Moving from theory to practice: implementing person-centred and efficient cancer care

Case study compendium

2026

All.Can Changing cancer care together

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About this compendium

This compendium of case studies from around the world demonstrates best-practice approaches to the provision of person-centred cancer care and more efficient use of healthcare resources. It has been informed by a structured review of peer-reviewed and grey literature from 2018 to 2025, insights from the All.Can person-centred care taskforce and 14 expert interviews. The final list of case studies was chosen by the All.Can person-centred care taskforce.

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This compendium complements the report *Person-centred cancer care: improving outcomes, experiences and efficiency*.

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Sweden: cancer care pathways improve early diagnosis

Introducing cancer care pathways has significantly increased the number of people being diagnosed with cancer at an earlier stage in Sweden, although ensuring timely access to treatment remains an ongoing challenge.

The challenge

Cancer incidence in Sweden has been steadily rising, with long wait times for diagnosis and treatment placing increasing pressure on healthcare services.[1-3] People with cancer faced wait times of up to 280 days for curative treatment from referral (2011–13 data).[2] Delays in referral and initiation of treatment result in poorer outcomes. Every month cancer surgery is delayed is associated with a 6–8% increase in the risk of death,[4] and causes psychological distress.[5]

What the care pathways have achieved

In 2015, Sweden introduced cancer patient pathways (standardiserade vårdförlopp, or SVF).[6] The programme ensures swift and equitable access to investigations for suspected cancer and fast initiation of treatment; this helps improve satisfaction with care and reduces regional variations.[6 7] Each pathway outlines the recommended diagnostic procedures and treatments for specific cancer types, along with time-defined targets for treatment initiation from first suspicion. The pathways may be used by any healthcare professional responsible for referrals, diagnostics and treatment.[6 8]

The programme set ambitious goals:

- 70% of cancer diagnoses should occur through SVF
- 80% of people with cancer should begin treatment within the defined lead times for each pathway.[7]

To receive funding for the programme, regions must record wait-time data and patient experiences in a national database.[6]

Over 157,160 people with suspected cancer were seen via SVF in 2024; approximately 30% of these referrals resulted in a diagnosis and treatment.[9] The programme exceeded its diagnostic target: 82% of total cancer diagnoses were made through the programme.[9] However, it fell short on time to treatment initiation: only 45% of people began treatment within the specified time frame, although this was still an improvement on 2023 (40%).[7]

What's next?

Annual analyses assess the programme's impact and its adherence to benchmarks. These findings inform updates to the benchmarks and time intervals along the care pathway.[7] The programme also incorporates patient experience data, gathered through patient-reported experience measures (PREMs) and clinical data, ensuring that the pathways remain responsive, effective and person centred.[7]

Key considerations when adapting this approach

- When adapting time-defined goals for diagnosis and treatment, ensure that clinical teams have the appropriate resources and infrastructure to escalate referrals in a timely manner.
- Collect PREMs along the care pathway to make sure care pathways align with the priorities and needs of people with cancer.
- Ensure that key performance indicators – such as data on regional and hospital-level wait times – are being clearly defined and measured to track success.

Key enablers: resources, infrastructure, workforce capacity

Canada: tailored patient navigation to guide people through the health system

To address fragmentation and inequities in cancer care, the province of Alberta has introduced patient navigation programmes that guide people with cancer and their families along the care pathway. The programmes also offer targeted support for underserved communities.

The challenge

A 2006 assessment of Alberta's cancer services found that two issues needed to be addressed in order to reduce inequities in cancer care:

- a lack of connection between healthcare services and people with cancer, and their loved ones and carers
- insufficient support for people in rural areas.[10]

These challenges were particularly acute for families navigating complex treatment pathways.[10]

What the patient navigation programmes have achieved

A pilot study conducted between 2008 and 2010 trialled the implementation of a patient navigation service.[10] Based on its success, Alberta introduced a provincial navigation programme in 2012.[10] The programme uses registered nurses and navigators with specialist training in cancer care to: guide people with cancer and their families through treatment transitions, provide access to resources and community support programmes, and help overcome barriers to care.[11]

Recognising the diverse needs of Alberta's population, the programme evolved to include specialist navigation streams tailored to certain groups:[10][11]

- The adolescent and young adult stream supports young people (ages 15–39) with cancer who have concerns about education, employment, relationships and fertility.[11]

- The Indigenous stream employs cancer patient navigators to act as advocates for culturally safe care; they help address the specific barriers and challenges Indigenous people with cancer may experience while trying to access care.[11]
- The rural stream serves the 22% of people living in rural areas of Alberta, offering guidance and acting as a liaison to address geographical barriers to care.[11 12]

Since inception, over 40,000 people have been assisted through the programme.[11] The majority (90%) of navigation appointments occur virtually, which supports accessibility and saves time and resources; this has resulted in over CAD 1 million in savings for Alberta's health system.[11]

People using the programme report that navigation has: helped them feel stable and secure; ensured timely access to information; coordinated community support; and reduced their hospital stays and emergency room visits.[11 13]

What's next?

Despite its success, a ten-year evaluation revealed that 25% of people were unable to access the service before their first oncology consultation.[10] The review also highlighted that there are variations in service provision and practices, and limited palliative care provision.[10]

These findings will be used to continually improve the service by aligning programme structure, refining navigators' roles and responsibilities, expanding navigation streams, and standardising processes.[10]

Key considerations when adapting this approach

- To ensure an equity-oriented approach, navigation streams must be adapted to appropriately support underserved communities.
- Ensure that there are awareness campaigns for the service, to promote engagement.
- Offer virtual navigation appointments to facilitate accessibility.

Key enablers: resources, digital infrastructure

UK: regional initiatives help strengthen survivorship care

In Lincolnshire, a regional programme has been implemented to address fragmentation between services and provide more coordinated, person-centred care.

The challenge

Cancer incidence in the UK is rising, and Lincolnshire – a predominantly rural and coastal county – has a high prevalence of cancer that is driven partially by its large (and growing) population of people over 65.[14,15] Lincolnshire faces distinct challenges, including limited access to services, high levels of deprivation, and social isolation.[15] These challenges contribute to poorer health outcomes and a higher premature mortality rate than in more urban areas.[15]

What the initiative has achieved

The Living With Cancer (LWC) programme was launched in 2017 by the NHS Lincolnshire Integrated Care Board as part of the 'Living with and Beyond Cancer Strategy for Lincolnshire 2017–2019'.[16] It was developed in collaboration with over 400 stakeholders, including people affected by cancer.[16] LWC's principles emphasise a person-centred, holistic and innovative approach that aligns with existing systems, prioritises individual choice and community assets, and encourages self-care.[16]

A multidisciplinary team of 12 delivers the programme across Lincolnshire's cancer pathways and communities through 3 sub-programmes:[16]

- the acute stream provides holistic needs assessments and end-of-treatment summaries to ensure continuity of care
- the personalisation stream focuses on tailored follow-up using a 'triage, report, refer and navigate' model
- the community development stream ensures that cancer care and wellbeing reviews are conducted through general practices.

The programme also includes a directory of services that support people to live well with and beyond cancer.[17 18] The directory allows people with cancer and their carers access to services focused on emotional, physical, financial and spiritual needs as well as peer support groups for lung, prostate, brain, bladder, colorectal, head and neck, bowel, kidney and secondary breast cancers.[17-19]

By mid-2024, 50% of people with cancer in Lincolnshire were offered a holistic needs assessment within a month of diagnosis; the rate was even higher (70%) among those following a cancer care pathway with a care coordinator.[20] More than 80% of people who accessed psychosocial support reported reduced distress levels within 12 weeks, highlighting the programme's efficacy at improving wellbeing.[20]

What's next?

Future priorities include rolling out an LWC dashboard to track outcomes, including outpatient appointments, patient experience scores and financial impact.[16] This data-driven approach will help demonstrate the programme's value and guide improvements.

Key considerations when adapting this approach

- Cancer care services must be flexible and meet the needs of local people. Involving people affected by cancer in their co-design is crucial to build trust, relevance and ownership.
- Use personalised care plans and involve community health practices to embed the provision of support services beyond acute care.
- Provide training and dedicated funding of roles in cancer care services to promote the effective implementation and long-term sustainability of the workforce.

Key enablers: resources, workforce capacity

The Philippines: national policy to protect people with cancer from financial hardship

The Philippines is tackling cancer-related financial strain through national funding programmes that expand access to treatment and medicines.

The challenge

Cancer was the third leading cause of death in the Philippines in 2023.[21] It is estimated that annual costs due to cancer reached PHP 110 billion (USD 1.9 billion) in 2023 and are projected to double within 20 years.[22] For people with cancer seeking treatment, out-of-pocket expenditure can range from PHP 120,000 to over 1 million. These costs place a substantial financial burden on individuals and their families, frequently forcing them to sell assets, take on debt or compromise on essential needs.[23 24] As a result, it is common for treatment to be abandoned, with around 70% of people discontinuing medical care due to financial constraints.[22]

What the policies have achieved

The 2019 National Integrated Cancer Control Act established national programmes, including the Cancer Assistance Fund (CAF) and the Cancer and Supportive-Palliative Medicines Access Program (CSPMCP).[25] By 2023, these programmes were in place and were funded through sustainable public–private partnerships and tax reforms.[26]

In 2023, the Department of Budget and Management allocated PHP 500 million to the CAF to expand financial protection for eight priority cancers, including breast, liver and lung cancers.[26 27] By early 2024, the CSPMCP was providing 61 different medicines for the most common cancers, across 35 access sites.[25]

The government also allocated PHP 1.06 billion to the National Integrated Cancer Control Program to increase awareness about cancer and its causes and prevention, and to promote healthy lifestyles.[26]

What’s next?

The government’s next priorities include providing improved facilities and technology for cancer screening and care.[26] Achieving these goals while ensuring sustainability and equitable access will require strong collaboration among the public and private sectors, academic and research institutions, non-governmental organisations and civil society.[26]

Key considerations when adapting this approach

- Providing greater financial support to people with cancer will be dependent on securing sustainable financial mechanisms, including ringfenced budgets and public–private partnerships.
- To maximise impact, it is essential to identify ‘priority cancers’ and at-risk populations, ensuring that funding and resources are strategically directed to those most in need.

Key enablers: large-scale funding

Europe: a network of pancreatic cancer registries helps shape best-practice care

A pan-European registry for pancreatic cancer has been established to address critical data gaps and inform best-practice, person-centred diagnosis and care.

The challenge

Pancreatic cancer is the fifth leading cause of cancer-related deaths in Europe and mortality rates are rising.[28 29] Poor outcomes from the disease are in part due to late diagnosis, with several contributing factors: the lack of identified biomarkers for the disease; rapid tumour growth rates; few specific symptoms; and low imaging sensitivity.[30] Increasing awareness of pancreatic cancer is critical to improve survival and outcomes.[31]

What the network has achieved

PancreOS is a network of pancreatic cancer registries in Europe initiated in 2015 by the Spanish Cooperative Group on Digestive Tract Tumours.[31] Its objectives are to collect comprehensive prospective data on pancreatic cancer at all disease stages, so as to better understand the disease and identify inequalities in care. This will in turn inform the development of efficient diagnoses and personalised treatments.[31]

Since its inception, PancreOS has created connections between existing pancreatic cancer registries in European Union (EU) Member States, and started to collect and analyse data.[30] By December 2024, 26 registries had applied to join PancreOS and 9 had provided data.[30]

Preliminary analyses indicate that there is a need for more comprehensive and standardised data to better understand the most effective diagnostic and treatment approaches.[30]

Analyses have also uncovered significant variability in treatment approaches, and the impact of this variability on pancreatic cancer outcomes needs to be better understood.[30]

What's next?

PancreOS will continue to increase the number of participating registries, collecting and analysing data to inform person-centred, efficient diagnosis and care. In addition, there are plans to disseminate findings to policymakers, clinicians and researchers to further inform best practice.[30]

Key considerations when adapting this approach

- To adapt a cross-border registry network to different countries and cancer types, a standardised list of metrics to capture must be agreed. These metrics should encompass data points that would inform best practice, including on demographics, survival, stage at diagnosis, available tumour information, where and how people are diagnosed, and the treatments delivered.
- If data are shared across borders, they must be shared in a secure way that adheres to data protection laws, for instance broader analyses of registry data rather than raw data points.

Key enablers: digital infrastructure, workforce, interoperability

Sweden: personalised treatment planning and quality communication transform cancer care

Sweden has introduced a personalised care planning approach to improve communication, coordination and person-centred cancer care.

The challenge

Involving people with cancer in care planning through better communication is vital to ensure that care is person-centred, fit for purpose, and respects patients' values and needs.[32] Yet in an analysis of people with cancer in Sweden, 51% reported communication failures along the care pathway,[33] which results in:

- limited access to care services due to a lack of contact[33]
- delays in receiving consultations, assessments and treatments[33]
- minimal information about treatment[33]
- limited opportunities to influence decisions about their care.[34]

What the personalised treatment plans have achieved

In 2009, the Swedish national cancer strategy mandated that all people with cancer be offered an individualised care plan.[35] This led to the creation of My Care Plan (Min vårdplan, or MVP) initiative, which is developed collaboratively by people with cancer and clinical staff to ensure that it is useful and appropriate.[36 37] The initiative aims to increase participation in care and facilitate effective communication, and covers most cancer types.[38 39]

Care plans are offered digitally (with paper versions by request) via the 1777 platform – an evidence-based, fact-checked website and helpline for health and care information.[38 40 41] Plans are a combination of standardised information about individual cancers, with guidelines for their management, and person-specific documentation on individualised care and treatment plans.

Each individual plan contains:

- information about a person's cancer and treatment
- information on the long-term effects of cancer and its treatment
- self-care advice
- a rehabilitation plan
- contact information for care providers
- a summary of follow-up care once primary treatment has finished.[41]

The service also allows people with cancer to independently report their symptoms and concerns through patient-reported outcome measures (PROMs).[41] By early 2024, more than 40,000 people had a care plan initiated.[35]

What's next?

The MVP initiative continues to expand and evolve. New cancer information and guidelines are being added, and existing information is updated through quarterly submission cycles that incorporate user feedback.[37 42] Working groups of service users, healthcare providers, researchers and patient advocates help update the standardised information in care plans; the plans are accompanied by a national impact statement that assesses the initiative's implications for regional care practices.[38 42 43] Individual regions are also developing devolved versions of the guidelines included in care plans.[44]

Key considerations when adapting this approach

- Ensure that there are opportunities for user feedback on care plans, through the systematic collection of PROMs, with subsequent revisions to incorporate feedback.
- Assess the impact that any changes to national care plans would have on different health systems/regions e.g. whether there are adequate resources to facilitate the recommended changes.

Key enablers: resources, workforce capacity

Australia: care pathways address disparities in care

In Australia, optimal care pathways (OCPs) have been introduced for a variety of tumour types to promote person-centred cancer care. Specific pathways for Aboriginal and Torres Strait Islander populations help address disparities in access to care.

The challenge

Receiving care for cancer in Australia can be complex. This is due to the multitude of specialists involved and the use of both private and public healthcare, resulting in a lack of continuity between systems.[45] There are persistent issues with disparities in access to cancer care.[45,46] Aboriginal and Torres Strait Islander peoples have higher probabilities of developing cancer and lower survival rates compared with non-Indigenous population groups.[47,48] This is attributed to greater exposure to cancer risk factors, lower participation in screening, inequitable access to healthcare and a lack of culturally appropriate care.[47,48]

What the optimal care pathways have achieved

In Australia, OCPs for cancer were first developed in 2014 and 2015 to address disparities in care for different tumour types.[46] These pathways define the key principles of care, time frames, quality standards, and what additional supportive care is needed.[46] Each OCP has specific recommendations for each stage of the care continuum: prevention and early detection; presentation, initial investigations and referrals; diagnosis, staging and treatment planning; treatment; care after initial treatment and recovery; managing recurrent, residual or metastatic disease; psychosocial needs and support; and end-of-life care.[49] Recommendations focus on care being person-centred, safe, multidisciplinary, supportive, coordinated and delivered with good communication.[49]

Since their inception, OCPs have expanded to include Aboriginal and Torres Strait Islander peoples.[48] In 2022, OCPs were broadened again to include specific guidance for adolescents and young adults, since outcomes are worse for this group than for children and adults.[50]An app has also been developed for the public as an access point to OCPs.[51]

In New South Wales, the Cancer Institute has supported uptake since 2015, with multiple programmes of work that connect with OCPs.[52] For example:

- the Canrefer system facilitates timely referral to a specialist who is part of a multidisciplinary team
- the Aboriginal Cancer Program and Multicultural Cancer Programs ensure equitable and culturally appropriate care
- a risk-stratified bowel cancer screening programme facilitates early detection.[52]

The availability of an integrated care team and key healthcare workers to help navigate the health system were identified as facilitators of optimal treatment and survivorship care for Aboriginal and Torres Strait Islander peoples.[53] However, Aboriginal and Torres Strait Islander peoples still report a lack of access to specialists and diagnostic procedures.[53]

The use of OCPs has been found to vary across different states and territories, and reports demonstrate gaps in the implementation of recommendations for metastatic breast cancer.[54]

Cancer Australia has developed a framework to support the implementation of OCPs and help service planners and policymakers develop strategies to enhance equitable access to care.[49]

What's next?

The integration of OCPs into existing cancer care pathways is a priority within the Australian Cancer Plan, with two-year (2026), five-year (2029) and ten-year (2034) evaluations planned.[49 55] The ambition is that, after ten years, health systems will deliver integrated, coordinated, data-driven and high-quality cancer care, and better outcomes for everyone with cancer in Australia.[49]

Key considerations when adapting this approach

- OCPs must be tailored to underserved populations to reduce inequities in access to care.
- OCPs must be comprehensive and highlight key recommendations for best-practice care along the care pathway, from prevention to end-of-life care.
- An implementation framework to support service planners should also be developed; it should highlight any additional resources that may be necessary to provide equitable access.

Key enablers: workforce capacity, resources

UK: holistic needs assessments enhance tailored care

In the UK, holistic needs assessments and personalised care planning are being embedded into cancer care services to address unmet needs and ensure care is responsive and inclusive.

The challenge

An estimated 3.5 million people in the UK are living with cancer – and rates are increasing.[56] There are gaps in care provision, including in supportive and survivorship care.[57] These challenges underline the need for a range of regular holistic needs assessments (questionnaires for people with cancer that help identify their care concerns and needs) to ensure that services meet the diverse needs of people living with cancer.

What the holistic needs assessments have achieved

In the UK, Macmillan Cancer Support – a charity that supports people affected by cancer– introduced a range of resources to enable personalised care and support planning.[58] These include personalised care and support plans (based on holistic needs assessments), end-of-treatment summaries, cancer care reviews, and health and wellbeing support.[58]

Care planning is facilitated by the completion of a holistic needs assessment. The assessment is discussed with a healthcare professional and converted into a care plan.[59] The assessment allows people with cancer to highlight any concerns – physical, emotional, practical, financial and spiritual. The care plan is co-created with the care team, and helps ensure that care is appropriate, practical and supportive.[58][59] The care plans also provide a reliable record of discussions, decisions and next steps agreed between the person with cancer and their care provider.[58] Macmillan has developed tools and resources to enable healthcare professionals to carry out holistic needs assessments on paper or electronically.[58]

Cancer care reviews provide an additional layer of support, offering people a structured opportunity to reflect on their cancer experience, and access guidance for self-management.[60] The reviews are recommended within three months of diagnosis and again within a year of completing acute treatment.[60] Macmillan has developed guidance and digital templates to help primary care doctors carry out cancer care reviews. These templates have been embedded into the National Health System's (NHS's) general practice IT systems, and they form part of the Quality and Outcomes Framework, demonstrating the importance of cancer care reviews in routine care.[60]

In 2024, Macmillan facilitated 65,000 holistic care assessments for people with cancer, meaning people were able to speak openly with their healthcare professional about their needs and receive a personalised care and support plan.[61]

What's next?

Macmillan continues to provide training and resources to support healthcare professionals, patients and their loved ones with needs assessments, care plans and reviews.[58-60] For broader support, Macmillan recommends involving social prescribers, cancer care coordinators and link workers in primary care practices. These team members could play a vital role in identifying patient needs and connecting them to appropriate information and local support services.[60]

Key considerations when adapting this approach

- Ensure that personalised care and support plans, holistic needs assessments and cancer care reviews tools are adapted to local, cultural and health system contexts. They should promote effective coordination across primary, secondary and community care through clear role definitions and referral pathways.
- Where possible, these tools should be integrated within existing IT infrastructure to support use.
- Establish monitoring systems to track assessment completion, plan development, experiences of the care pathway, and care outcomes.

Key enablers: workforce capacity, resources, digital infrastructure

Brazil: the Propulmão project enhances early detection of lung cancer

In the state of Bahia, a regional initiative is improving access to lung cancer screening in rural and remote populations to support earlier diagnosis among people at high risk.

The challenge

Lung cancer is the third leading cause of cancer-related deaths in Brazil, and annual cases are expected to double by 2025 – to over 88,500.[62 63] Five-year survival rates are low (around 18%); this is attributed to the vast majority of diagnoses (over 85%) being made at a late stage, when treatment options are limited.[64 65] Bahia reports lower survival rates than other states in Brazil.[66] One of the factors associated with these poor outcomes is a lack of access to diagnostic imaging.[67]

What the project has achieved

Recognising the considerable and disproportionate impact of lung cancer in Bahia, in 2013 healthcare practitioners at Hospital Israelita Albert Einstein initiated the Propulmão project.[68] The low-dose computed tomography (LDCT) screening programme aims to detect lung cancer earlier in the state's high-risk populations. Eligibility criteria include people who: are 50 to 80 years of age; currently smoke or have stopped smoking in the past 15 years; have smoked a pack of cigarettes a day for 20 years; and have no lung cancer symptoms.[69]

To overcome issues with access, resourcing and limited infrastructure, and to support the reduced incidence of lung cancer, the Propulmão project:

- deploys a mobile CT unit, along with trained healthcare professionals, to bring scanners to remote communities[69]
- uses telemedicine to enable local healthcare workers to connect with specialists in urban centres and receive real-time assistance with consultations, diagnosis and treatment planning[69]
- has trained 400 community workers (including local leaders and health officials) to provide tailored and targeted outreach to people at high risk of lung cancer, to educate them on lung cancer risks and the importance of early detection and to encourage them to participate in the screening programme[68]

- increases capacity in rural areas by training local healthcare workers in LDCT screening and lung cancer management[69]
- engages in primary prevention activities, including smoking cessation support.[70]

Propulmão also publishes research on screening Brazilian populations; collaborates with life sciences organisations for additional resourcing; and works alongside the Brazilian Unified Health System to create policy tools and processes aimed at healthcare professionals who work in lung cancer screening.[70]

By mid-2024, the programme had registered 4,701 people and screened 1,497. Initial results demonstrate that 63% of people screened were at high risk of developing lung cancer within the next six years.[70] Additionally, in 2024, the Bahia State Health Department announced that anyone diagnosed with lung cancer through the Propulmão project would be guaranteed treatment.[71]

What’s next?

The project is being studied as part of the Brazilian Early Lung Cancer Detection Trial (BRELT3), to assess the challenges associated with implementing screening programmes for lung cancer in resource-limited, rural settings.[69]

It is the hope that lessons from the programme can be used to provide a blueprint for a national screening programme.[68]

Key considerations when adapting this approach

- When designing a screening programme, barriers to uptake in communities need to be identified and planned for – for example, by using mobile scanning equipment, upskilling community workers and providing direct connections between rural healthcare facilities and large urban centres.
- Investment is needed to build local capacity for the regional application of screening programmes; it is integral to successful implementation.

Key enablers: resources, workforce capacity (including engagement with community workers)

Canada: innovative models of cancer care help underserved communities

Canada is advancing equitable, person-centred cancer care by developing and scaling innovative models of service delivery that bring care closer to underserved communities.

The challenge

Cancer is the primary cause of death in Canada, and two in five Canadians are expected to receive a diagnosis in their lifetime.[72] Delivering equitable, person-centred cancer care remains a challenge, particularly for rural, remote, Indigenous and marginalised communities.[73-75] These populations often face travelling long distances, limited access to specialists, and systemic inequities that hinder timely access to care.[74 75]

What the care models have achieved

To address these barriers, the updated Canadian Strategy for Cancer Control (2019–2029) focuses on sustainable and innovative care models.[76] In 2022, the Canadian Partnership Against Cancer invested CAD 13 million in innovative models of care across the country.[77] One of these projects, the Models of Care Toolkit, aims to foster efficient, person-centred cancer care by improving collaboration with primary care, optimising cancer team roles and leveraging networks to provide care closer to home.[77 78]

Between 2023 and 2024, the Canadian Partnership Against Cancer supported 19 projects across 10 provinces and territories. For example:[79]

- In Alberta and Quebec, transfer-of-care letters were made available with cancer-specific information outlining what to expect from follow-up care from primary care providers, following active treatment. The letters also signpost people to resources and contacts for additional information. Having these letters in place supports communication between people with cancer and primary care providers.[79]

- In Quebec, personalised support guides were implemented in select regions to enhance communication between people with cancer and their healthcare providers. The guides led to 84% of participants reporting feeling safe to manage their own care after treatment.[77]
- In the Northwest Territories, virtual health technologies enable people to access specialist oncology services without leaving their communities.[79]
- The Adolescents and Young Adults with Cancer Oncofertility Initiative is expanding nationwide to offer vital fertility preservation information and support to people aged 15 to 39.[79]

What's next?

The Canadian Partnership Against Cancer's continued knowledge-sharing through the Models of Care Toolkit and new survivorship resource hub ensures that partners all over the country can adopt, adapt and sustain these approaches.[79] Additionally, the progress of the Strategy for Cancer Control will be tracked through collaborative data collection, target-setting and annual reporting, with a commitment to respectful engagement and data governance with Indigenous communities.[80]

Key considerations when adapting this approach

- Health system decision-makers must assess how cancer care models should be tailored to address inequities among underserved populations.
- To ensure the sustainability of interventions and support continued implementation, models of care must also collect cost-effectiveness data.
- Virtual care and patient navigation should be employed as part of care models to overcome geographical barriers to accessing cancer care.

Key enablers: resources, digital infrastructure, workforce capacity

US: co-creating patient navigation programmes for breast cancer

In Boston, Massachusetts, a patient navigation programme has been implemented to reduce delays in breast cancer care among underserved populations and to improve equity of access to care.

The challenge

Breast cancer is the most common cancer in the US, and there are major disparities in outcomes between different ethnic and socioeconomic groups.[81-83] These inequalities are present in Boston, where analyses found that Black non-Hispanic women and people on state-funded Medicaid insurance were two to three times more likely than insured White people to experience delays of more than 60 days from the diagnosis of breast cancer to the initiation of treatment.[84]

What the patient navigation programmes have achieved

Recognising these disparities in care, the Translating Research into Practice (TRIP) trial was initiated in five hospitals in Boston, with the aim of implementing interventions to reduce delays in breast cancer care in underserved groups.[84 85] The trial was co-designed with breast oncology patient navigators, healthcare supervisors, and medical and surgical oncology representatives to ensure usability and feasibility.[84 86] Populations who experience the longest delays in care and worse outcomes were eligible for the trial;[84] they include people who are Black, Hispanic, do not speak English as their primary language, and/or are on public health insurance (Medicare or Medicaid).[84]

To combat disparities and delays in care, TRIP used the following interventions: patient navigation services; a shared patient registry across academic medical centres; and a web-based social determinants of health platform.[84]

Patient navigators in the programme are responsible for a wide range of tasks, including:[85]

- management activities (e.g. identifying people eligible for the scheme, tracking them and monitoring caseloads)
- direct patient contact (e.g. social needs assessments, accompanying patients to medical visits, counselling, education)
- clinical supervision
- quality assurance.

In one year, the programme: helped 63 people with breast cancer receive timely care; reduced the number of emergency room visits by over 50%; reduced rates of hospitalisation by 70%; and increased the percentage of patients receiving timely treatment by 13%.[85] TRIP resulted in per-person savings of USD 21,798–30,429 thanks to reduced hospitalisations, and USD 2,536–5,692 in reduced emergency room visits.[85]

What's next?

Boston Medical Center has developed a toolkit for implementing a patient navigation programme, drawing on a variety of resources and insights from the TRIP trial.[87] These include social needs assessments, training and support, quality monitoring frameworks, evaluation strategies and cost surveys.[87] It is hoped that these resources will be used to set up similar programmes to combat the ongoing disparities in cancer outcomes throughout the US.[87]

Key considerations when adapting this approach

- Registry data are key to monitoring and evaluating the needs of underserved communities, understanding the scale of disparities in care, and identifying bottlenecks that may be preventing better outcomes.
- Implementing patient navigation programmes is critical for quality assurance, and for managing and monitoring caseloads.
- Co-designing interventions with people who will be responsible for executing services, or with service users, is essential to ensure feasibility, usability and acceptability.

Key enablers: resources, workforce capacity

Australia: co-designing a national screening programme for lung cancer

Australia has implemented a national screening programme for lung cancer to combat the rising rates of cancer mortality. The programme has a strong focus on equity and co-design with Aboriginal and Torres Strait Islander peoples.

The challenge

Lung cancer is the leading cause of cancer-related deaths in Australia, and the incidence of lung cancer is expected to rise by more than 70% between 2022 and 2050.[88 89] Survival rates remain low; only 27% of people diagnosed between 2017 and 2021 survived for over five years.[90] Lung cancer disproportionally affects certain Australian populations; Aboriginal and Torres Strait Islander peoples are over twice as likely than the general population to be diagnosed with lung cancer, and almost twice as likely to die from it.[91] People living in rural and remote locations also experience worse outcomes; lung cancer incidence is 31% higher and survival rates are 12% lower than in people living in metropolitan areas.[92]

What the screening programme has achieved

Screening of high-risk populations using low-dose computed tomography (LDCT) has been shown to reduce mortality due to lung cancer and to increase survival.[93] In 2023, based on a series of enquiries and recommendations, the Australian government announced an investment of AUD 263.8 million to establish a national screening programme for lung cancer.[94] The programme, which was officially launched in July 2025, targets people in high-risk populations who: are 50 to 70 years of age; show no signs or symptoms of lung cancer; currently use or have used tobacco in the past 10 years and smoked the equivalent of one pack per day for 30 years.[94 95]

The screening programme was co-designed with representatives from Aboriginal and Torres Strait Islander peoples, led by the National Aboriginal Community Controlled Health Organisation (NACCHO).[96] To ensure uptake among the target population, NACCHO has:[96]

- developed tailored information and materials
- partnered with other Aboriginal health organisations to assess the most appropriate implementation strategies
- co-designed clinical materials, including guidelines, protocols and data governance
- developed programme information, including customised communication and training materials, to ensure that it is culturally safe and meets community needs.

Aboriginal and Torres Strait Islander peoples are also represented in the Program Advisory Group and the Expert Advisory Committee, which guide the development and implementation of the programme.[96]

As well as embedding co-design into the development of the programme to ensure acceptability, screening services – including mobile CT screening trucks and travel support – are made available for people in rural, remote and very remote areas.[97]

It is estimated that the programme will save more than 12,000 lives by 2035.[95]

What's next?

The Australian Institute of Health and Welfare is monitoring the programme; its first report is due to be published in June 2027.[97] The Department for Health, Disability and Ageing is developing a quality improvement programme to ensure continuous refinement of the screening programme.[97] Cancer Australia is also leading a research project to help adapt and integrate new evidence and technologies into the programme.[97]

Key considerations when adapting this approach

- It is important to co-design screening programmes, implementation strategies, guidelines and protocols with communities who are disproportionately affected by the disease, to ensure that all measures are culturally safe.
- Quality improvement processes should be implemented alongside screening programmes to ensure the ongoing acceptability of services and to allow for iterative improvements.

Key enablers: resources, workforce capacity

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