diagnosis. What may appear to be a series of small and medium-sized expenses (travel, medication, parapharmacy, informal care, loss of income and other needs), when added together over the course of the process, become an expense that many diagnosed people struggle to afford [19]. Although the proportion of cancer patients at risk of poverty and social exclusion is lower in the Basque Country than in other regions, it is still essential to continue promoting health equity policies that guarantee fair access to prevention, early diagnosis, treatment and continuity of care, without socio-economic conditions being an obstacle [16].

Ultimately, not all people have the same opportunities to prevent cancer, obtain an early diagnosis or receive appropriate treatment. Environments that promote healthy lifestyles must be guaranteed from childhood, especially in the most vulnerable populations, along with comprehensive care that responds to the needs of each person. All people diagnosed with cancer, especially those in a situation of economic or social vulnerability, must receive specific support from the outset, with clear information about their rights and the help and resources available. For all these reasons, and despite the Basque Country making progress in this area, it is essential to continue analysing the social impact of cancer and to adopt measures to reduce inequalities.

2.10 Gender perspective

Sex- and gender-sensitive medicine recognises that biological and gender differences have an influence on health, the disease and its management, affecting prevention, diagnosis and treatment [20]. Despite numerous sex and gender differences in common tumours, oncology studies have historically been biased towards male models (cells, animals and patients). This has impacted diagnosis, progression and response to treatment in women [21]. In recent years, the importance of including these variables in cancer research has been recognised, as they influence the pathophysiology, progression and response of tumours to treatment [15-16]. Understanding these differences will allow the development of more personalised treatment and better clinical management of cancer.

Globally, the incidence and mortality of cancer are higher in men than in women [24]. Genetic, hormonal, immunological and metabolic factors play a key role in these differences [25]. Sex chromosomes are also fundamental to cancer susceptibility. Inactivation of the X chromosome in females offers a protective advantage by preserving tumour suppressor genes, whereas males, with a single X chromosome, are more vulnerable to mutations [26]. There are also gender differences in the immune system that influence the response to cancer. Women have stronger immune responses, reducing the risk of cancer related to chronic infections [27]. Sex hormones also regulate immunity and tumour progression. For example, oestrogen appears to have a protective effect against liver and colon cancer, which are more common in men, but favours the progression of meningiomas and thyroid cancer, which are more common in women [25]. Cellular metabolism is another relevant factor. In many cancers, male cells rely more on aerobic glycolysis, which promotes tumour growth. There are also differences in the metabolism of lipids. Obesity is associated with an increased risk of colon cancer, liver cancer and haematological cancers in men [21-24].

Once cancer has been diagnosed, the humanisation of cancer care involves recognising the patient as an active subject in their health process, respecting their values, preferences and autonomy in decision-making. In this sense, shared decision-making is fundamental; however, a recent study highlighted the gender bias in shared decision-making within prostate and endometrial cancer clinical guidelines, limiting women's involvement in their own treatment decisions [32]. In guidelines published between 2015 and 2021, 47.4% of prostate cancer guidelines included recommendations on shared decision-making, compared to just 16.5% in endometrial cancer guidelines.

There are also notable differences in the toxicity of cancer treatments such as immunotherapy, radiotherapy and chemotherapy. Women have a 34% higher risk of suffering serious side effects compared to men [33]. In general terms, they have a higher toxicity due to slower drug elimination, which prolongs their exposure [33]. These differences highlight the need to personalise cancer treatments, taking into account the pharmacokinetic and pharmacodynamic particularities of each sex.

In general, biomedical research has traditionally focused on male physiology, with a clear under-representation of women in clinical trials [27-28]. This has resulted in the neglect of sex differences in oncology, leading to biases in clinical practice [36]. Gender inequality also impacts scientific publication in the oncology sector, a key factor in professional development. Recent studies highlight the under-representation of women as first and last authors, as well as a lack of gender parity in authorship in medical oncology journals [30, 31].

To achieve more equitable oncology, it is essential to consider the influence of sex on cancer at molecular level, encouraging studies that analyse sex and gender differences in response to treatment, and promoting policies that encourage the equal participation of women in cancer research and leadership.

Addressing these challenges will improve the personalisation of treatment and quality of care, ensuring that all patients, regardless of sex, receive cancer management based on the best evidence and tailored to their individual needs.

Some significant sex and/or gender differences in some types of cancer are shown below as examples:

Colorectal cancer.
Worldwide, colorectal cancer (CRC) is the third most common cancer and the third leading cause of death from cancer[24]. Gender differences can be partly explained by health habits. Men generally consume more meat, alcohol and tobacco, and lead a more sedentary lifestyle, increasing their risk of CRC [32, 33]. It is estimated that 22% of CRC risk in men and 11% in women in Europe is attributable to unhealthy habits [41]. In addition, although men are at higher risk of CRC, women participate more in screening programmes, whereas men tend to avoid them due to disinterest or perceived lack of need. [35, 36].

Tumour biology varies between sexes due to the influence of hormones and sex chromosomes, which affect immunity [40]. The gut microbiome has also been identified as a key gender-differential element in CRC carcinogenesis [44]. Furthermore, due to differences in tumour metabolism, right-sided colon cancer subtype (RCC), which is more aggressive and has a worse prognosis, is more common in women [45].

Lung cancer.
Lung cancer is the most common cancer in men worldwide and the second most common cancer in women, after breast cancer. It is the leading cause of death from cancer in men and the second leading cause of cancer death in women [24]. Sex differences in incidence and mortality have changed over the last 50 years, with incidence and mortality declining in men, but increasing in women, mainly due to the late onset of smoking in women decades ago [39,40]. In the Basque Country, although smoking prevalence is still higher in men (17.2%) than in women (13.8%), there has been a greater reduction in smoking in men since 2007, while in women there have been no significant changes since 2018 [17]. In addition, gender disparities in lung cancer incidence are mainly characterised by a rise in adenocarcinoma cases, a trend that is magnified in young, non-smoking women [47].

Bladder cancer.
Smoking accounts for 50-65% of bladder cancer cases in men and 20-30% in women [48]. Although the incidence is four times higher in men, women have higher grade tumours, shorter five-year survival and are often diagnosed at a later stage, possibly due to less early access to diagnostic tests. The most common symptom, haematuria, does not always lead women to consult a urologist as frequently as men [41,42]. In addition, this cancer has a high tumour mutational burden, with genetic differences between sexes, possibly related to exposure to carcinogens such as tobacco, which affects tumour characteristics and clinical outcomes [43, 44].

Melanoma.
Melanoma shows a differential impact depending on sex and gender. Exposure to ultraviolet rays is the main risk factor, and its incidence varies with age: up to the age of 45 it is more common in women, while from the age of 65 upwards it is more common in men [52]. In general, men are less likely to detect melanoma on their own, they attend fewer check-ups and are less informed about skin cancer risks, which delays diagnosis and worsens prognosis [46, 47]. In men, melanomas occur more frequently on the head, neck and torso, while in women they are more common on the limbs[52]. Although hormonal and genetic factors may play a role in its development, UV exposure, tumour location and age are the main determining factors.

03

Cancer Plan 2018-2023 and its evaluation

Cancer Plan 2018-2023 and its evaluation

In recent years, the Department of Health has implemented the Basque Cancer Plan (BCP) 2018-2023 with the aim of improving the approach to cancer in the Basque Country [6]. This strategy has sought to provide a structured response to the needs of people affected by the disease, both now and in the future. Its main objectives have included reducing mortality and improving quality of life.

The period covered by the **BCP 2018-2023,** structured into **6 Areas and 39 Objectives** (Figure 21), is now complete, and we urgently need to turn the future in the context of a new strategic framework, with the new Health Plan 2030 [5] and the Osakidetza Strategic Plan 2023-2025 [55]. Both plans set out objectives and strategic lines to which the future Cancer Plan will need to respond.

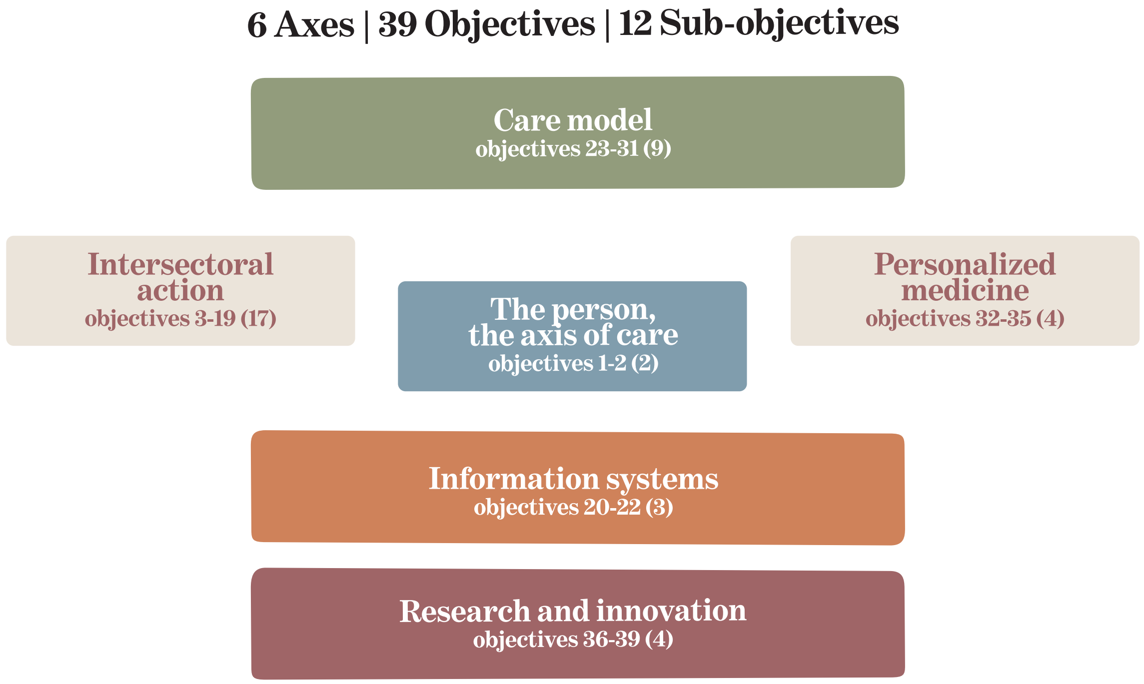


Figure 21. Schematic structure of BCP 2018-2023.

Following the conclusion of the BCP 2018-2023, a comprehensive evaluation of its implementation has been carried out, to assess its achievements and results, as well as to draw lessons and learnings from it[56]. This has served as a solid basis for initiating the design, drafting and implementation of the new BCCP, which will be a key instrument for the comprehensive approach to cancer in the Basque Country. The objectives of this evaluation are as follows:

- Estimate the achievements of the 2018-2023 BCP, identify its added value, lessons learned, success factors, barriers and obstacles in its implementation.
- Establish recommendations with a view to giving greater strategic value to the next Basque Country Comprehensive Cancer Plan (BCCP) 2025-2030.

The evaluation took place between June and September 2023 and was based on extensive document analysis, individual and group interviews with 35 spokespeople and 8 focus groups, including a patient focus group.

The BCP 2018-2023, the first Cancer Plan in the Basque Country, was a suitable framework for reflecting on and pooling the main issues relating to cancer and the basic strategic reference from which actions were rolled out to respond to the specific needs of the population in the field of oncology. The BCP allowed progress to be made in the approach to cancer with a corporate focus, helping to standardise processes with the aim of ensuring the best care regardless of the municipality of residence.

Overall, there was a high level of compliance with the objectives of the BCP 2018-2023. All objectives were addressed and over 80% of them were achieved, although the pandemic that came about during its rollout slowed down the development of some actions.

One of the main achievements is the definition of a Healthcare Model that contributed to strengthening the governance and deployment of the plan itself, highlighting the figure of the BCP Coordination and the BCP Nursing Coordinators network (one in each of the five IHOs referring to oncology care). The implementation of the BCP also made the Tumour Boards, based on multidisciplinary work, the backbone of the care model and reinforced rapid circuits, known as Minbizi, with a view to minimise response times in diagnosis and providing differential care to people with suspected cancer. Another important aspect of the model was the creation of the Regional Healthcare Coordination Committee for the management of paediatric and adolescent cancer care, and the promotion of the network operation of the Ezkerraldea-Enkarterri-Cruces and Donostialdea IHOs, which act as reference points in the field of paediatric oncology patient care.

In relation to screening programmes, a population-based cervical cancer screening programme was implemented for women aged 25 to 65, with a centralised laboratory to optimise response times. Onkobide, the first corporate system standardised for the entire network, was also established for the management of the drug therapy process, covering the prescription, preparation and administration of cancer treatments and enabling the implementation of results in real life.

One of the shortcomings identified is the need for greater depth in terms of actions targeting specific groups such as children and adolescents, the elderly, and long-term survivors. It was also concluded that the Plan's governance should be reviewed and the coordination figure should be supported by a coordination team, as well as reconsidering the makeup and functions of the Advisory Councils. It was also felt that a dashboard would have helped to monitor the progress of the BCP rollout, and could also be used to assess the effectiveness of certain actions.

On the other hand, an area for improvement was identified in the communication of the BCP, as a certain lack of knowledge about the objectives pursued, the actions proposed and the results obtained was found, especially among professionals who are not directly involved in cancer treatment, such as Primary Care and the IHOs without oncology care. A key takeaway was the need to involve professionals and related stakeholders to a greater extent in the definition of the new Plan, to ensure the Person-Centred Care approach is maintained.

04

Strategic framework

Strategic framework

4.1 Cancer Mission. Europe's Beating Cancer Plan.

One of the main innovations of Horizon Europe is the launching of Missions as a new way to implement R&D&I with a social and economic impact in areas of interest to the EU and its citizens. Cancer Mission, in particular, has the overarching goal of achieving progress in the next decade that will save at least 3 million lives in Europe [3]. In general terms, it aims to extend the life expectancy of cancer patients, to achieve a better quality of life - including for survivors and their families - and to consolidate mechanisms that prevent or delay the onset of the disease.

The Cancer Mission believes that, in order to achieve effective interventions in the areas of prevention, diagnosis and treatment, and to improve the quality of life of people exposed to cancer, a better understanding of the disease is needed. A better understanding of the factors and mechanisms that cause cancer is therefore the basis for the three main areas of prevention, diagnosis and treatment. The mission is expected to achieve the transversal goal of equitable/equal access to all interventions developed throughout the EU.

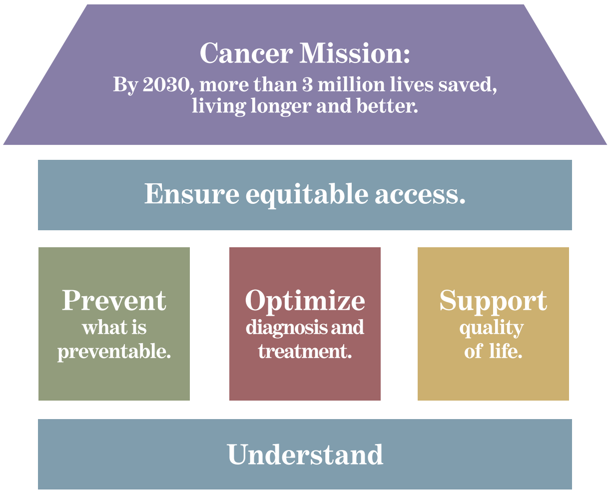


Figure 22. Core pillars of the Cancer Mission

Cancer Mission has five complementary objectives:

a) Understanding

b) Preventing the preventable

c) Optimising diagnosis and treatment

d) Improving quality of life

e) Ensuring equitable access.

Europe's Beating Cancer Plan is presented as an essential complement to the Cancer Mission, with the aim of tackling cancer on all possible fronts. This plan includes specific strategies and initiatives in areas such as prevention, early diagnosis, treatment and improving the quality of life of patients and survivors [4].

The Cancer Mission and the European Cancer Plan are aligned in their aim to reduce the impact of cancer by tackling all types of cancer at all stages. From prevention of risk factors to support for survivors and end-of-life care, for all ages and in all circumstances across Europe. This includes children and adolescents, adults and the elderly, people living in remote areas, those with rare cancers, and socially or economically vulnerable families, among others.

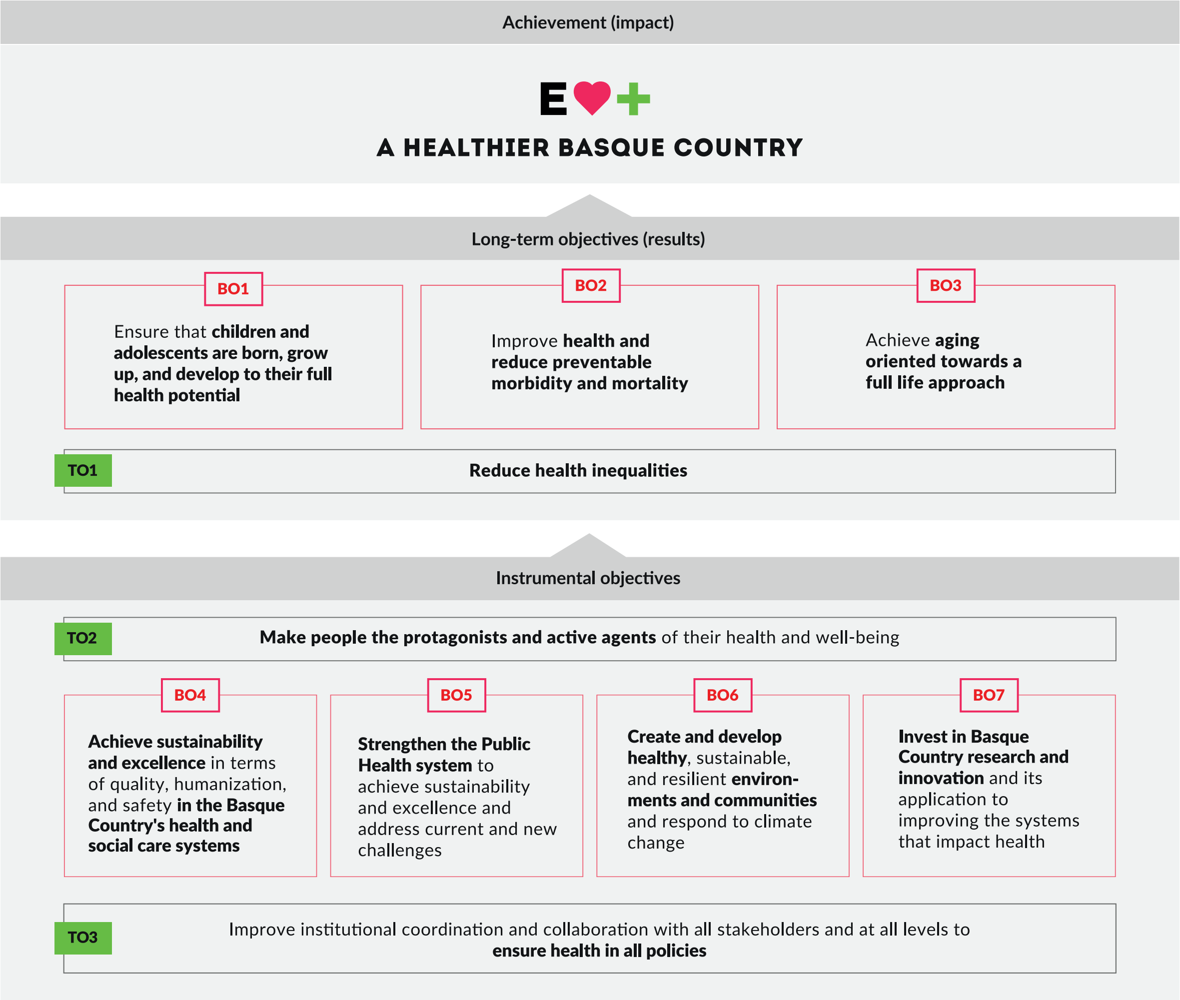
In addition, the likelihood of receiving a diagnosis early enough to survive the disease differs substantially across Europe and even within countries. Overcoming imbalances in access to cancer knowledge, prevention, diagnosis, treatment and care is a priority.

4.2 Health Plan 2030

The Basque Health Plan is the system's highest planning and programming instrument, which establishes the basic health objectives for healthcare policy and defines the priorities to be met with the available resources during its term, as established in Article 13 of Law 8/1997, of 26 June 1997, on Health Planning in the Basque Health Plan [57].

The Health Plan 2030 was approved by the Basque Government Council in the summer of 2023, making up the roadmap to define the health policies to be developed in the coming years with the aim of leading a healthier Basque Country [5].

MAJOR OBJECTIVES OF THE HEALTH PLAN



Achievement (impact)

E❤+

A HEALTHIER BASQUE COUNTRY

Long-term objectives (results)

BO1 Ensure that **children and adolescents are born, grow up, and develop to their full health potential**

BO2 Improve **health and reduce preventable morbidity and mortality**

BO3 Achieve **aging oriented towards a full life approach**

TO1 **Reduce health inequalities**

Instrumental objectives

TO2 **Make people the protagonists and active agents** of their health and well-being

BO4 **Achieve sustainability and excellence** in terms of quality, humanization, and safety **in the Basque Country's health and social care systems**

BO5 **Strengthen the Public Health system** to achieve sustainability and excellence and address current and new challenges

BO6 **Create and develop healthy**, sustainable, and resilient **environments and communities** and respond to climate change

BO7 **Invest in Basque Country research and innovation** and its application to improving the systems that impact health

TO3 Improve institutional coordination and collaboration with all stakeholders and at all levels to **ensure health in all policies**

Figure 23. Main objectives of Basque Country Health Plan 2030

The Plan's objectives to achieve this aim include four main ones: to promote the healthy development of children and adolescents; to encourage active ageing and a full life; to reduce avoidable morbidity and mortality in the Basque population; and to reduce inequalities in healthcare.

To achieve this, the Basque Country Health Plan 2030 sets out a set of 10 Objectives with their corresponding strategic lines, some of which are more purpose-based, specifying a health horizon for the different population groups, while others are more instrumental, aimed at the structural aspects needed to achieve the health objectives pursued.

4.3 Other strategies

A review of a range of documents related to healthcare and cancer strategies was carried out, including programmes, strategic plans, regulations, health status data, sectoral strategies with an impact on people's health and reports on global health trends. This review aimed to identify key actions and aspects to be considered in the preparation of the new BCCP.

At least the following will need to be considered:

- National Health System Cancer Strategy [58].
- Osakidetza Strategic Plan 2023-2025 [55].
- Other health strategies and plans:

  Transversal strategies:

  Basque Country Palliative Care Plan 2023-2027 [59],
  Patient Safety Strategy 2030 [60],
  Basque Country Mental Health Strategy 2023-2028 [61],
  Osakidetza Humanisation Model [62],
  Health Research and Innovation Strategy 2022-2025 [63],
  VIII Basque Country Addiction Plan [64].

  Cross-sector strategies:

  Mugiment [65],
  Basque Country Environmental Framework Programme 2030 [66],
  Basque Strategy for Health and Safety at Work 2021-2026

- Regulatory framework..
- Social Determinants of Health (SDH) Model.
- Agenda 2030.

It should be remembered that that the term of the BCCP extends beyond that of some of these strategies, to ensure that the premises they provide for are qualified.

05

Strategic Formulation

Strategic formulation

The strategic formulation of the BCCP is composed of its MISSION, VISION, PRINCIPLES, and PRIORITY AREAS.

The purpose of defining the Mission and Vision is to construct the STRATEGIC PURPOSE of the BCCP by answering the following key questions:

What should truly be the core reason for the existence of the BCCP—what defines its purpose?

What do we aspire to achieve by 2030?

The PRINCIPLES are the guiding elements that must shape the BCCP, both in its content and in the process used to develop it.

PRIORITY AREAS identify the major issues that must be the focus for all actions in the approach to cancer in the coming years.

For each Priority Area, a set of objectives has been defined and translated into concrete actions to be implemented during the 2025–2030 timeframe.

5.1 Mission and vision

MISSION

> *"Establish a **comprehensive, participatory, sustainable and dynamic strategy** to guide **cancer** actions based on **excellence, scientific evidence and equity,** generating **value for Basque citizens** in terms of **better health outcomes**".*

VISION

With this BCCP, the Basque Country hopes to achieve the following:

- Improve the **survival rate of people with cancer.**
- Reduce the **potential years of life lost due to cancer.**
- Improve the **quality of life** of people, cancer patients and survivors, their families and carers.
- Maintain and enhance the commitment to **equity.**
- Improve the **public's perception** of how the System addresses cancer.

To this end, the BCCP will prioritise its efforts in the following areas:

- An **integrated, comprehensive approach** to cancer at all stages, with advanced oncological care and a healthcare model which makes this possible.
- The promotion of **education/prevention programmes** to achieve the participation of **all citizens.**
- **Progress in prevention and early diagnosis.**
- **Access to personalised care and advanced treatments.**
- **Information systems** that provide data in epidemiology, in the clinical field, in management and in research.
- **Universal, equitable, and humane access** to all resources of the system, both healthcare and non-healthcare.
- The ability to dynamically **implement innovative advances.**

5.2 Guiding principles of the BCCP

The guiding principles underpin the formulation, design and roll-out of all strategies, programmes and related interventions.

The BCCP is based on the following principles:

1. People-centredness and humanisation

- **People as the main players and active agents of their health and illness,** with a key role in decision-making.
- **Community involvement, people's experience, community, patients and humanisation** as essential elements in cancer prevention and care.
- **Reducing social inequalities and equity,** ensuring fair and equal access to promotion, prevention and health and social and health care programmes.
- **Gender perspective,** ensuring that interventions are inclusive and adapted to diversity and specific patient needs.

2. Prevention and early detection

- **Health promotion and primary prevention,** action on modifiable risk factors.
- **Early detection and population tumour screening,** recommended to improve health outcomes.
- **Rapid diagnosis in people with suspected cancer,** allowing fast and effective response times.

3. Comprehensive care and continuity of care

- **Comprehensive, continuous and personalised care model,** ensuring coordination between care levels at all stages: suspected diagnosis, diagnosis, treatment, survival and end of life.
- **Thinking beyond healthcare,** promoting cross-sector collaboration to improve the quality of life of people at risk and cancer patients.

4. Organisation, coordination and networking

- **Recognition and promotion of collaboration between professionals and teams,** reinforcing network operation.
- **Organisational model based on strategic specialisation,** guaranteeing equal accessibility to all citizens.
- **Promote the adaptation of the plan locally and over time, ensuring flexibility in its implementation.**

5. Quality, innovation and evidence-based decision-making

- **Quality, continuous improvement, sustainable development, effectiveness and efficiency of interventions** as fundamental pillars of the plan.
- **Up-to-date available information and evidence-based decision-making, ensuring science-backed interventions.**
- **Dynamisation of the plan based on advances in R&D&I,** progressively implementing technological and scientific innovations.

6. Leadership and governance

- **Transformative leadership** to facilitate progressive, flexible and sustained system adaptation.
- **Develop a shared vision** that involves all key players in cancer prevention and care.
- **Involve citizens, community, patients and professionals,** promoting an inclusive strategy.
- **Make implementation a key focus from the outset, ensuring the effective rollout of the plan.**
- **Measure results** as a basis for monitoring, evaluation and continuous improvement of the plan.

06

Priority Areas for Action

Priority Areas for Action

The definition of priority areas is a fundamental step as it identifies the major issues that must be the focus for all actions in the approach to cancer in the coming years.

There are different possible types of priority areas (collectives, themes, concepts, etc.); the most important aspect is their relevance and criticality, both current and future, to guide policies and actions with an impact on cancer.

Based on the evaluation of the 2018-2023 Basque Oncology Plan (BOP), it was proposed to highlight the impact of this first Plan on cancer care, and to maintain its six-axis structure. A benchmarking exercise was also carried out on the priority areas of several Oncology Plans both nationally (SNS 2021, Andalusia 2021-2025, Castilla y León 2018; Catalonia 2022-2026; Extremadura 2022-2026 and Galicia 2022-2028) and internationally (Australia 2023-2033, Canada 2019-2029, Chile 2018-2028, United States 2023, France 2021-2030, New Zealand 2019-2029 and United Kingdom 2024)(available in 8.2 Benchmarking). From this comparison it was concluded that all the areas considered in the different plans could be summarised into a total of eight axes.

- Cancer prevention
- Early detection
- High quality care service
- Quality of life for patients, survivors and their relatives
- Research and innovation
- Reinforcement of registration, reporting and monitoring systems
- Equity throughout the care process
- Governance and implementation

Based on the structure of the 2018-2023 BOP, and with minor modifications to be consistent with the eight axes generally shared by the national and international plans studied, it was proposed to structure the new BCCP into 7 Priority Areas (PAs), as shown in the following diagram:

Outline of the seven priority areas of the Basque Country Comprehensive Cancer Plan 2025-2030.

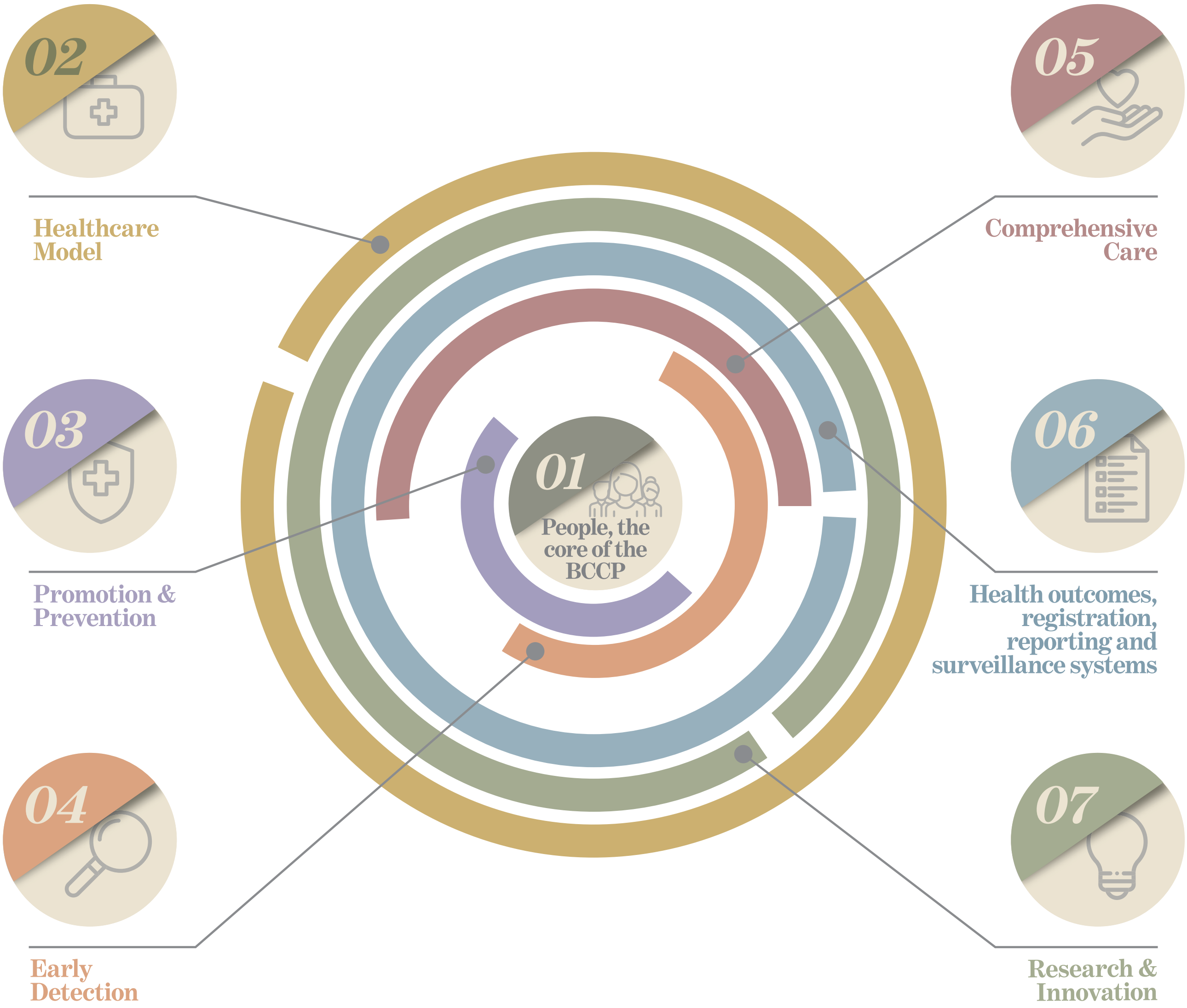


Figure 24. Outline of the seven priority areas of the Basque Country Comprehensive Cancer Plan 2025-2030.

A **Conceptual Framework** is defined for each priority area, providing context and content to guide its scope. This also sets out its specific **Objectives** for each PAA and the **Actions** required to meet them. Finally, the **indicators** to be used to assess compliance are identified.

Additionally, in response to one of the needs identified in the evaluation of the 2018-2023 BOP, some actions aimed at specific groups have been collected and subsequently ordered by scope of action in the different priority areas. These specific groups are:

- Children.
- Adolescents and Young Adults (AYAs).
- Elderly people.
- Long-term survivors.

This document includes 20 actions aimed specifically at these groups, and also aims to ensure that actions targeting a wider population reflect on the adequacy of care for these groups. The actions explicitly referring to these groups are listed in Annex 9.1.

6.1 People, the core of the BCCP

6.1.1 Conceptual framework

All the Priority Areas and therefore the BCCP itself are based on a people-centred care model, understanding that each individual, in their individual and community context, is the backbone of all actions. This approach includes people in the broadest sense: healthy people, community, patients, carers, healthcare and non-healthcare professionals, all integrated into an ecosystem of care that transcends pure healthcare to extend to emotional, social and cultural aspects.

As already stated in the previous BCCP, given that the Person is at the heart of this priority area, its contents focus on continuing **working on HUMANISATION,** and on the **improvement of PEOPLE'S EXPERIENCE**

In this sense, the humanisation of cancer care promotes holistic attention that guarantees not only the quality of care, but also the dignity and overall well-being of those going through the cancer process, addressing their emotional, psychological, spiritual and/or social needs [66]. This vision aligns with the Osakidetza Humanisation Model, which states that "humanising healthcare is an action, task and skill that must be undertaken by all parties involved: organisations, teams, managers, healthcare professionals and also patients and their families or relatives. It also constitutes an ethical commitment that focuses on the consideration of the person as a whole and requires holistic, global, people-centred and personalised intervention."[58] This approach aims not only to improve the quality of care and the patient experience, but also to strengthen the role of professionals, providing them with tools and strategies to help them to carry out their work in a more humane, empathetic and efficient environment.

From this perspective, humanisation also means eliminating barriers that may create inequalities or discrimination for those who have overcome cancer. Along these lines, the Royal Decree -Law 5/2023, of 28 June 2023, introduced the right to be forgotten in Spain, a measure that facilitates access to insurance and financial products for people who have survived cancer [69]. This means that people who have completed their cancer treatment and have gone more than five years without relapse are not obliged to declare their cancer history, ensuring greater equity and avoiding any kind of discrimination.

This Priority Area therefore promotes, among others, the personalisation of care, the involvement of patients and their relatives in decision-making and the continuous improvement of their experience, promoting empathetic care, facilitating access to clear information and available resources, and guaranteeing appropriate physical and care environments for their well-being.

6.1.2 Objectives

This Priority Area is deployed through the following objectives:

1.1 Promote an organisational culture focused on the humanisation of care, encouraging leadership in personalised and empathetic care at all levels of care.

1.2 Encourage active and significant involvement of patients and their relatives in shared decision-making regarding their care.

1.3 Offer comprehensive and personalised care that respects the dignity, needs, values and preferences of each patient, ensuring empathetic and clear communication at all stages of the oncological process, with resources that are accessible and adapted to their circumstances.

1.4 Create physical and care environments that favour emotional and physical well-being, for patients, relatives and professionals, adapting them to the specific needs of each group, especially in paediatrics.

1.5 Guarantee the emotional and physical well-being of professionals, ensuring that they are provided with a healthy working environment, as well as the tools necessary to provide quality care.

6.1.3 Actions

Objective 1.1 *Promote an organisational culture focused on the humanisation of care, encouraging leadership in personalised and empathetic care at all levels.*

1.1.1 **Develop and implement awareness and training programmes** to strengthen empathetic communication, shared decision-making, handling bad news, bereavement support and ethical aspects, among others, in all areas and levels of care.

***Objective 1.2** Encourage the active and meaningful involvement of patients and their relatives in shared decision-making regarding their care, as well as in the design, evaluation and improvement of care processes.*

1.2.1 Promote a **shared and deliberative care planning model** that respects patients' values and choices, enabling informed decisions about their care.

1.2.2 Draw up, publicise and integrate the **Map of Available Resources in the community** offered by associations and other non-profit organisations, promoting their active recommendation within the care process so that patients and families can benefit from their support and services.

1.2.3 Promote and disseminate the Bizia Active Patient/Peaceful Patient scheme for empowerment and self-management of health **throughout the healthcare system,** so that a greater number of cancer patients can benefit from it. Create a "Patient Mentoring" programme for current patients to share their experiences with new patients, promoting active participation.

***Objective 1.3** Offer comprehensive and personalised care that respects the dignity, needs, values and preferences of each patient, ensuring empathetic and clear communication at all stages of the oncological process, with resources that are accessible and adapted to their circumstances.*

1.3.1 Implement standardised protocols that guarantee clear, accessible and humanised information for patients in all their interactions with professionals throughout all phases of the care process.

- Guarantee **continuous patient support** with **in-person and remote consultations,** ensuring asynchronous attention to resolve doubts between consultations, especially during long waiting periods.

- **Offer reliable and adapted information** on the care process, including treatment phases, adverse effects, timetables, referral contacts, home care and **resources from the available associative network, in written, oral and digital formats.**

1.3.2 Establish a **coordination model that enables non-face-to-face consultations,** when preferred by the patient, in order to **avoid unnecessary travel,** and that supports the planning of future appointments.

1.3.3 Adopt digital systems such as tracking apps, SMS and **automatic notifications to inform patients and their families** about treatment progress, appointments and any other relevant processes, allowing them greater flexibility and control over their time and travel.

1.3.4 Define the **methodology for identifying social distress,** train both healthcare and non-healthcare professionals, and establish standardized referral pathways to social care services.

Objective 1.4 *Create physical and care environments that favour emotional and physical well-being, for patients, relatives and professionals, adapting them to the specific needs of each group, especially in paediatrics.*

1.4.1 Encourage the participation of patients and relatives in the design of specific and appropriate spaces.

1.4.2 Provide, through the Social Services, **access to technical and/or housing adaptation** grants that patients may need.

1.4.3 Streamline **communication channels with social workers and associations** to facilitate early access to social resources and guide and speed up the **necessary help for the most vulnerable groups** (migrants, the elderly, mental health, addictions, etc.).

Objective 1.5 *Guarantee the emotional and physical well-being of professionals, ensuring that they are provided with a healthy working environment, as well as the tools necessary to provide quality care.*

1.5.1 Incorporate the methodology of cancer professionals' **experience and encourage the creation of spaces for active listening** for the continuous improvement of care processes.

1.5.2 Establish institutional programmes and activities to recognise professionals, highlighting their commitment, effort and dedication, in order to strengthen the emotional link with the organisation.

1.5.3 Harmonize **psychological support programmes and emotional care strategies** for professionals.

6.2 Healthcare model

6.2.1 Conceptual framework

The previous BCP established as **healthcare model** the tools and mechanisms used for the organisation and management of the cancer process, to guarantee a **multidisciplinary approach** to the care of cancer patients, facilitating coordinated decision-making in the different care settings through which each patient's care process passes.

The ultimate goal of the healthcare model is to **maximise health outcomes,** increasing effectiveness and efficiency throughout the health system. In this sense, the care model must guarantee that **all cancer patients have the same opportunities and ability to access the system.** This requires optimal integration of all actors involved, including the different levels of care and medical specialities involved in prevention, diagnosis, treatment, continuity of care, rehabilitation and/or end of life. The model must also respond to both the general and specific needs of each process and patient group.

The definition of standardised **Cancer Care Pathways** is key to making progress in comprehensive care, covering all phases of the process, as well as the commitment to strengthen the leadership of process management through the multidisciplinary vision of the **Tumour Boards.**

Strengthening the care model should also integrate cancer research into care processes, promoting innovation and continuous improvement of care. In this respect, collaboration and coordination with current and future European initiatives is essential to optimise health outcomes and define a more advanced care model[70]. Participation in strategies stemming from the Cancer Mission and Europe's Beating Cancer Plan will contribute to improving cancer care in our community. These include the CCC strategy, which aims to create a European network that will enable 90% of cancer patients to receive care in these referral centres 2030 [4].

On the other hand, communication must be a transversal axis for both the care model and the Plan itself, strengthening coordination between institutions, healthcare and non-healthcare professionals, and society in general. An effective communication strategy allows the Plan's objectives and actions to be disseminated among the professionals playing a key role in comprehensive cancer care, promoting their involvement in its development and implementation. Clear and accessible communication with society is also essential to inform and raise awareness of the importance of prevention, early detection, and comprehensive support for patients and their carers, among others.

In short, the care model must evolve towards an integrated, innovative and person-centred system that ensures quality, equity and efficiency in cancer care in the Basque Country.

6.2.2 Objectives

This Priority Area is deployed through the following objectives:

2.1 Guarantee an equitable and efficient Healthcare Model that pursues quality and integrated care for cancer patients in the Basque Country.

2.2 Provide specific care pathways to guarantee rapid, efficient and homogeneous responses, adapted to the changing needs of patients.

2.3 Integrate cancer research into the healthcare model to drive innovation and continuous improvement in care.

2.4 Focus on European accreditations and standards.

6.2.3 Actions

Objective 2.1 *Guarantee an equitable and efficient Healthcare Model that pursues quality and integrated care for cancer patients in the Basque Country.*

2.1.1 **Systematize the management of the Cancer Services Portfolio,** within the competencies of the Department of Health, in order to ensure its continuous updating and to provide an overview of the resources available in the Basque Country for cancer care.

2.1.2 Review the current **organisational model** to deepen a connected, efficient and equitable model that includes mechanisms for citizen participation.

2.1.3 Create **patient engagement mechanisms** to assess, design and improve cancer care processes, by ensuring that patients' needs, experiences and preferences are considered.

2.1.4 Review the **functioning of the Tumour Boards and Tumour Committee:** Tumour Boards map, functions, work systematics, participants, integration of Primary Care, incorporation of molecular committees, dedication, etc. to ensure a multidisciplinary approach in the evaluation of cases, improvement of care processes, and a corporate approach.

2.1.5 Strengthen **the lead process management teams within each Tumour Board.**

2.1.6 Implement a **specific approach to processes of low prevalence and high complexity** under a consensual model, based on technical requirements and necessary human competencies in each case, and grounded in integrated teams.

2.1.7 **Advance the process of incorporating new professional profiles** that can contribute to improving comprehensive patient care.

2.1.8 Add to the model **elements that take into account coordination with the social, educational and employment spheres** to provide patients and their relatives with information on the resources and support available to meet their needs.

2.1.9 Improve **coordination between Public Health, Osakidetza, and Osalan** regarding exposure to carcinogenic agents and other occupational risks, and establish the necessary data exchange flows.

***Objective 2.2** Provide specific Care Pathways to guarantee rapid, efficient and homogeneous responses, adapted to the changing needs of patients.*

2.2.1 Design and implement Care Pathways by type of tumour, based on scientific evidence and efficiency criteria.

2.2.2 Clearly inform patients and their relatives about the available channels for **communication with specialized healthcare professionals,** to address their questions and ensure they feel supported and accompanied throughout the entire process.

2.2.3 Ensure a structured transition to adulthood and a continuum of care for paediatric and adolescent patients through a coordinated strategy between paediatrics, different levels of care and different medical specialities.

2.2.4 Facilitate the implementation of standardized protocols aimed at assessing overall functional status (such as the Comprehensive Geriatric Assessment), shared between the healthcare professional and the patient and/or their support network, in order to avoid unnecessary diagnostic tests and to ensure appropriate treatment based on the patient's specific characteristics, minimizing risks and aiming to maintain or improve the patient's functionality and quality of life.

***Objective 2.3** Integrate cancer research into the healthcare model to drive innovation and continuous improvement in care.*

2.3.1 Include a **research representative on the Tumour Boards** to facilitate synergies and coordinated tasks.

2.3.2 Establish a **Translational Research Corporate Committee:** Define the Strategy; include a specialised team to address care needs through innovation

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2.3.3 **Use a unique Clinical Trials/Cancer Research Projects public-private tool,** so that all patients in our community have equitable access to innovative drugs/treatment strategies.

***Objective 2.4** Focus on European accreditations and standards.*

2.4.1 Work towards **obtaining accreditation as a Comprehensive Cancer Centre (CCC)** through a unique network model in the Basque Country, with a body that leads, coordinates and assesses the development of the project

2.4.2 Move forward with obtaining **ISO 15189 certification for the laboratories in the Biological Diagnostic Network.**

2.4.3 Take part in **international networks and European projects aligned with the European Plan Against Cancer** and integrate their standards into our organisations.

6.3 Health promotion and cancer prevention

6.3.1 Conceptual framework

Health promotion and prevention are the most effective measures, and they constitute the most cost-effective control strategies in the short, medium and long term to the incidence of cancer and mortality. These strategies not only reduce the occurrence of new cases, but also reduce their impact on the population by modifying risk factors and creating healthier environments.

Health promotion is a process that empowers individuals, communities and the general population to manage and control their own health. This approach not only seeks to strengthen individual abilities to adopt healthy lifestyles, but also to address social, environmental and economic determinants to optimise their positive impact on health [71].

Primary prevention focuses on reducing exposure to risk factors by reducing the incidence of the disease. Globally, it is estimated that 40-50% of cancer cases can potentially be prevented by reducing risk factors such as tobacco and alcohol consumption, promoting healthy habits such as a balanced diet and exercise, and through evidence-based preventive strategies such as vaccination [69, 70].

Within health promotion, two different approaches can be identified. On the one hand, an individual, person-centred approach, which promotes awareness and self-responsibility for the effects of lifestyle on health at all stages of life. Secondly, a more global and intrasectoral approach involving the integration of health in all public policies, promoting the creation of healthy environments and the development of public programmes and strategies that contribute to improving the public health as a whole.

This Priority Area addresses primary cancer prevention, considering the high potential for reducing new diagnoses through the effective implementation of preventive measures. These include the recommendations in the European Code Against Cancer (ECAC) [74]. The ECAC, approved by the European Union as a basic prevention instrument (also including secondary prevention measures such as screening), has been drawn up based on a review of the evidence available from the International Agency for Research on Cancer. The fourth edition of the ECAC consists of 12 recommendations that every citizen can take to help prevent cancer, which in turn require supportive policies and collective action (see list):

12 ways to reduce the risk of cancer:

01. Do not smoke or use any type of tobacco or electronic cigarettes.

02. Create smoke-free homes and support smoke-free workplace policies.

03. Maintain a healthy body weight.

04. Exercise daily and reduce the amount of time spent sitting.

05. Eat a healthy diet:

    a. Increase the consumption of whole grains, pulses, fruit and vegetables.

    b. Limit high-calorie foods (high in sugar or fat) and avoid sugary drinks.

    c. Avoid processed meat, limit consumption of red meat and foods high in salt.

6. Limit alcohol consumption, although the best prevention for cancer is to avoid alcohol altogether.

07 Avoid excessive sun exposure, especially in children. Use sun protection and do not use sunbeds.

08. At work, protect yourself from carcinogenic substances by following the instructions of the occupational health and safety protection regulations.

09. Investigate the levels of radon radiation exposure in the home, and if necessary, take measures to reduce them.

10. In the case of women:

    a. Encourage breastfeeding.

    b. Limit treatment with Hormone Replacement Therapy.

11. Participate in childhood vaccination programmes against hepatitis B (newborns) and human papillomavirus.

12. Participate in cancer screening programmes: colorectal (men and women), breast (women), cervical (women).

As part of Europe´s Beating Cancer Plan, a process has been initiated to update the ECCC to reflect the latest scientific developments and improve health literacy. The project to develop the fifth edition of the ECAC began in 2022, aiming for publication in 2025. This new edition will include recommendations based on scientific evidence to optimise cancer prevention and promote healthy habits. .

6.3.2 Objectives

This Priority Area is deployed through the following objectives:

3.1 Implement policies to promote healthy environments to encourage the adoption of healthy lifestyles, reduce exposure to environmental and social risks associated with cancer, and reinforce preventive interventions.

3.2 Promote healthy lifestyles in relation to the risk factors associated with cancer, taking into account: life stages, health inequalities and the gender perspective.

3.3 Protect the health of workers by reducing exposure to occupational carcinogens and promoting healthy working environments.

6.3.3 Actions

Objective 3.1 *Implement policies to promote healthy environments to encourage the adoption of healthy lifestyles, reduce exposure to environmental and social risks associated with cancer, and reinforce preventive interventions.*

3.1.1 Extend the **Network of Smoke and Aerosol Free Spaces** both in number and type (university campuses, educational centre environments, workplace environments, etc.).

3.1.2 Promote the implementation of **Physical Activity Guidance Services (PAGS)** in the municipalities of the Basque Country.

3.1.3 Provide the public with up-to-date information and recommendations on exposure to and the effects of air pollution in collaboration with other sectors to support the achievement of the objectives set out in the Basque Country Air Quality Plan 2030.

3.1.4 Maintain vaccination rates of over 95% against HBV and HPV in children and adolescents in the Basque Country, through the application of the Department of Health's vaccination and immunisation programme, in accordance with the established schedules.

3.1.5 Design guidelines for: (i) the integration of health and equity criteria in the planning and execution of **public policies** (urban planning, environment, housing, etc.), and (ii) to promote the evaluation of the health impact of the different policies, plans and programmes.

Objective 3.2 *Promote healthy lifestyles in relation to the risk factors associated with cancer, taking into account: life stages, health inequalities and the gender perspective.*

3.2.1 Promote **recommendations and advice** on healthy lifestyle habits in Primary Care with the support of the community nurse, including: physical activity, diet, alcohol and tobacco consumption, taking into account the community assets (Euskadi Aktiboa) and the community health centre guidelines.

3.2.2 Develop a **literacy** programme, especially aimed at children, adolescents and young adults, in coordination with Osasun Eskola, on protective factors and cancer risk factors, including multilevel dissemination and communication actions.

3.2.3 Strengthen the **Basque Country smoke- and aerosol-free strategy,** with special emphasis on adolescents and young adults, by reinforcing inter-sectoral and inter-institutional action to contribute to achieving a **tobacco-free** generation by 2040. The interventions are structured around the following objectives: (i) preventing the initiation of tobacco use, (ii) protecting against second-hand smoke through the creation of smoke-free spaces, and (iii) providing support for smoking cessation by improving public awareness of available cessation programs.

3.2.4 Promote a **de-normalisation strategy for alcohol consumption** sustainable over time, as established under the Addictions Plan, incorporating information on risks and actions to reduce social acceptance and to protect minors from covert advertising.

3.2.5 Design and disseminate **campaigns** to **promote physical activity and reduce sedentary lifestyles** as a daily habit, aimed at preventing different types of cancer and improving the recovery and quality of life of cancer patients.

3.2.6 Support the adoption of a **healthy and sustainable diet** through: information campaigns, and nutritional supervision of school menus.

3.2.7 Design and implement informational and awareness campaigns to: (i) promote adequate protection against **solar radiation** (with special emphasis on children and exposed workers), and (ii) reduce the use of UV tanning beds.

Objective 3.3 *Protect the health of workers by reducing exposure to occupational carcinogens and promoting healthy working environments.*

3.3.1 **Reduce exposure to occupational carcinogens** such as asbestos, wood dust, silica and others listed in the National Occupational Cancer Agenda. Identify and evaluate products that contain carcinogenic agents and establish preventive measures.

3.3.2 Promote the **healthy businesses** programme.

6.4 Early detection of cancer

6.4.1 Conceptual framework

Early cancer detection (secondary prevention) consists of the early detection of the disease through rapid diagnostic circuits in symptomatic patients and through population-based screening programmes in asymptomatic individuals. It has been shown that survival rates are significantly higher when cancer is detected at earlier stages and treated appropriately, compared to cases diagnosed at later stages [75]

The greatest progress in recent years has been made with population-based screening programmes, targeting medium-risk individuals for certain types of cancer such as breast, colorectal and cervical cancer. In December 2022, the European Council Recommendation on strengthening prevention through early detection: a new EU approach on cancer screening was published to replace the Council Recommendation of 2003 [11]. These recommendations, together with the initiatives of the European Commission in cancer screening, aim to standardise population-based screening programmes for breast, colorectal and cervical cancer [76]. They also aim to promote the evaluation of the suitability of new population-based programmes for screening for prostate, lung or gastric cancer, bearing in mind local epidemiological data.

Similarly, with the aim of reducing health inequalities, the barriers to and facilitators of participation in population-based screening programmes must also be analysed, paying special attention to people with difficulties in accessing health services, and more specifically, to vulnerable populations, such as people with disabilities, ethnic minorities or groups with a low socio-economic status.

In addition to population-based screening, it is crucial to increase surveillance and follow-up programmes targeting people at higher risk. It is estimated that 5-10% of diagnosed solid tumours and haematological malignancies are hereditary. The most common hereditary cancer syndromes are Hereditary Breast and Ovarian Cancer Syndrome and Lynch Syndrome [72]. In 2014, care for patients and their relatives in the area of genetics, including genetic counselling and genetic testing, was included in the National Health service portfolio [58].

In conclusion, the reinforcement of cancer screening requires a comprehensive strategy that combines updated screening in line with European recommendations with equal access, rigorous monitoring of results and attention to high-risk populations. The implementation of these actions will contribute significantly to the reduction of mortality, early-stage diagnosis and improvement of the quality of life of the population.

6.4.2 Objectives

This Priority Area is deployed through the following objectives:

4.1 Adapt the approach to secondary prevention in line with European recommendations and scientific evidence.

4.2 Increase participation in population-based screening and reduce inequalities.

4.3 Understand the results of screening in terms of impact on incidence and mortality, as well as benefits and adverse effects.

4.4 Ensure access to surveillance and monitoring programmes for people with increased risk criteria: hereditary cancer, family history and occupational exposure.

6.4.3 Actions

Objective 4.1 *Adapt the approach to secondary prevention in line with European recommendations and scientific evidence.*

4.1.1 Evaluate the feasibility of implementing new evidence-based screening recommendations.

4.1.2 Participate in European screening projects to generate new evidence and keep the criteria up to date.

Objective 4.2 *Increase participation in population-based screening and reduce inequalities.*

4.2.1 Establish and implement a **systematic system for updating the census of the target population** for annual breast, colorectal and cervical cancer screening, cross-referencing it with data on the resident population using Eustat as a source.

4.2.2 **Study the reasons for non-participation and design and implement actions for non-participating groups,** carrying out joint actions with UPV/EHU, patient associations, representatives of specific groups and professionals.

4.2.3 Introduce **HPV test through self-collection for cervical cancer screening.**

4.2.4 Launch **communication campaigns aimed at increasing population participation in screening programs,** using both social media and traditional media to ensure equitable reach across all population groups.

Objective 4.3 *Understand the results of screening in terms of impact on incidence and mortality, as well as benefits and adverse effects.*

4.3.1 Define and implement a **systematic approach for the evaluation of the whole screening process** following the Clinical Practice Guidelines and the European Cancer Information System proposal.

4.3.2 Conduct **incidence, mortality and cost-effectiveness simulation analyses of established and proposed EU pilot schemes.**

Objective 4.4 *Ensure access to surveillance and monitoring programmes for people with increased risk criteria: hereditary cancer, family history and occupational exposure.*

4.4.1 Design, standardise and disseminate the circuit of access to high-risk consultations, including hereditary cancer, in certain specialist areas as a specific consultation, where patients are assessed and the recommended screening and monitoring criteria are followed depending on the type of tumour.

4.4.2 Development and updating of health monitoring guidelines for the early detection of cancer associated with exposure to various occupational carcinogens: respiratory and dermatological.

4.4.3 Deploy programmes to train, raise awareness and disseminate knowledge about occupational cancer aimed at professionals caring for this population in Osakidetza.

6.5 Comprehensive care

6.5.1 Conceptual framework

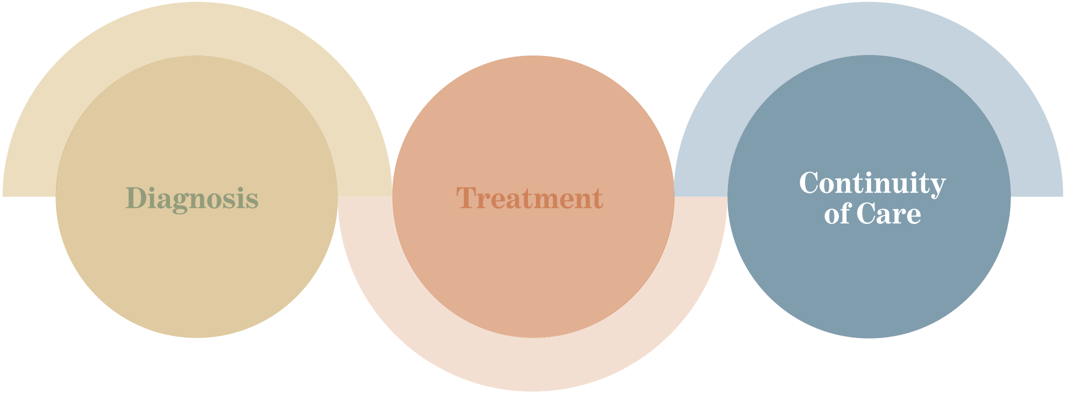
One of the principles of the BCCP is an **integrated and comprehensive approach** to cancer throughout the entire process from diagnosis to the monitoring of long-term survivors or end of life, with advanced oncological care and a healthcare model that facilitates this.

Comprehensive care refers to an integral view of the disease process, which emphasises efficient coordination between the different agents involved in each phase of the cancer process. This includes the optimisation of all available resources in the health system (human, financial, technical, organisational, clinical and social care) aiming ensure person-centred care for the patient and their relatives, addressing their different needs during the course of the disease.

Comprehensive care includes both healthcare and non-healthcare aspects, ensuring early diagnosis, the application of innovative therapies and personalised treatments, as well as quality care at every stage of the care process. This is why the integration of new advances, such as those relating to **Personalised Precision Medicine, Artificial Intelligence, digitisation and telemedicine,** must not be forgotten, while at the same time attending to the other essential needs of patients and their relatives.

This comprehensive care must also focus on the fight against **rare cancers, cancers with poor prognosis and/or low survival rate,** as well as the needs of **specific patient groups** (children, adolescents and young adults, vulnerable populations etc.). Comprehensive care must also ensure **equity of access to treatment, health outcomes as a determining factor in value-based decision making, shared decision making, communication with patients and their relatives, and the coordination of all actors involved in the oncological process, advanced therapies and general care.**

As shown in the diagram, the care process is structured in the following phases:



• Diagnosis:

Cancer morbidity and mortality is directly related to the stage the diagnosis is made. Early diagnosis is therefore key to increasing the chances of survival. Minimising the interval from the time the disease is suspected to the start of treatment is a priority objective, and efficient coordination of all actors involved in the cancer diagnosis process is fundamental in achieving this. The new BCCP reinforces this line of work, with a focus on improving diagnostic accuracy and timeliness. In order to achieve this, key tools such as biological and radiological diagnostics and Personalised Precision Medicine will be consolidated and expanded, together with the incorporation of the latest technological advances. The development of rapid diagnostic circuits will also continue, promoting extension and standardisation of these for a larger number of cancer types. Among them, the Minbizi model has served as a benchmark, incorporating nursing figures to accompany, assess and facilitate access to the system.

However, it is acknowledged that this implementation has been inconsistent, and therefore work will be done to ensure a more even application throughout Osakidetza.

• Treatment:

Innovation in surgical, medical or radiological therapies is an ongoing need to improve patient prognosis. Progress must therefore be made in the implementation of different types of advanced therapies, precision, cellular, biological, proton therapy, etc. and their incorporation into the Service Portfolio. Universal and equitable access to all types of treatment is essential, while ensuring adequate specialisation and expertise of the professional teams administering these therapies.

• Continuity of care:

This involves identifying the care needs of the person with cancer and their relatives at all stages of the process (diagnosis, treatment, recovery, chronicity and end of life) using a holistic patient approach. These care needs include issues such as: pre- and post-surgical preparation, rehabilitation, nutrition, physical activity, psycho-social support, palliative care, etc. The coordination of all agents involved in the oncological process, both medical (Primary Care, hospitals, home hospitalisation, palliative care units, etc.) and non-medical (social services, psychologists, physical activity counsellors, educational counsellors, etc.) is a key element in guaranteeing this continuity of care. In relation to survivors who, after completing a clinical treatment plan, resume their activity and leave the hospital circuit, it is particularly relevant to address the specific needs that affect their quality of life (side effects of treatments, physical and emotional condition, etc.) [73, 74].

6.5.2 Objectives

This Priority Area is deployed through the following objectives:

DIAGNOSIS

5.1 Reduce waiting times for cancer diagnosis through specialised staff and advanced technologies, ensuring rapid detection and accurate diagnosis of disease.

5.2 Consolidate the implementation of Personalised Precision Medicine as a standard in cancer diagnosis, based on genomic data, biomarkers and updated guidelines.

TREATMENT

5.3 Ensure equitable, effective, and sustainable access to treatments and medications available within the public health system, avoiding unjustified variability and ensuring that therapeutic decisions are based on clinical value, scientific evidence, and the consensus of multidisciplinary teams, with the aim of improving health outcomes and patients' quality of life.

5.4 Optimise effective, equitable and sustainable access to innovative treatments.

5.5 Improve patient health outcomes by concentrating on high complexity, low prevalence surgical procedures, in accordance with recognised standards.

CONTINUITY OF CARE

5.6 Ensure that the patient is provided with the necessary care and resources based on a functional assessment carried out at each stage (diagnosis, treatment, rehabilitation, chronicity, end of life) to cope with the disease and clinical decision-making.

5.7 Optimise palliative care support within the cancer care process.

5.8 Improve coordination between the different levels of care involved in the oncological process by means of flexible, two-way communication between professionals in the medical, social and educational spheres, with the adaptation of digital tools.

5.9 Offer both professionals in the field of Osakidetza and patients, their environment and the community specific training in the field of care which has an impact on improving quality of life at all stages of the process.

6.5.3 Actions

DIAGNOSIS

Objective 5.1 *Reduce waiting times for cancer diagnosis through specialised staff and advanced technologies, ensuring rapid detection and accurate diagnosis of disease.*

5.1.1 Determine the cancers that should have **rapid diagnostic circuits using the MINBIZI model,** analyse the current situation in terms of implementation and draw up an action plan, with the necessary corrective measures, to extend it homogeneously in all Integrated Healthcare Organisations (IHOs).

5.1.2 Standardise rapid diagnostic circuits with a uniform structure, including updated protocols, access procedures, care, monitoring and communication.

5.1.3 Harmonise and standardise response times for diagnostic tests for each type of tumour and with the rest of the actors in the oncological process.

5.1.4 Implement mechanisms for the improvement of diagnostic imaging assessment to reduce the number of late diagnoses. This includes: **AI tools in screening and diagnosis that optimise image stratification and interpretation** in order to reduce the number of late diagnoses.

5.1.5 Centralise and strengthen reference laboratories equipped with high-performance technologies and define care circuits to guarantee: (i) networking with the rest of the hospitals and IHOs; and; (ii) that all patients have access to quality diagnostics based on the latest technologies.

5.1.6 Order **sample referral circuits** to reference centres and ensure their traceability.

5.1.7 Promote networking and collaboration between professionals in the different IHOs and with other expert centres.

5.1.8 Improve training in the early identification of symptoms and suspicions for professionals in primary care, emergency services, pulmonology, etc. and other specialist departments, taking into account scientific evidence related to gender differences, in order to optimise early diagnosis and appropriate referrals.

Objective 5.2 *Consolidate the implementation of personalised precision medicine as a standard in cancer diagnosis, based on genomic data, biomarkers and updated guidelines.*

5.2.1 Extend the use of **digital pathology** as it facilitates: (i) professional networking, (ii) correct sample coding and (iii) the promotion of diagnostic reference units for certain cancers.

5.2.2 Progress with **universal access to Personalised Precision Medicine for all cancer patients.**

5.2.3 Provide **continuous training** to professionals in diagnostic units to **facilitate the rapid implementation of new technologies.**

TREATMENT

Objective 5.3 *Ensure equitable, effective, and sustainable access to treatments and medications available within the public health system, avoiding unjustified variability and ensuring that therapeutic decisions are based on clinical value, scientific evidence, and the consensus of multidisciplinary teams, with the aim of improving health outcomes and patients' quality of life.*

5.3.1 **Review the prioritization process for pharmacological therapies t**o improve efficiency and streamline procedures.

5.3.2 Optimise **operational and administrative** management to achieve efficient and sustainable therapeutic processes, applying better and more innovative treatments.

5.3.3 Ensure the availability of **multidisciplinary teams as reference points during the therapeutic phase,** so that patients can clearly identify them and feel supported and accompanied throughout the entire process.

5.3.4 Analyse and manage the **need for technology and resources in organisations with a vision of equitable access, professional training of teams and optimal use of resources.**

5.3.5 Implement **procedures and technical and human resources to provide and develop home-based and day hospital treatment administration,** ensuring equity and accessibility, and guaranteeing patient safety, especially for more vulnerable groups such as: children and adolescents, the elderly and others.

5.3.6 Create **specific protocols and circuits for the treatment of rare and complex tumours, ensuring access to centres of reference, multidisciplinary teams, and to clinical trials and personalised treatments.**

5.3.7 Implement the **continuous and multidisciplinary evaluation of therapeutic outcomes,** ensuring that this evaluation allows personalisation and optimisation of treatment, improving both clinical efficacy and efficiency in resource management, and considering, among other factors, the scientific evidence on gender differences in response to treatments.

Objective 5.4 *Optimise effective, equitable and sustainable access to innovative treatments.*

5.7.1 Develop and implement a process of innovation and technological updating, ensuring the regular incorporation of devices and technologies based on scientific evidence and clinical cost-effectiveness.

5.4.2 Ensure access to clinical trials and, more broadly, to research-based treatments, especially for children and adolescents, guaranteeing equitable access to advanced and experimental therapies, with appropriate management and monitoring.

5.4.3 Achieving effective implementation of Proton Therapy. This will require clearly identifying key milestones, training professionals, designing clinical pathways, and establishing a Clinical Decision Committee, while also designing and deploying a Functional Operational Plan that ensures its launch within the established timelines, with appropriate safety and quality measures and adequate coverage for patients within the reference area who require it.

Objective 5.5 *Improve patient health outcomes by concentrating on high complexity, low prevalence surgical procedures, in accordance with recognised standards.*

5.5.1 Specify the **surgical procedures that need to be centralized due to their high complexity and low prevalence,** based on a consensus model and considering, among other criteria, clinical guidelines, as well as the technical requirements and necessary human competencies.

5.5.2 Develop and roll out the **Implementation Plan** required for the **centralisation arising from the previous action:** structure provision, patient flows, etc.

CONTINUITY OF CARE

Objective 5.6 Ensure that the patient is provided with the necessary care and resources based on a functional assessment carried out at each stage (diagnosis, treatment, rehabilitation, chronicity, end of life) to cope with the disease and clinical decision-making.

5.6.1 **Promote and strengthen home-based and community-based care, where this is the preference of the patient and their carers, and appropriate from a clinical perspective,** with special consideration for the paediatric, elderly or vulnerable patient population.

5.6.2 **Increase the number of cancer surgery preparation consultations within the peri-operative process with proactive actions,** so that recommendations are adapted and integrated in all phases before, during and after surgery. These recommendations may cover: nutritional advice, physical and respiratory exercise, controlling anaemia, emotional support, cessation of toxic habits (smoking, alcohol, etc.) or others.

5.6.3 **Integrate rehabilitation for people with cancer** especially when hospital admissions are required, with the involvement of the physiotherapy specialist and the provision of specialised material support.

5.6.4 Increase **rehabilitation for paediatric patients with motor, cognitive or functional problems** in an attempt to help them reach their maximum potential for physical development, socio-educational integration and incorporation into normal life activities at each paediatric stage.

5.6.5 Continue the progressive implementation of **personalised physical exercise programmes** adapted to the situation of each patient, improving **coordination between the Primary Care Units and the Physical Activity Guidance Service (PAGS)** and developing alternative resources for patients who are in active phases of the disease receiving toxic treatment or with other issues that make it difficult to refer them to the PAGS.

5.6.6 Facilitate **assessment by the nutrition-endocrine specialist to reduce the prevalence of malnutrition** during the oncological process, prioritising it for hospitalised patients.

5.6.7 Facilitate **referral to specialised fertility preservation units** for people diagnosed with cancer and who are candidates for this procedure, ensuring equal access for both genders, with special focus on AYAs population.

5.6.8 Promote the **recommended preventive vaccination in oncology patients** preferably before starting treatment: herpes zoster, tetanus, pneumococcus, influenza.

__Objective 5.7__ Optimise palliative care support within the cancer care process.

5.7.1 **Encode palliative care into the diagnosis and activate the alarm** early the multidisciplinary team is taking a palliative approach to treatment. Adapt the tool so that the alert reflects each patient's specific circumstances.

5.7.2 **Define an end-of-life plan with the patient,** providing information on: palliative care, euthanasia, shared decision-making, and advance healthcare directives to facilitate advance decision planning.

5.7.3 **Homogenise and standardise advance healthcare directives and advance decision planning documents.**

__Objective 5.8__ Improve coordination between the different levels of care involved in the oncological process by means of flexible, two-way communication between professionals in the medical, social and educational spheres, with the adaptation of digital tools.

5.8.1 Make the target population of patients with an active oncological process **visible on the clinical panel of the primary care professional.**

5.8.2 Ensure that **discharge reports include both the nursing and medical parts,** covering all aspects to be taken into account for patient monitoring in primary care, with special attention to the early detection of complications and relapses.

5.8.3 **Draw up an Individual Care Plan (ICP)** with patients and keep it up to date. The ICP must be given to the patient by hand and shall include, at least, the treatment received, possible medium and long-term side effects and toxicities that may have arisen during treatment, sequelae, care plan, and psychological care. The ICP should be a dynamic document that meets to the needs of the patient at each stage of the oncological process.

5.8.4 **Open channels of communication and coordination with healthcare professionals** involved in the care pathways (Minbizi nurses, doctors and primary care) **and non-healthcare professionals** (social care, education, employment, associations, etc.) who are involved in or provide support during the oncological process.

5.8.5 Move forward with **access to Electronic Medical Records for social services professionals** by obtaining Informed Consent, so that they can enter the action carried out with each of the patients.

Objective 5.9 *Offer both professionals in the field of Osakidetza and patients, their relatives and the community, specific training in the field of care which has an impact on improving quality of life at all stages of the process.*

5.9.1 Offer **training** to all healthcare professionals on **specific oncological topics** that need to be more widely disseminated (side effects of cancer, holistic pain management, physical exercise, nutrition, palliative care, palliative sedation, assisted dying, etc.).

5.9.2 Provide **information, forums and secure Internet links** to cancer patients regarding **pain, signs of treatment toxicity, and identification of signs of recurrence to improve early detection and treatment.**

6.6 Health Outcomes, Registration, Reporting and Surveillance Systems

6.6.1 Conceptual framework

The World Health Organisation defines health outcomes as changes in the health status of an individual, a group of individuals or a population attributable to an intervention or series of interventions.

All actions defined in the BCCP should be geared towards improving health outcomes. Efficient cancer care is considered to be that which has the best health outcomes based on the human, financial, infrastructural or technological resources available and keeps the focus on what matters most to patients and society itself[75, 76].

Health outcomes can be measured through a set of indicators integrating 5 distinct areas for analysis:

- Epidemiological results: risk factors, equity, incidence, survival, mortality, etc.
- Clinical outcomes.
- Health management: quality of care, performance of services and the health system.
- Value: efficiency and impact of investment made in relation to the health outcomes achieved.
- Outcomes in humanisation: quality of life, level of satisfaction, patient preferences, etc.

The measurement of these health outcomes, the registration and information systems are of particular relevance, as well as the available resources, human and technological, for the analysis and exploitation of data and data governance (how the data is obtained, who is the entity/person responsible for providing it, the clarity of the registration process, as well as the architecture and integration of systems to generate information usage, etc.). These factors all play a key role in this Priority Area.

In relation to the Cancer Registry, the previous BOP already focused on creation of a **cancer registry model** that would allow real-time analysis of the information available. This objective is still in place today and will also need to be addressed in this new plan.

All this must also align with the legal framework developed in recent years for the European Health Data Space (EHDS)[81]. It is understood that better use of data in the EHDS environment will contribute to more equitable access to high quality healthcare, as well as to therapeutic and digital innovation, improving health outcomes across the European Union. However, the implementation of the EHDS is a challenge in itself, but at the same time an opportunity to continue working on legal aspects, data governance structures, technical capacity and skills, or secondary data use.

6.6.2 Objectives

This Priority Area is deployed through the following objectives:

6.1 Create a Management Model based on providing value to cancer patients and the population in general, focused on improving health and overall well-being and promoting prevention, safety, efficiency and the sustainability of the health system.

6.2 Use a robust Cancer Information System, which complies with the standards set by the European Data Space

6.3 Establish a decision-making model to assess the health impact of different interventions at macro, meso and micro levels, as well as accountability to society. This model will assist in the use of objective data for service portfolio management, and promote value-based funding and payment, facilitating sustainable access to new medical treatments and healthcare technologies.

6.6.3 Actions

Objective 6.1 *Create a Management Model based on providing value to cancer patients and the population in general, focused on improving health and overall well-being and promoting prevention, safety, efficiency and the sustainability of the health system.*

6.1.1 Define and agree, with a corporate vision, the **concept of health outcomes in cancer** for the different oncological diseases and specific patient groups.

6.1.2 Develop **corporate dashboards to measure prevalence, incidence and health outcomes in oncological processes,** differentiated by sex, that allow evaluation and comparability in terms of clinical effectiveness, survival and complications (CROM), quality of life, functional status of the disease (PROM), patient experience (PREM), and their evolution over time.

6.1.3 Implement a **system for measuring the healthcare costs associated with the process,** making it possible to evaluate the economic impact of actions, programmes and technologies, to assess their contribution to the health system in terms of sustainability and the value provided to patients.

6.1.4 Train healthcare professionals in the measurement of health outcomes.

***Objective 6.2** Use a robust Cancer Information System, which complies with the standards set by the European Data Space.*

6.2.1 Identify and integrate sources for the collection of data on oncological processes, avoiding the creation of duplicate records and taking advantage of data entry automation: Osabide Global, Onkobide, Radiotherapy oncology, Population-based cancer registry, Minbizi form, Biobank, research data, etc.

6.2.2 Facilitate, and automate where possible, the collection of information at source: Professionals: simple forms tailored to their needs, activity logs; Patients: optimise survey records included in medical notes and accessible from tablets; systematise data audits, etc. to guarantee data quality.

6.2.3 Standardise pathology procedures and diagnoses (White Paper) and SNOMED, following Clinical Practice Guidelines and the updated nomenclature in the Osakidetza network.

6.2.4 Unify the population-based cancer registry with the hospital-based cancer registry, preserving the function and usefulness of each, so that they continue to meet their specific objectives.

6.2.5 Promote the **collaboration of the Basque Cancer Registry with national and international registries for childhood cancer and other types of tumours.**

6.2.6 Use dynamic and accessible platforms: Develop dashboards to visualise clinical, pharmacological, administrative and financial data in real time, facilitating decision-making for professionals and managers.

6.2.7 Incorporate digital tools for remote monitoring of symptoms and quality of life (mobile apps, wearable devices), reported by patients.

6.2.8 Implement advanced cybersecurity: Adopt international regulations (such as General Data Protection Regulation) and **collaborate on data sharing and data standardisation using an advanced cybersecurity system.** Establish agreements with external actors for the secure and efficient exchange of data within legal and ethical frameworks.

Objective 6.3 *Establish a decision-making model to assess the health impact of different interventions at macro, meso and micro levels, as well as accountability to society. This model will assist in the use of objective data for service portfolio management, and promote value-based funding and payment, facilitating sustainable access to new medical treatments and healthcare technologies.*

6.3.1 Develop a **methodology for the evaluation and improvement of cancer care processes.**

6.3.2 Develop **public policies on cancer that are transparent and accountable to the public** regarding: I) The health outcomes of the plans for cancer prevention, care and research; II) Compliance with equity and equal opportunities to tackle cancer, etc. iii) Promoting a public register of data and indicators and the publication of the annual report on cancer data in the Basque Country.

6.3.3 Develop a **methodology to move forward with value-for-money results-based funding** under the **Contract Programme.**

6.3.4 Incorporate **advanced technology tools (AI, predictive analytics, etc.)** to anticipate clinical outcomes and optimise treatments.

6.7 Research and Innovation

6.7.1 Conceptual framework

Research and innovation play a key role in the health and economic development of a country, with a direct relationship between investment in R&D&I and progress measured in terms of GDP.

In oncology, it is essential to implement scientific advances in clinical practice, promoting a translational approach that transforms research results into concrete improvements in prevention, diagnosis, treatment and quality of life for people with cancer.

In the Basque Country, cancer research is one of the priorities for the Health Research Institutes (HRI) - Bioaraba, Biobizkaia, Biogipuzkoa and Biosistemak -, in coordination with their corporate body, the Basque Foundation for Health Innovation and Research (BIOEF). Cancer research in the Basque Health System covers the entire spectrum from prevention, diagnosis, prognosis, treatment and improving patient quality of life. In 2023, the 32 cancer research groups received more than 15 million euros in external funding and carried out 577 projects, representing 28% of all research. Over the last five years, more than 800 cancer studies have been published.

In addition to the HRIs, the Basque health research and innovation ecosystem includes other research centres and universities where work is also being carried out in the oncological field, and whose collaboration is essential for increasing the impact of scientific advances.

There is a clear commitment to research in Personalised Precision Medicine and Advanced Cancer Therapies. Both disciplines, as areas of specialisation of the Health Research and Innovation Strategy[63] and as priority areas in the PCTI2030[13], have helped to promote cancer research in recent years. Beyond biomedical research, which is fundamental, it is essential to promote research in other areas to identify people's needs and improve their quality of life before, during and after cancer treatment.

During the BCCP timeline, important advances will be made in the field of cancer research and innovation, both at European and international level, and it is important that the Basque Country is aligned and positioned at the forefront of the new diagnostic techniques, treatments, and scientific and research advances developed. The BCCP will be the benchmark for establishing prioritisation criteria and the areas that should be the object of research and innovation during its period of validity.

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6.7.2 Objectives

This Priority Area is deployed through the following objectives:

7.1 Promote and reinforce cancer research and innovation, with a comprehensive and collaborative approach, drawing on the strengths of the Basque health ecosystem and enhancing the position of the Basque Country and its capabilities on the international arena with a clear commitment to improving care for patients and the general public.

7.2 Promote the integration of clinical practice, research and innovation, highlighting translational research and the effective implementation of solutions to optimise health outcomes.

7.3 Leverage the full potential of the cancer research and innovation ecosystem, involving all stakeholders engaged in cancer R&D&I — public and private, governmental and non-governmental — to strengthen the international positioning of the Basque Country.

7.4 Encourage citizen participation in research, innovation and evaluation.

7.5 Enhance the value of research activity, integrating it as an essential part of the development of the health profession.

7.6 Optimise access, development and participation in clinical trials, guaranteeing accessibility for patients and professionals.

7.7 Facilitate the comprehensive, ethical and efficient management of data and samples for cancer research.

6.7.3 Actions

Objective 7.1 *Promote and reinforce cancer research and innovation, with a comprehensive and collaborative approach, drawing on the strengths of the Basque health ecosystem and enhancing the position of the Basque Country and its capabilities on the international arena with a clear commitment to improving care for patients and the general public.*

7.1.1 Establish the **Research and Innovation Strategy** on cancer, aligned with the policies of the **EU Cancer Mission,** strengthening the position of the Basque Country at international level.

7.1.2 Increase lines of **research and innovation in:**

- Health promotion and cancer prevention.
- Early detection and diagnosis/prognosis.
- Personalised Precision Medicine (biomarkers).
- Advanced and innovative therapies.
- Therapeutic adaptation.
- Health services and health outcomes in cancer.
- Psychosocial support, care and welfare improvement programmes.
- New techniques in radiation treatments (photons, protons, image-guided radiotherapy, adaptive radiotherapy, etc.) and research into patient safety with this type of treatment.
- Needs of specific patient groups: children, AYAs, the elderly and long-term survivors (adverse effects, chronicity, mental health, etc.).
- Implementation of measures in the health system based on health outcomes and cost-effectiveness criteria.

7.1.3 Include indicators **of experience, patient perception and value-based medicine** (PREMS & PROMs) in research projects to assess health outcomes and guide clinical decisions.

Objective 7.2 *Promote the integration of clinical practice, research and innovation, highlighting translational research and the effective implementation of solutions to optimise health outcomes.*

7.2.1 Establish **procedures and/or agreements to facilitate the sharing** of infrastructure, data and staff, the use of epidemiology records, clinical records and research results at the level of care and research.

7.2.2 Identify and prioritise the **research and innovation needs** of cancer services in the Basque Country and **discuss and transmit them to researchers and developers** in order to promote research and innovation projects aimed at responding to these needs.

Objective 7.3 *Draw on the full potential of the cancer research and innovation ecosystem, including all actors involved in cancer R&D&I, both public and private, governmental and non-governmental, promoting the position of the Basque Country at international level.*

7.3.1 Define and implement a system to keep the **Map of Basque agents, infrastructures and capacities in cancer R&D&I permanently updated and disseminated.**

7.3.2 Create a **common vision of the cancer research ecosystem** in the Basque Country, integrating all the key players into a single collaborative framework and working as a network.

7.3.3 **Facilitate agreements to strengthen cancer research capacity.**

Objective 7.4 *Encourage citizen participation in research, innovation and evaluation.*

7.4.1 Define and implement the model for patient/citizen participation in research and innovation.

7.4.2 Encourage **patient/citizen participation** in the identification of topics of interest and evaluation processes for cancer research and innovation projects.

7.4.3 Develop patient/citizen participation in health technology assessments for **inclusion in the portfolio of complementary services.**

7.4.4 Define a strategy for publicising cancer research activity **to the public and to patients.**

Objective 7.5 *Enhance the value of research activity, integrating it as an essential part of the development of the health profession.*

7.5.1 Create **accredited ongoing training programmes** for researchers, clinicians and managers aligned with the BCCP objectives.

7.5.2 Promote the **continuous and specialised training** of medical, nursing and technical staff in research and the **implementation of technological innovations.**

7.5.3 Promote professional profiles that combine clinical and research activities.

7.5.4 Develop programs for the recruitment, development, and retention of talent within the Basque Health System and the Basque Science and Technology Network.

Objective 7.6 *Optimise access, development and participation in clinical trials, guaranteeing accessibility for patients and professionals.*

7.6.1 Create an **accessible and centralised Clinical Trials platform** with detailed information on active trials, inclusion and exclusion criteria, available hospitals and participation statistics, available to professionals and patients.

7.6.2 Establish a **Comprehensive Management Process** that includes proactive identification, improvement of management **taking into account all stakeholders,** and analysis of the implementation and evaluation of results of relevant current national and international clinical studies, promoting their transfer and execution in the Basque Country.

7.6.3 Foster the **functioning and coordination of centres' ethics committees** with the **Basque Country Research and Ethics Committee** and communication with the research teams to facilitate procedures, guaranteeing ethical principles.

7.6.4 Review the legal framework and establish initiatives aimed at facilitating multi-centre clinical studies in the Basque Country.

7.6.5 Promotion of **academic trials and independent research.**

7.6.6 **Improvement and optimisation of the human resources and health infrastructures** of the HRIs and the health care setting to support the implementation of Clinical Trials, with special attention to early phase trials.

7.6.7 Move forwards with the **development of the Joint Unit for Clinical Research in Childhood Cancer,** to facilitate the opening of new international clinical trials.

Objective 7.7 *Promote the comprehensive, ethical and efficient management of data and samples for cancer research.*

7.7.1 Simplify procedures to optimise the collection, storage, access and use of tumour and biological samples and associated data for research.

7.7.2 Develop **collection, analysis and storage programmes for specific samples** for rare cancers, to boost translational research.

7.7.3 Strengthen the **use of the Basque Biobank** to ensure correct sample management and develop procedures to facilitate the exchange of samples to promote multi-centre and international projects.

7.7.4 Facilitate access to, and the use and management analysis of data for research in compliance with data protection regulations at European, national and local level.

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Governance of the BCCP

Governance of the BCC

The governance of the BCCP facilitates its rollout, development, monitoring and evaluation. This governance should be consistent with the defined mission and principles, facilitating the achievement of the stated vision and objectives, and should address issues relating to:

- Leadership and impetus in the deployment and monitoring of the BCCP.
- The commitment of all stakeholders to adopt the Goals and Actions, taking into account the principle of Health in All Policies.
- Supporting and monitoring rollout.
- Monitoring the development of the Strategic Lines. The evaluation of the BCCP rollout and the achievement of objectives.

7.1 Organisational structure

The BCCP has an organisational structure based on different forums and/or bodies, with defined roles, participants and operations, ensuring that the governance elements (leadership, support, monitoring, etc.) are included and establishing a participatory system aimed at the prioritisation of actions, follow-up, monitoring and evaluation of the BCCP. Figure 25 shows the organisational chart with the main elements of the BCCP governance structure.

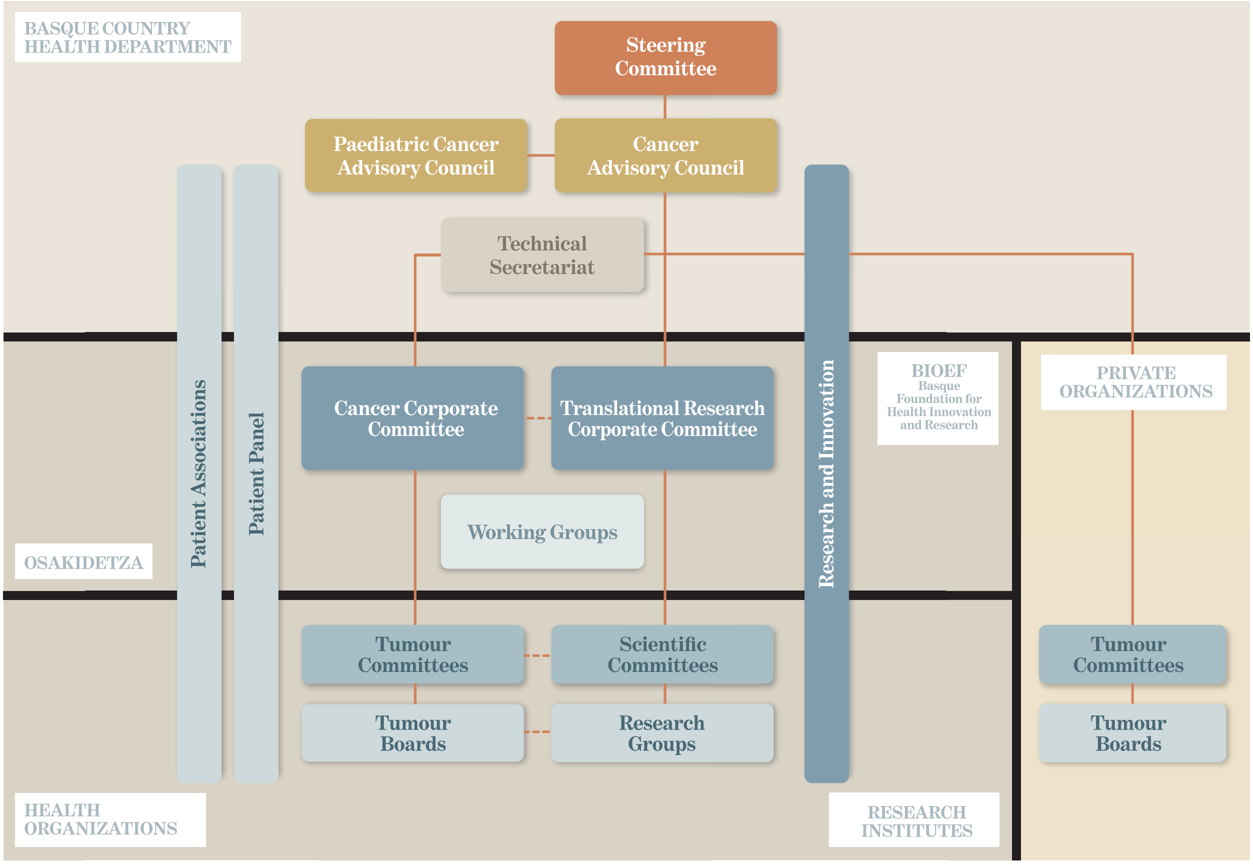

Figure 25. Organisational chart showing the main elements of the governance structure of the BCCP 2025-2030.

Steering Committee

The Steering Committee will be responsible for leading and ensuring institutional commitment to the implementation of the new Cancer Plan, certifying its correct application and coordination between the different organisations involved. This is the highest management and validation body for the implementation of the BCCP and its results.

STEERING COMMITTEE	
FUNCTIONS	Its functions are: • Lead the rollout, follow-up, monitoring and evaluation of the BCCP. • Ensure compliance with the guiding principles of the BCCP. • Ensure inter-institutional and interdepartmental commitment of the actors involved in realising the BCCP Vision. • Decide on the updating and/or adjustments of the BCCP as proposed by the Cancer Advisory Councils.
MAKEUP / OPERATIONAL	Its makeup is as follows: • Health Advisor. • Deputy Health Advisor. • Directorate for Health Transformation, Planning and Digitalisation. • Directorate General of Osakidetza • Osakidetza Health Care Directorate.
PROFILE	It shall meet, in the absence of extraordinary needs, on a **six-monthly** basis to analyse the results of the follow-up and monitoring of the BCCP rollout and to establish measures based on the results.

Cancer Advisory Council

The Cancer Advisory Council will be responsible for coordinating and managing the development of the actions of the Basque Country Comprehensive Cancer Plan. It will be responsible for managing the implementation of the BCCP, as well as its monitoring and continuous evaluation, proposing changes and/or improvements dynamically, as necessary.

CANCER ADVISORY COUNCIL	
FUNCTIONS	Its functions are: • Manage BCCP communications and deployment. • Establish the actions necessary for the rollout and development of the general objectives of the BCCP. • Appoint those responsible for the implementation of actions, agreeing on their prioritisation and schedule. • Monitor and evaluate the progress of the BCCP, and propose changes and adjustments to objectives and actions. • Ensure compliance with the guiding principles of the BCCP.
MAKEUP / OPERATIONAL	Its makeup is as follows: • Directorate for Health Transformation, Planning and Digitalisation. • Directorate for Health Research, Innovation and Evaluation. • Public Health Directorate • Pharmacy Directorate. • Representatives of other departments involved. • Osakidetza Health Care Directorate. • Representation of the Corporate Cancer Committee. • Representatives of services involved in the diagnosis and treatment of cancer patients. • Representatives of Private Health Care Organisations. • Citizen/patient representatives. • Representatives of Euskampus (UPV-EHU)
PROFILE	It shall meet, in the absence of extraordinary needs, **on a quarterly** basis to analyse the results of the follow-up and monitoring of the deployment of the BCCP and establish measures based on the results.

Paediatric Cancer Advisory Council

The purpose of this body is to ensure quality criteria for the optimal organisation and management of care for all cases of cancer in childhood and adolescence. It will be responsible for the BCCP rollout in its area, addressing the specific objectives and actions aimed at children and adolescents with cancer, as well as ensuring the specific needs of this group for the rest of the objectives as required. It will work directly with the Cancer Advisory Council, to communicate its needs and report on the development of the Plan in its area.

PAEDIATRIC CANCER ADVISORY COUNCIL	
FUNCTIONS	Its functions are: • Manage BCCP communications and rollout within its scope. • Establish the actions required for the development of the BCCP objectives in its area. • Prioritisation of actions, appointment of persons responsible and scheduling • Monitor and evaluate the progress of the BCCP, and propose changes and adjustments to objectives and actions. • Ensure compliance with the guiding principles of the BCCP.
MAKEUP / OPERATIONAL	Its makeup is as follows: • Directorate for Health Transformation, Planning and Digitalisation. • Representative of the Directorate for Health Research, Innovation and Evaluation. • Representatives of other departments involved. • Osakidetza Health Care Directorate. • Representatives of services involved in the diagnosis and treatment of paediatric cancer patients. • Citizen/patient representatives.
PROFILE	It shall meet, in the absence of extraordinary needs, **on a quarterly** basis to analyse the results of the follow-up and monitoring of the deployment of the BCCP and establish measures based on the results.

Technical Secretariat

The Technical Secretariat will be the operational core of the BCCP, responsible for guaranteeing the continuity and dynamics of the Plan, and supporting the meeting of its objectives and established timelines. It will act as the key support for the governance bodies and working groups, and will be the main link between the Advisory Council and the Osakidetza Corporate Cancer Committee.

TECHNICAL SECRETARIAT	
FUNCTIONS	Its functions are: • To be the driving force for the BCCP rollout, carrying out continuous monitoring. • To be the support body for the Steering Committee, the Advisory Board and the Corporate Cancer Committee. • Support and coordinate the working groups established for the rollout of the BCCP, participating in them when necessary to facilitate momentum and coordination. • Design the methodology for the evaluation of the BCCP and collect the necessary information for this evaluation. • Prepare the necessary documentation for the governance bodies. • Facilitate and prepare the meetings of the Governance bodies, and acting as their Technical Secretariat.
MAKEUP / OPERATIONAL	Its makeup is as follows: • The Technical Secretariat is the responsibility of the Directorate for Health Transformation, Planning and Digitalisation. • It has a permanent team made up of professionals from the Department of Health, Osakidetza and Bioef.
PROFILE	Regular **monthly** meetings

Corporate Cancer Committee

The Corporate Cancer Committee will be responsible for informing Health Care Organisations of the decisions taken by the Advisory Boards regarding the rollout of the Plan. It will be the body responsible for the rollout of the Plan in the clinical and healthcare field, taking into account the needs of other Corporate Committees and the Healthcare Organisations themselves and simultaneously evaluating and monitoring performance in its field. Its functions include promoting the integration of research into clinical practice.

CORPORATE CANCER COMMITTEE	
FUNCTIONS	Its functions are: • Transferring the decisions taken by the Advisory Boards • Identify adjustments needed for the implementation of the Plan in its area. • Define Corporate Care Pathways. • Review and improve Care Pathways • Review the role of Tumour Boards • Establish protocols to be followed • Periodically review the Indicators for its area. • Receive and respond to the needs of other corporate committees. • Receive and respond to the needs of the IHOs • Promote the integration of research into clinical practice.
MAKEUP / OPERATIONAL	Its makeup is as follows: • Representatives of the Healthcare Sub-directorates. • Representative of the Human Resources Directorate. • Representative of the Directory for Economy and Infrastructure. • Tumour Committees Representatives. • Representatives of the BCCP Nursing Coordinators. • Biological Diagnostics Network Coordinators. • Pharmacy Committee Coordinators. • PPM Committee Coordinators. • Research Committee Coordinators.
PROFILE	It shall meet, in the absence of extraordinary needs, on a **quarterly basis.**

Corporate Translational Research Committee

This will be the governance body responsible for designing and rolling out the Cancer Research and Innovation Strategy. It will also be the body that ensures compliance with the objectives and actions relating to Research and Innovation. This newly-created body will need to comply with the relevant regulations.

CORPORATE TRANSLATIONAL RESEARCH COMMITTEE	
FUNCTIONS	Its functions are: • Define and establish the Cancer Research and Innovation Strategy. • Identify and prioritise cancer research and innovation needs. • Monitor and evaluate the progress of the BCCP in Cancer Research and Innovation. • Promote the integration of research into clinical practice.
MAKEUP / OPERATIONAL	Its makeup is as follows: • BIOEF • Health Research Institutes (Bioaraba, Biobizkaia, Biogipuzkoa, Biosistemak) • Osakidetza representatives • Other related actors to be defined.
PROFILE	It shall meet, in the absence of extraordinary needs, on a **quarterly basis.**

Tumour Committee

This is a committee, at organisational level, composed of a multidisciplinary team of experts from the departments involved in the diagnosis and treatment of cancer. It shall be responsible for the transfer of the decisions of the Corporate Cancer Committee and their implementation in its organisation, and shall be responsible for maintaining two-way communication

TUMOUR COMMITTEE	
FUNCTIONS	Its functions are: • Transfer proposals and return information from the Corporate Tumour Committee • Responsible for the implementation and active monitoring of BCCP actions in their organisation. • Advise the management on all organisational and/or clinical aspects that impact work with these patients to facilitate the development of the necessary structures and care circuits. • Coordinate the different aspects of care that arise in each of the Tumour Boards
MAKEUP / OPERATIONAL	Its makeup is as follows: • Representatives of the organisation's management. • Representatives of services involved in the diagnosis and treatment of cancer patients. • Nursing coordination.
PROFILE	It shall meet, in the absence of extraordinary needs, on a **quarterly basis** to

Tumour Boards

Its main function will be to lead the management of processes in the corresponding area and to discuss cases to make a multidisciplinary decision on the most appropriate treatment for each patient. With the aim of integrating research into clinical practice and facilitating synergies and coordinated work, progress should be made in the inclusion of a reference research figure on the Tumour Boards.

TUMOUR BOARDS	
FUNCTIONS	Its functions are: • Undertake the role of "knowledge and decision teams for the oncological process", proposing the contents of the care pathways within their remit. • Review clinical cases for multidisciplinary decision-making. • Define and propose to the Committee for its rganisation the specific protocols to be followed in its area. • Define the indicators for the care pathways within its remit and evaluate the activity and results.
MAKEUP / OPERATIONAL	Its makeup is as follows: • Multidisciplinary team defined depending on the field in question.
PROFILE	It shall meet on a weekly basis, depending on cases..

Patient and citizen participation

Involving **patients**, their **representatives** and/or **citizens** at different levels of the Plan, where they can share their knowledge and perspectives, can improve the quality of care, increase patient satisfaction and promote the transparency and accountability of health systems. Similarly, including the perspective of patients/citizens and their representatives in research processes, from the formulation to dissemination of results, not only ensures that research is aligned with patients' needs, but also amplifies its social impact.

In line with the comprehensive approach to cancer promoted by this BCCP, work must also be done on the **participation and collaboration of other related community agents,** mainly for actions aimed at cancer awareness and prevention.

It will be therefore necessary to define the model for patient/citizen/association participation in the **organisational model, care processes and research**.

Working groups

The creation of working groups is planned; they will be responsible for the implementation of the BCCP actions.

7.2 Accountability: Monitoring, Tracking and Evaluation

In the coming months, the **prioritization of the BCCP's actions** must be defined, along with **the timeline for their implementation.**

The BCCP must be subject to continuous **monitoring, tracking, and periodic evaluation**s to ensure that the actions undertaken are properly deployed and aligned with the established objectives.

This will take place within the framework of an **Evaluation Model**, which includes a Dashboard combining both progress and outcome indicators, with defined frequencies and the involvement of the governance bodies previously identified.

7.3 Dashboard

A dashboard is a “management tool that facilitates decision making and provides a coherent set of indicators that give senior management an understandable view of an area of activity or responsibility. The information provided on the dashboard makes it possible to focus and align management teams, functional units, resources and processes with the organisation’s strategies” (UNE 66175:2003).

The dashboard is divided into:

- A table of **General Indicators,** linked to the VISION, and therefore more focused on the achievement of results and impact.
- A set of **Indicators for each Priority Area,** which are intended to guide the level of achievement of their objectives:

The proposed indicators will require further development, including the establishment of their definition, current value, and setting target outcomes following the implementation of this BCCP.

General Indicators

0.1. Cancer incidence rates in the Basque Country by type of cancer.

0.2. Cancer mortality rate in the Basque Country by type of cancer..

0.3. Overall survival and relative survival at 1, 3 and 5 years of people diagnosed with cancer in the Basque Country, by type of cancer.

0.4. Potential years of life lost by people who died of cancer in the Basque Country.

0.5. Years of life adjusted for quality of life.

0.6. Quality of life of cancer patients and survivors and their carers.

0.7. Public satisfaction on how the system deals with cancer.

Indicators by Priority Areas

1. PEOPLE, THE CORE OF THE BCCP

1.1. Humanisation Index in the oncology field (Level of implementation of the Humanisation model - Self-assessment tool).

1.2. Degree of Satisfaction with the experience in relation to Humanisation (Satisfaction Surveys): communication, treatment, spaces, etc. (look for a specific tool as a reference).

1.3. Degree of satisfaction with the experience in relation to the humanisation of healthcare professionals (Satisfaction Surveys): training, spaces, etc.

1.4. Quantitative data on training for professionals: participants, hours, training actions, etc. % participation rates.

1.5. Prescription/completion rate of Active Patient-Paziente Bizia workshops

2. HEALTHCARE MODEL

2.1. Degree of progress on the document defining the healthcare model.

2.2. Degree of progress on the Plan for incorporating patients into the model.

2.3. % of cancers with a defined Corporate Care Pathway.

2.4. Number of Tumour Board and Tumour Committees sessions, corporate or by IHO, by cancer type.

2.5. % Tumour Boards with the participation of a referral nurse, primary care representatives and research referral.

2.6. % of care pathways with annual report and improvement plan.

2.7. % of care pathways with a monitoring protocol for people free of disease.

2.8. Number of low prevalence and/or high complexity processes being developed and implemented.

2.9. CCC corporate accreditation: YES/NO.

2.10. ISO 15189 corporate accreditation: YES/NO.

3. ROMOTION AND PREVENTION

3.1. Design of guidelines that integrate health and equity criteria in the planning and implementation of public policies (YES/NO).

3.2. Number and % of Local Bodies adhering to the Network of Smoke and Aerosol Free Spaces

3.3. Number and % of local councils with PAGS and of the population of the Basque Country benefiting from PAGS..

3.4 % of population exposed to annual average level of PM2.5 above the reference values (Basque Country Air Quality Statistics).

3.5. % of persons aged 18 and over with reported Body Mass Index greater than or equal to 30. .

3.6. % of population aged 15 and over reporting high-risk alcohol consumption.

3.7. % of population aged 15 and over reporting smoking at least one cigarette per day.

3.8. % of population aged 14-18 who have used tobacco in the last month.

3.9. Number of people accessing smoking cessation resources.

3.10. % coverage in HPV vaccination programmes. Target >95%.

3.11. % coverage in HPV vaccination programmes. Target >95%.

3.12. Number of asbestos removal plans in the Basque Country.

4. EARLY DETECTION

4.1. % Coverage and participation in implemented population-based screening.

4.2. Number of actions carried out to encourage participation.

4.3. % cancers diagnosed by screening in early stages..

4.4. Rate of adverse effects (complications).

4.5. Number of guidelines, protocols and clinical pathways aimed at early detection in patients at increased risk developed and/or updated.

4.6. Number of people seen in the High-Risk Consultations by speciality.

4.7. Number of cancers reported as suspected occupational disease.

4.8. Number of training activities focused on early detection and/or occupational cancer carried out for professionals.

4.9. % of patients seen within the established time frame from suspicion, confirmatory diagnosis to initiation of treatment.

5. COMPREHENSIVE CARE

DIAGNOSIS

5.1. % IHOs with rapid diagnostic circuits in place for each type of cancer..

5.2. % of tests outsourced from the National Health System's genomics and genetics portfolio.

5.3. Number of new biomarkers implemented by category (TIER1-standard biomarkers, TIER2-biomarkers used in clinical trials, TIER3-biomarkers used in research).

5.4. Number of AI systems rolled out to improve the accuracy of cancer diagnosis.

5.5. Number of professionals who have received training in new diagnostic technologies and their level of satisfaction.

TREATMENT

5.6. Time elapsed from the time a medicine is financed (National Health System) until it is available in the Basque Country.

5.7. % of patients receiving treatment in the home setting..

5.8. Number of concentrated surgical procedures.

5.9. Number of patients treated with proton therapy..

5.10. % of patients who received chemotherapy in the last 14 days of life..

CONTINUITY OF CARE

5.11. % of cancer patients referred to the PAGS.

5.12. % of cancer patients of childbearing age who have undergone fertility preservation.

5.13. % of cancer patients receiving recommended vaccines.

5.14. Number of patients admitted to medium-stay units for cancer treatment.

5.15. Days of hospitalisation generated by delayed discharges ("bed blocking").

5.16. % of people with cancer who have an Individualised Care Plan.

5.17. % of people with cancer identified as palliative patients (Z515, V66.7) who have an Individualised Care Plan in place.

5.18. Creation of the clinical panel with the target patient group under active cancer care for primary care professionals (YES/NO).

6. HEALTH OUTCOMES, REGISTRATION, REPORTING AND SURVEILLANCE SYSTEMS

6.1. % of Care Pathways with a dashboard. .

6.2. % of Care Pathways for which PROMs are collected systematically.

6.3. % of care pathways managed with a value approach (measurement and analysis of health outcomes and cost). .

6.4. Number of patients included in a value-based care pathway.

6.5. Number of procedures aimed at standardising pathology diagnostic reports.

6.6. Number of Contract Programme indicators linked to value in cancer.

6.7. Degree of development of a system to facilitate the implementation of performance-based purchasing and number of purchasing processes in which it has been applied.

7. RESEARCH AND INNOVATION

7.1. Number of cancer research projects.

7.2. % of cancer research projects (compared to total number of research projects).

7.3. Funding of cancer research projects..

7.4. % of projects with a translational approach that reach clinical practice (including clinical practice guidelines).

7.5. Number of collaborative projects between agents in the Basque health ecosystem.

7.6. Number of international cancer projects.

7.7. Number of public cancer awareness campaigns.

7.8. % of cancer projects with at least one citizen and/or association on the research team.

7.9. Number of cancer publications and % in the first quartile in oncology.

7.10. Number of clinical trials with cancer drugs (% Phase I, II, III, IV clinical trials and % of observational studies) by type of sponsor.

7.11. Number of clinical studies with medical devices (post-marketing or clinical trial) in cancer.

7.12. Number of optimised Basque biobank processes.

7.13. Number of activities related to improving access to and use of data for research.

* Indicators will be calculated by sex, age groups and socio-economic status where relevant.

08

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8.2 Benchmarking

Several oncology plans, both national and international, have been analysed with the aim of providing a comprehensive overview of current strategies in the fight against cancer. Below is a list of these plans; by clicking on each one, you can access a detailed summary of the strategic lines, objectives, and actions included in each strategy. This compilation may be especially useful for those wishing to review different approaches or find points of reference.

National Plans

- Cancer Strategy of the SNS (Nnational Health System)
- Andalusia
- Castile and León
- Catalonia
- Extremadura
- Galicia

International Plans

- Europe´s Beating Cancer Plan 2021-2024
- Australia
- Chile
- US
- France
- Netherlands
- United Kingdom
- Action guide for efficient cancer care, an implementation toolkit (All.Can)

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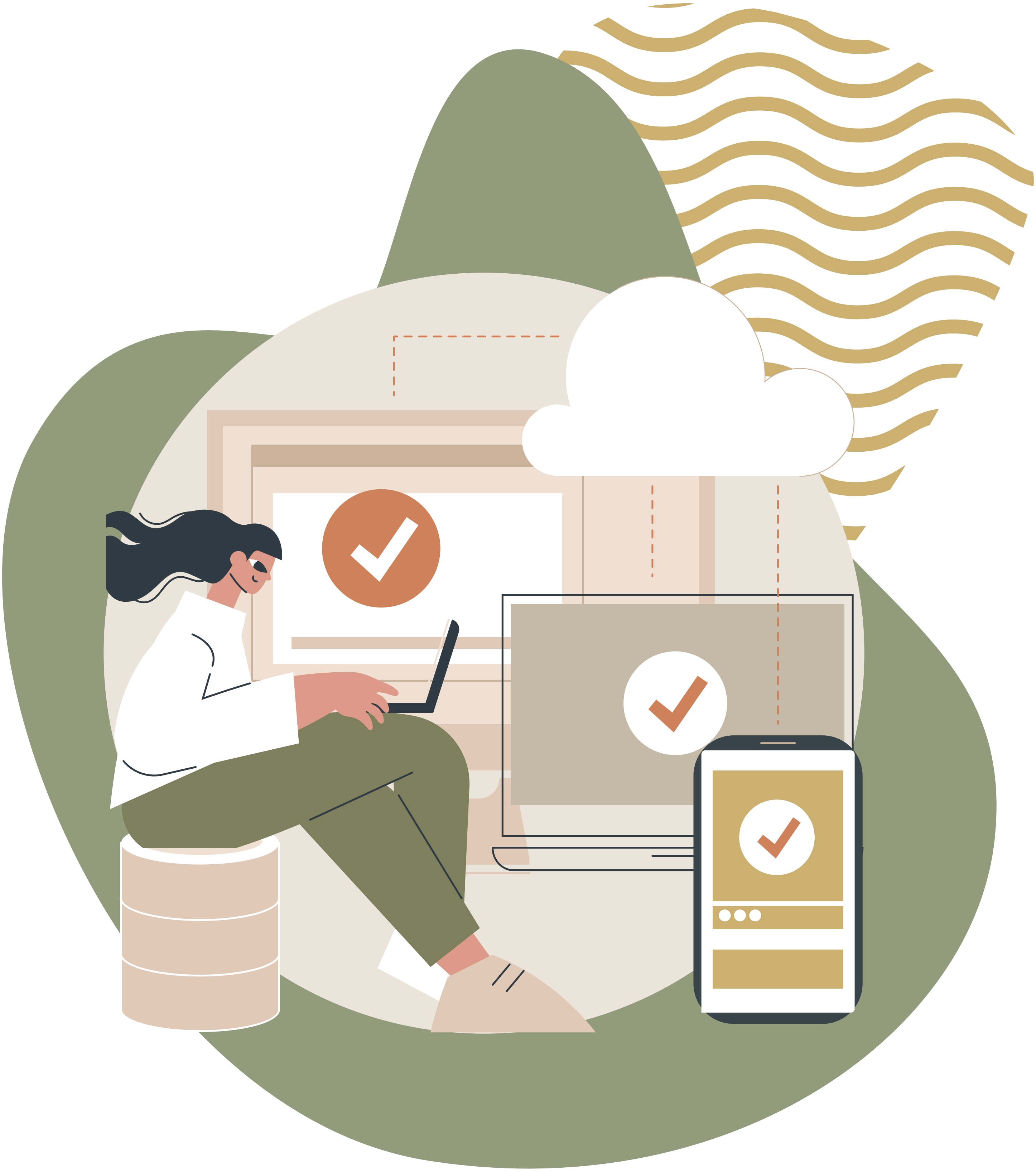


09

Annexes

9.1 Actions Targeted at Specific Populations

The objectives and actions outlined in this document are designed with a people-centred approach, ensuring homogeneous and equitable implementation for all, regardless of their specific needs. However, it has been identified that, for certain objectives and actions, it is essential to place special emphasis on specific population groups, such as **children, AYAs (Adolescents and Young Adults), elderly, and long-term survivors,** among others. Below is a presentation of the objectives and actions—grouped by Priority Area—in which it is particularly important to address the specific needs of these groups in a differentiated manner:

People, the Core of the BCCP

Objective 1.4 *Create physical and care environments that favour emotional and physical well-being, for patients, relatives and professionals, adapting them to the specific needs of each group, especially in paediatrics.*

1.4.3 Streamline communication channels with social workers and associations to facilitate early access to social resources and guide and speed up the necessary help for **the most vulnerable groups (migrants, the elderly, mental health, addictions, etc.).**

Healthcare model

Objective 2.2 *Provide specific Care Pathways to guarantee rapid, efficient and homogeneous responses, adapted to the changing needs of patients.*

2.2.3 Ensure a structured transition to adulthood and a continuum of care for paediatric and adolescent patients **through a coordinated strategy between paediatrics, different levels of care and different medical specialities.**

2.2.4 Facilitate the implementation of standardized protocols aimed at assessing overall functional status (such as the Comprehensive Geriatric Assessment), shared between the healthcare professional and the patient and/or their support network, in order to avoid unnecessary diagnostic tests and to ensure appropriate treatment based on the patient's specific characteristics, minimizing risks and aiming to maintain or improve the patient's functionality and quality of life.

Promotion and prevention

***Objective 3.1** Implement policies to promote healthy environments to encourage the adoption of healthy lifestyles, reduce exposure to environmental and social risks associated with cancer,, and strengthen preventive interventions.*

3.1.1 Extend the Network of Smoke and Aerosol Free Spaces **both in number and type (university campuses, educational centre environments, workplace environments, etc.)**.

3.1.4 Maintain vaccination rates of over 95% against HBV and HPV in children and adolescents in the Basque Country, **through the application of the Department of Health's vaccination and immunisation programme, in accordance with the established schedules.**

***Objective 3.2** Promote healthy lifestyles in relation to the risk factors associated with cancer, taking into account: life stages, health inequalities and the gender perspective.*

3.2.2 Develop a literacy **programme, especially aimed at children, adolescents and young adults, in coordination with Osasun Eskola, on protective factors and cancer risk factors, including multilevel dissemination and communication actions, and taking into account** life stages and health inequalities.

3.2.3 Strengthen the Basque Country smoke- and aerosol-free strategy, with a special focus on adolescents and young adults, by reinforcing intersectoral and interinstitutional action to help achieve a tobacco-free generation by 2040.

3.2.4 Promote a de-normalisation strategy for alcohol consumption sustainable over time, as established under the Addictions Plan, incorporating information on risks and actions to reduce social acceptance and to protect minors from covert advertising.

3.2.6 Support the adoption of a healthy and sustainable diet **through: information campaigns, and nutritional supervision of school menus.**

3.2.7. Design and implement informational and awareness campaigns to: **(i) promote adequate protection against solar radiation (with special emphasis on children and exposed workers), and (ii) reduce the use of UV tanning beds.**

Early detection

Objective 4.2 *Increase participation in population-based screening and reduce inequalities.*

4.2.2 Study the reasons for non-participation and design and implement actions for non-participating groups, **carrying out joint actions with UPV/EHU, patient associations, representatives of specific groups and professionals.**

Comprehensive care - treatment

Objective 5.3 *Ensure equitable, effective, and sustainable access to treatments and medications available within the public healthcare system, avoiding unjustified variability and ensuring that therapeutic decisions are based on clinical value, scientific evidence, and the consensus of multidisciplinary teams, with the aim of improving health outcomes and patients' quality of life.*

5.3.5 Implement procedures and technical and human resources to provide and develop home-based and day hospital treatment administration, ensuring equity and accessibility, and guaranteeing patient safety, especially for more vulnerable groups such as: **children and adolescents, the elderly and others.**

Objective 5.4 *Optimise effective, equitable and sustainable access to innovative treatments.*

5.4.2 Ensure access to clinical trials and, more broadly, to research-based treatments, especially for children and adolescents, guaranteeing equitable access to advanced and experimental therapies, with appropriate management and monitoring.

Comprehensive care – continuity of care

Objective 5.6 *Objective 5.6 Ensure that the patient is provided with the necessary care and resources based on a functional assessment carried out at each stage (diagnosis, treatment, rehabilitation, chronicity, end of life) to cope with the disease and clinical decision-making.*

5.6.1 Promote and strengthen home-based care, where this is the preference of the patient and their carers, and community-based care **with special consideration for the paediatric, elderly or vulnerable patient population.**

5.6.4 Increase rehabilitation for paediatric patients with motor, cognitive or functional problems in an attempt to help them reach their maximum potential for physical development, socio-educational integration and incorporation into normal life activities at each paediatric stage.

5.6.7 Facilitate referral to specialised fertility preservation units for people diagnosed with cancer and who are candidates for this procedure, ensuring equal access for both genders, with special focus on AYAs population.

Health outcomes, Registration, Reporting and surveillance system

Objective 6.2 *Use a robust Cancer Information System, which complies with the standards set by the European Data Space.*

6.2.5 Promote the collaboration of the Basque Cancer Registry with national and international registries for **childhood cancer** and other types of tumours.

Research and Innovation

Objective 7.1 *Promote and enhance cancer research and innovation, with a comprehensive and collaborative approach, leveraging the strengths of the Basque healthcare ecosystem and boosting the Basque Country's positioning and capabilities internationally, with a clear commitment to improving patient and public care.*

7.1.2 Increase lines of research and innovation in:

- Needs of specific patient groups: children, AYAs, the elderly and long-term survivors (adverse effects, chronicity, mental health, etc.).

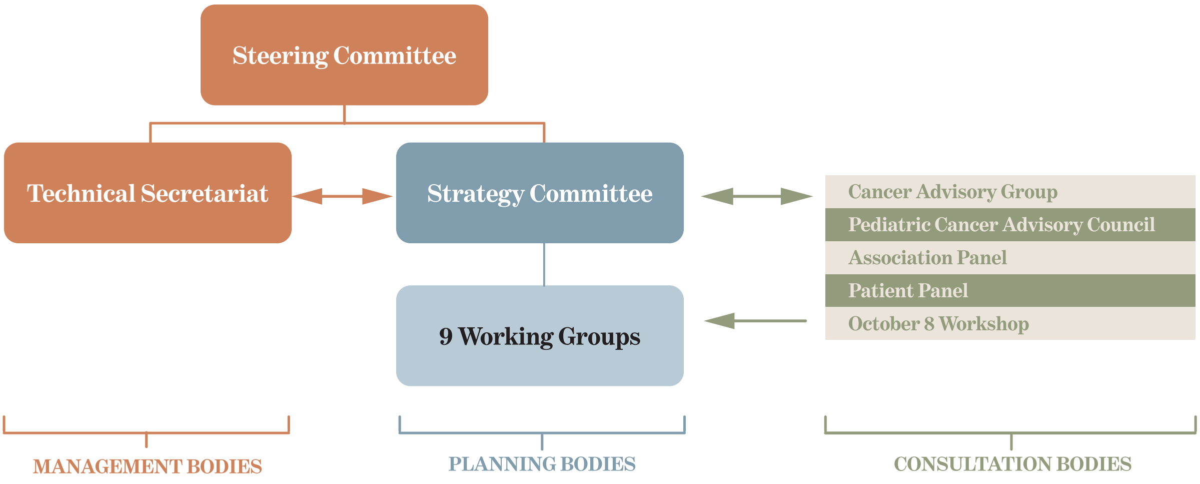
***Objective 7.6** Optimise access, development and participation in clinical trials, guaranteeing accessibility for patients and professionals.*

7.6.7 **Move forwards with the** development of the Joint Unit for Clinical Research in Childhood Cancer, **to facilitate the opening of new international clinical trials.**

9.2 BCCP development process

Within the framework of this project, the participation of professionals has been a strategic and cross-cutting element, integrated throughout all phases of the BCCP development process. In total, more than **250** people have taken part in the various forums that were established, including participants from both the health and non-health sectors, and representing a range of profiles such as political and technical decision-makers, public and private managers, and healthcare professionals from various fields and specialties.

To structure the participation of all stakeholders, the project implemented its own governance model. This model defined a total of 9 bodies with different levels of authority and specific functions. Below is a detailed description of each forum, its role, and the number of participants.



9.2.1 Project Management Bodies

STEERING COMMITTEE	
Mission	Highest-level body composed of political representatives from the Department and the Deputy Ministry of Health, as well as from Osakidetza.
Funtions	Final validation of content and approval of thE BCCP.
N° Participants	3
N° of meetings held	2

TECHNICAL SECRETARIAT	
Mission	Operational management body of the BCCP, composed of BCP Coordinators, the director and technical staff from the Directorate of Health Transformation, Planning, and Digitalisation.
Funtions	• Validate and approve project documentation prior to its review by the Strategic Committee. • Approve the content and dynamics of meetings with the Strategic Committee.
N° Participants	8
N° of meetings held	5

9.2.2 Planning Bodies

STRATEGIC COMMITTEE	
Mission	Defines the strategic content of the BCCP. Composed of healthcare professionals from Osakidetza and the private sector, along with directors from Osakidetza and the Department of Health (Health Transformation, Planning and Digitalisation; Health Research, Innovation and Evaluation; Pharmacy; Public Health and Addictions).
Funtions	• Define the mission and vision of the BCCP. • Identify the priority areas. • Validate and review the objectives and actions proposed by the working groups. • Identify individuals involved in the working groups.
N° Participants	24
N° of meetings held	6

WORKING GROUPS (WG)	
Mission	Advisory body responsible for identifying the strategic objectives, actions, and indicators of the BCCP. Composed of professionals from both the healthcare and non-healthcare sectors with expertise in each of the priority areas defined by the Strategic Committee. A total of 9 working groups were formed—one for each Priority Area—except for the area of Comprehensive Care, which was split into three groups due to the scope and relevance of its content, in order to better focus and facilitate discussion: WG1 - People, the core of the BCCP WG2 - Health promotion and prevention WG3 - Early detection WG4 - Healthcare model WG5 - Diagnosis WG6 - Treatment WG7 - Continuity of care WG8 - Health outcomes, registration, reporting and surveillance systems WG9 - Research and innovation
Funtions	• Define the objectives of each priority area • Define the actions for each objective • Propose indicators for the BCCP dashboard
N° Participants	139
N° of meetings held	27

9.2.3 Consultation bodies

WORKSHOP	
Mission	Validation and technical review body for the content developed by the Strategic Committee. Composed of healthcare professionals and experts with relevant knowledge in the cancer field.
Funtions	• Validate the Priority Areas proposed by the Strategic Committee. • Identify strategic issues within each Priority Area in order to define the objectives and actions that each Working Group subsequently worked on.
N° Participants	58
N° of meetings held	1

PATIENTS’ PANEL

Mission	Advisory body composed of patients who have faced or are currently facing the disease.
Funtions	• Identify key areas for improvement related to cancer in the Basque Country. • Propose actions for each Priority Area defined by the Strategic Committee.
N° Participants	7 Patients
N° of meetings held	2

ASSOCIATIONS’ PANEL

Mission	Advisory body composed of various cancer patient associations.
Funtions	• Identify key areas for improvement related to cancer in the Basque Country. • Propose actions for each Priority Area defined by the Strategic Committee.
N° Participants	8 Associations
N° of meetings held	1

CANCER ADVISORY COUNCIL AND PAEDIATRIC CANCER ADVISORY COUNCIL

Mission	Consultation body composed of members from both Advisory Councils.
Funtions	• Review the BCCP´s Priority Areas as defined by the Strategic Committee. • Identify key areas for improvement related to cancer in the Basque Country. • Propose areas for action.
N° Participants	18 Adults | 15Paediatric
N° of meetings held	1 Adults | 1 Paediatric

9.3 Participants

Steering Committee

Martínez Ruiz, Alberto
Peiró Callizo, Enrique
López Altuna, Susana
Tamayo Medel, Gontzal
Martínez de Albéniz Zabaleta, Maite

Technical Secretariat

Peiró Callizo, Enrique
Tamayo Medel, Gontzal
Martínez de Albéniz Zabaleta, Maite
Sala Gonzalez, Maria Ángeles
Urraca De la Serna, Jose Maria
Arrospide Elgarresta, Arantzazu
Diez Ozaeta, Iñaki
Sorrarain Odriozola, Yon

Strategic Committee

Peiró Callizo, Enrique
Tamayo Medel, Gontzal
Martínez de Albéniz Zabaleta, Maite
Sala Gonzalez, Maria Ángeles
Urraca De la Serna, Jose Maria
Arrospide Elgarresta, Arantzazu
Diez Ozaeta, Iñaki
Sorrarain Odriozola, Yon
Betolaza San Miguel, Jon Iñaki
Gutierrez Ibarluzea, Iñaki
Herrero Alaña, Guillermo
Amutio Diez, Elena
Arévalo Lobera, Sara
Armenteros Yeguas, Victoria
Astigarraga Aguirre, Itziar
Cambra Contin, Koldo
Ferreiro Quintana, Josefa
Gallego Camina, Inés
Guerra, Nicolás
Malda Salinas, Verónica
Mendoza Arteche, Lorea
Murga Eizagaechevarria, Nekane
Otaolea Santacoloma, Leire
Portillo Villares, Isabel

Working Groups (WG)

- **People, the core of the BCCP**

Inés Gallego (coordinator)
Álvarez de Eulate Lopez, Coloma
Bañuelos Gordon, Ana
Cobos Baena, Patricia
Domezain Del Campo, Monica
Esnaola Aguirrezabala, Maria Jose
Etxeguren Urkixo, Ianire
Fernández Martínez de Mandojana, Magdalena
Lamiquiz Linares, Eva
Lopez De la Serna, Maria Jose
Neve Lete, Itziar
Pombo Ramos, Haizea
Saizarbitoria Suinaga, Maddi

- **Healthcare Model**

Tamayo Medel, Gontzal (coordinator)
Arevalo Lobera, Sara
Astigarraga Aguirre, Itziar
Berganzo Corrales, Koldo
Ciordia Domínguez, Roberto
Eíto Valdovinos, Clara
Ferreiro Quintana, Josefa
Garate Echenique, Lucia
García Ruiz, Juan Carlos
Martínez de Albéniz Zabaleta, Maite
Murga Eizagaechevarria, Nekane
Romeo Ollora, Jorge
Sala Gonzalez, Maria Ángeles
Urraca De la Serna, Jose Maria

- **Promotion and prevention**

Cambra Contin, Koldo (coordinator)
Aldasoro Unamuno, Elena
Carassa, Wladimir
Gisasola Yeregi, Aitor
Herrero Alaña, Guillermo
Iturralde Pinedo, Arrate
Iturriaga Madariaga, Gorka
Latasa Zamalloa, Pello
Martin Diez, Maria Jesus
Nuin Gonzalez, Beatriz
Romeo Ollora, Jorge

- **Early detection**

Portillo Villares, Isabel (coordinator)
Alayo Bueno, Itxaso
Arenaza Lamo, Edurne
Armenteros Yeguas, Victoria
Bao Pérez, Fidencio
Del Rio Pisabarro, Camino
Garitano Gutierrez, Ignacio
Gonzalez Rábago, Yolanda
Gisasola Yeregi, Aitor
Gutierrez Stampa, Maria Ángeles
Lekumberri Cortes, Iñigo
Mujika Eizmendi, Karmele
Otaolea Santacoloma, Leire
Quesada Ramos, Cristina
Sainz de Rozas Aparicio, Irene

- **Comprehensive Care - Diagnosis**

Otaolea Santacoloma, Leire (coordinator)
Aloa Hermoso de Mendoza, Irantzu
Amutio Diez, Elena
Ciordia Domínguez, Roberto
García Etxeberria, Larraitz
Gil Molet, Alejandra
Gómez Lamas, David
Hernández Santos, Esther
Lopez De Gamboa, Itziar
Martínez Kareaga, Mireia
Moro Casuso, Inmaculada
Oyarzabal Pérez, Igor
Ruiz Diaz, Irune

- **Comprehensive care - Treatmento**

Urraca De la Serna, Jose Maria (coordinator)
Areizaga Albisua, Ane
Benítez Delgado, Beatriz
Betolaza San Miguel, Jon Iñaki
De Miguel Cascon, Monike
Diaz del Val, Ismael
Domínguez Fernández, Severina
Ferreiro Quintana, Josefa
Gainza Gonzalez, Eukene
Jimenez Agüero, Raúl
Mallabiabarrena Ormaechea, Gaizka
Murga Eizagaechevarria, Nekane
Omaechevarria Legarra, Edurne
Panizo Santos, Carlos
Pomposo Gastelu, Iñigo
Poza De Celis, Raúl

- **Comprehensive Care – Continuity of Care**

Sala Gonzalez, Maria Ángeles (coordinator)
Arriba Marcos, Beatriz
Barandiaran Igoa, Aitziber
Barayazarra Irazola, Dalda
Blanco Zapata, Rosa
Bringas Diez, Mikel
García Vaquero, Nuria
Gómez Mediavilla, Jenifer
Hasson, Naomi
Ispizua Ojanguren, Maite
Larrañaga Unanue, Ihintza
Muñoz Tena, Ramón
Ochoa de Retana García, Lourdes
Ortiz Zaldumbide, Paula
Sáenz Del Burgo Guerra, Estibaliz
Sistiaga Suarez, Alexander
Zeberio Etxetxipia, Izaskun

- **Health outcomes, registration, reporting and surveillance systems**

Sorrarain Odriozola, Yon (coordinator)
Alberdi Arbelaiz, Ander
Cantero Gonzalez, David
Cobos Baena, Patricia
Gallego Camina, Inés
García Lorenzo, Borja
Gil Molet, Alejandra
Gómez Inhiesto, Elisa
Gómez Iturriaga, Alfonso
Iruretagoiena Sánchez, Maria Luisa
Latasa Zamalloa, Pello
Lázaro-Carrasco De la Fuente, Maria Jesus
Lopez Arbeloa, Gonzalo
Lopez de Munain Marques, Arantza
Madrid Conde, Maite
Millán Ortuondo, Eduardo

Muruaga Infante, Maria Asunción
Ogueta Lana, Mikel
Segurola Lázaro, Blanca
Tamayo Medel, Gontzal

- **Research and Innovationn**

Mendoza Arteche, Lorea (coordinator)
Astigarraga Aguirre, Itziar
Azkona Uribelarrea, Eider
Borrego Rabasco, Francisco
Bourantas, Dimitri
Cacicedo Fernández-Bobadilla, Jon
Eíto Valdovinos, Clara
Fullaondo Zabala, Ane
Galve Calvo, Elena
García Fidalgo, Marian
Garitano Gutierrez, Ignacio
Gutierrez Ibarluzea, Iñaki
Jimenez Barbero, Jesús
Mendibe Bilbao, Mar
Muñoz Caffarel, María
Otaño Arino, María
Ulibarri Ochoa, Ainhoa
Verdoy Berastegui, Lola
Vergara Mitxeltorena, Itziar

Workshop

Peiró Callizo, Enrique
Tamayo Medel, Gontzal
Martínez de Albéniz Zabaleta, Maite
Sala Gonzalez, Maria Ángeles
Urraca De la Serna, Jose Maria
Arrospide Elgarresta, Arantzazu
Diez Ozaeta, Iñaki
Sorrarain Odriozola, Yon
Betolaza San Miguel, Jon Iñaki
Gutierrez Ibarluzea, Iñaki
Herrero Alaña, Guillermo
Amutio Diez, Elena
Arévalo Lobera, Sara
Armenteros Yeguas, Victoria
Astigarraga Aguirre, Itziar
Cambra Contin, Koldo
Ferreiro Quintana, Josefa
Gallego Camina, Inés
Guerra, Nicolás
Malda Salinas, Verónica
Mendoza Arteche, Lorea
Murga Eizagaechevarria, Nekane
Otaolea Santacoloma, Leire
Portillo Villares, Isabel
Berganzo Corrales, Koldo
Romeo Ollora, Jorge
Serna Rodríguez, Francisco
Aldasoro Unamuno, Elena
Almaraz Ruiz Eguilar, Maria Jose
Aritzeta Iraola, Jose Maria
Arrizabalaga Azurmendi, Javier
Calzada Barrena, Javier
Cantero Gonzalez, David
Cintora León, Elena
Diez Del Val, Ismael
Elduayen Olleta, Leire
Fullaondo Zabala, Ane
Garate Echenique, Lucia
Garitano Gutierrez, Ignacio
Gil Molet, Alejandra
Gisasola Yeregi, Aitor
Hidalgo, Emma
Iruretagoiena Sánchez, Maria Luisa
Iturriaga Madariaga, Gorka
Latasa Zamalloa, Pello
Leizea Ortega, Xabier
Loizate Totoricaguena, Alberto
Lopez de Munain Marques, Arantza
Mendibe Bilbao, Mar
Muñoz Llarena, Alberto
Neve Lete, Itziar
Nuin Gonzalez, Beatriz
Ocio Armentia, Jesus Ángel
Omaetxebarria Legarra, Edurne
Regalado De los Cobos, Jose
Ruiz Diaz, Irune
Segurola Lázaro, Blanca
Vergara Mitxeltorena, Itziar

Patients' panel

Cabezas Rodríguez, Jose Antonio
Gonzalez Bustinza, Enara
Olaeta, Pedro Maria
Oregui Unamuno, Oier
Ozaeta Domaica, Montserrat
Pina Rubio, Enrique
Rodríguez Gómez, Leire

Associations' panel

ACAMBI
Association of people affected
by Breast Cancer in Bizkaia.

AECC
Association Against Cancer

IZAN INURRI

KATXALIN
Association of Women Affected by Breast
and Gynaecological Cancer of Gipuzkoa

MAITE TA BIZI
Association for Metastatic Breast Cancer of the
Basque Country

PAUSOZPAUSO
Support for Oncohaematological Patients

POP
Platform of Patient Organizations

UMEEKIN
Basque Federation of Associations of Parents
of Children and Adolescents with Cancer

Other Professionals Consulted

Basterretxea Badiola, Laura
López Almaraz, Ricardo
López de San Vicente Hernández, Borja
Uriz Monaut, Jose Javier

Other Consultation Bodies

Official College of Physiotherapists
of the Basque Country

ONKO-ON Mission, Euskampus Fundazioa,
University of Basque Country

Cancer Advisory Council

Tamayo Medel, Gontzal (president)

Sala Gonzalez, María Ángeles (secretariat)

Armenteros Yeguas, Victoria

Arévalo Lobera, Sara

Ferreiro Quintana, Josefa

Fuertes Vélez, Francisco Javier

Martínez de Albéniz Zabaleta, Maite

Martínez Del Prado, Purificación

Poza de Celis, Raúl

Urrutikoetxea Ribate, Ander

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Arrieta Ayestarán, Milagros
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Escalante Martín, Maite
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Society of Digestive Pathologya)

García Echeberria, Larraitz
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Society of Respiratory Pathology)

Goyenechea, Ane
(representing Osatzen)

Lekuona Artola, Arantxa
(representing the Basque Society
of Gynaecology and Obstetrics)

Malda Salinas, Verónica
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Regional Care Coordination Committee for the Management of Pediatric and Adolescent Cancer Care

Tamayo Medel, Gontzal (president)

Astigarraga Aguirre, Itziar (president)

Aguirre Pascasio, Lizar

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Garrote Llanos, Elisa

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López Duarte, Mónica
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Osakidetza

EUSKO JAURLARITZA GOBIERNO VASCO

OSASUN SAILA DEPARTAMENTO DE SALUD