Person-centred cancer care

improving outcomes, experiences and efficiency

2026

All.Can Changing cancer care together

All.Can International is a not-for-profit organisation (ASBL) registered in Belgium. The person-centred cancer care pathway project is made possible with financial support from Bristol Myers Squibb, Roche, MSD, Johnson & Johnson, Pfizer, Illumina, Daiichi Sankyo and Astellas.

About this report

This report demonstrates that implementing a person-centred approach to cancer care improves outcomes and experiences for people living with cancer and beyond, and makes more efficient use of healthcare resources. It offers practical recommendations for policymakers, decision-makers and health system leaders, which could be adapted to local country or regional contexts, health system maturity levels and funding structures.

This work is based on a structured review of peer-reviewed and grey literature from 2018 to 2025, supported by insights from the All.Can Person-centred Cancer Care Pathways Taskforce and 18 expert interviews/written responses to a questionnaire. The interviews were conducted with cancer clinicians and advocates in Australia, Belgium, Bulgaria, Canada, India, Ireland, Malaysia, Sweden, the UK, the US and a representative from a global cancer organisation based in Switzerland.

Analysis and drafting were led by Emily Medhurst, Laura Habashi and Eleanor Wheeler, and editorial support was provided by Kasia Trojanowska, Mo Forman and Lisa Hillman, all at The Health Policy Partnership (an independent specialist health consultancy supporting All.Can). Design is by Jumpingstone. Draft outputs were shared with expert contributors and the All.Can Person-centred Cancer Care Pathways Taskforce members for their feedback and final approval.

For a full list of contributors, see page 47.

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Foreword

Cancer has a considerable and increasing impact on individuals, health systems and wider society – it demands urgent policy action. The number of people with cancer is rising rapidly and will challenge already overstretched health systems.

Together with the All.Can Person-centred Cancer Care Pathways Taskforce, we have developed a report which provides a robust evidence base to make the case for urgent political prioritisation of person-centred cancer care. Our findings show that investing in person-centred cancer care – delivered through national and regional cancer control plans – offers multiple benefits: better outcomes, improved experiences of care and more efficient use of healthcare resources. Using resources in ways that matter most to people living with and beyond cancer ensures care is more sustainable (thus lowering pressures on health systems), while also improving their outcomes.

It is vital to prepare now to build a future of high-quality and efficient cancer care. We invite decision-makers to use this report as a catalyst for change. We urge you to build person-centred cancer care pathways that save lives, reduce inequities and meet the needs of every person affected by cancer.

Christobel Saunders,
All.Can President, Melbourne
University, Australia

Eduardo Pisani,
CEO, All.Can International, Belgium

Executive summary

Cancer is placing an increasing strain on individuals, health systems and society, making it vital to redefine how cancer care is provided. The number of new cancer diagnoses is projected to rise by almost 77% between 2022 and 2050, which will strain already overstretched health systems.[1] Many countries cite limited access to treatments, staff shortages and long wait times as the biggest challenges to their health systems.[2] It is therefore essential that health system leaders, decision-makers and policymakers redefine their approach to providing cancer care to use limited resources effectively and ensure access to high-quality cancer care.

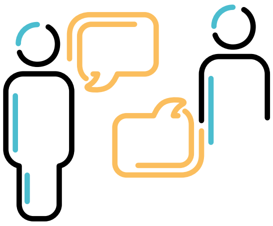
Person-centred cancer care offers a practical, high-impact route to better experiences for people and greater system resilience. Person-centred cancer care orientates care around individual needs, values and goals, rather than a universal clinical pathway; it is an essential component of equitable and responsive care, and can also ease pressures on health systems.[3-5] Approaches such as precision medicine and strengthened clinician–patient communication, among others, enable personalised care that improves effectiveness while reducing unnecessary interventions.[3 6]

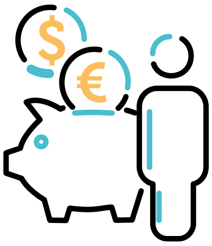
How can policy- and decision-makers improve provision of person-centred and efficient cancer care?

Decision-makers must treat person-centred cancer care as a strategic priority to achieve more resilient health systems and better lives for people affected by cancer. National and, where relevant, local cancer control plans must include interventions that support person-centred and efficient cancer care. This should be underpinned by adequate financing, and ideally co-designed with people who have lived experience of cancer, including structurally underserved communities and people disproportionately impacted by cancer (*Table 1*).

Table 1. All.Can policy checklist for person-centred and efficient cancer care pathways

Current health system challenges	Person-centred cancer care interventions	Opportunities for policy action
Globally, there are considerable delays in cancer diagnoses. Early detection is hampered by poor health literacy and screening uptake, and limited downstream resources that hinder timely access to treatment.	1. Enable swift and effective diagnosis with timely initiation of care	• With target populations, co-create information materials on cancer symptoms, the importance of early detection and health-seeking behaviours. • Implement cancer screening programmes that have been co-designed with target populations and, where appropriate, utilise alternative screening methods (e.g. self-sampling). • Ensure healthcare professionals have the resources and support to implement rapid investigation pathways for suspected cancer, with appropriate resourcing to ensure diagnostic laboratory capacity is increased. • Prepare health system capacity for the integration of precision medicine to ensure access to innovative therapies and the selection of the most effective treatment options. • Implement cancer care pathways that align to globally recommended standards of care to reduce time from diagnosis to treatment.
The use of coordinated, multidisciplinary care is limited. This results in delays, variable care provision, worse clinical outcomes and poor care experiences for people affected by cancer.	2. Provide coordinated and multidisciplinary cancer care	• Implement patient navigation programmes, enhanced through the use of peer navigators and navigation software, to ensure people with cancer are supported and guided through complex cancer care. • Provide all people with cancer with access to a multidisciplinary team, offering clearly explained options for treatment that respects the preferences and needs of the person. • Involve integrated primary care teams throughout the care pathway to ensure people with cancer are fully supported and experience continuity of care. • Where possible, implement comprehensive cancer centres to provide cancer care that is research-led, high-quality and specialist. • Utilise hub-and-spoke models of care to ensure everyone has access to comprehensive cancer care.

Current health system challenges	Person-centred cancer care interventions	Opportunities for policy action
High-quality cancer care is hindered by stretched workforce capacity, poor data collection practices and limited interoperability between systems.	 3. Optimise processes using digital technologies in the care pathway	- Prioritise the development and implementation of interoperable data infrastructure (including electronic medical records), and establish and adopt universal data-sharing standards within and between countries. Standards should include data collection, analysis, reporting and governance. For care continuity, data should be securely shared with all associated primary, secondary and tertiary care services. - Establish national cancer registries and use reference networks to link them to other registries and data sets, to enable cross-border collaboration; and work with healthcare professionals and people with cancer to ensure key data are captured and shared, such as staging and metastases data. - Explore the integration of AI tools along the care pathway to improve workflow efficiency and workforce capacity. - Implement digital tools training for healthcare professionals and managers, including on the importance of consulting people with cancer on their preferences regarding the use of digital tools.
Use of technologies facilitating access to remote care is not optimal; there are barriers for certain groups (such as people with poor digital literacy) and lack of resources to obtain and use technologies, such as for people in rural and remote communities.	 4. Incorporate remote and telemedicine care approaches in the cancer care pathway	- Ensure that infrastructure (such as broadband connectivity) is in place to facilitate equitable access to telehealth. - Provide corresponding training for people with cancer to improve digital literacy. - Promote the use of wearable technologies and apps for remote monitoring, and invest in making them available through the health service or by providing subsidies for their use.
Communication is consistently ineffective between people with cancer and healthcare professionals, and around cancer-related information. This creates feelings of mistrust and discontent with care provision.	 5. Facilitate effective communication and shared decision-making for cancer care plans	- Empower healthcare professionals to use shared decision-making at all stages of the care pathway (following validated frameworks/models) to ensure the needs and preferences of the person with cancer are central to all care decisions. - Co-design the standardisation and implementation of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) based on the valued expertise of people with lived experience. - Collect PROMs/PREMs throughout the care pathway to evaluate outcomes that matter to people with cancer and their personal experiences of care, and use these to iteratively improve cancer care services while ensuring people feel involved and listened to. - Provide training to healthcare professionals (integrated in medical curricula, webinars, seminars) on culturally appropriate and safe communication, and involve carers in discussions, to improve trust and engagement in the health system.

Current health system challenges	Person-centred cancer care interventions	Opportunities for policy action
Globally, survivorship and supportive care is lacking, leading to avoidable deficits quality of life.	 6. Incorporate supportive care and survivorship approaches in the cancer care pathway	• Embed supportive and survivorship care along the care pathway, based on globally recognised recommendations, ensuring carers' needs and advance care planning discussions are included. • Provide training opportunities for healthcare professionals to effectively deliver supportive and survivorship care throughout the care pathway. • Invest in digital and telehealth technologies that can enable remote access to supportive and survivorship care and reduce geographical barriers to care.
Many people with cancer experience barriers to accessing vital cancer care due to its high costs and limited financial support.	 7. Provide financial advice and support to people living with cancer and their loved ones	• Reimburse cancer treatment and medications to ensure equitable access to high-quality cancer care. • Use managed entry agreements to ensure access to innovative cancer treatments while limiting payer risk. • Provide financial navigation services to reduce the financial burden of a cancer diagnosis. • Provide support, through subsidies and stipends, to address the indirect costs of cancer.

Why is person-centred cancer care vital?

Despite the significant human and economic toll of cancer, few countries are prioritising basic management. New cancer diagnoses are projected to exceed over 35 million globally by 2050, almost a 77% increase from 2022.[1] Between 2020 and 2050, the cost of cancer to the global economy is estimated to be USD $25 trillion.[7] Despite this projected impact, a World Health Organization (WHO) global survey found that only 39% of countries provided funding for basic cancer management.[8]

Disparities in access to cancer care and widening gaps in outcomes are already apparent in overstretched health systems; resource limitations make efficient care crucial. Globally, significant resource limitations are affecting cancer care.[9] In a survey of 30 countries, over 40% cited limited access to treatments, staff shortages and long wait times as the biggest challenges to their health systems.[2] These issues can cause diagnostic and treatment delays, and – ultimately – poor outcomes. To address these challenges, the delivery of cancer care must be managed more efficiently (*Box 1*).

Box 1. What is efficient cancer care?

Efficient cancer care delivers the best possible health outcomes using the available resources in a way that focuses on what really matters to people living with the disease and society. All.Can has defined eight metrics for cancer care efficiency:[10]

1. Time to diagnosis
2. Percentage of patients documented as having seen a clinical nurse specialist
3. Percentage of cancers diagnosed through emergency presentation
4. Percentage of patients who received chemotherapy in the last 14 days of life
5. Primary care interval (the number of days from the date of the first presentation with symptoms in primary care to the final cancer diagnosis date)
6. Patient experience
7. Time from tissue diagnosis to treatment
8. Patient involvement in decision-making.

Ensuring that cancer care is person centred would improve experiences of care while also making care more efficient. Person-centred cancer care (*Box 2*) focuses on an individual's needs, values and goals; it respects their preferences and facilitates their involvement in care through communication with healthcare professionals.[3] It also improves the quality and timely provision of health services, so people can access care when and where they need it.[4] Person-centred cancer care boosts people's satisfaction with their care, improves outcomes and reduces pressure on health systems by making the best use of available resources.[4 11]

Box 2. What is person-centred cancer care?

Definitions of people-centred cancer care vary, but the WHO defines it as:[12]

- an approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care.

Person-centred care should comprise the following key elements:[3-5 11 13-15]

- respect for people's goals, values, physical and emotional preferences and needs
- care that is acceptable, affordable, accessible and appropriate
- healthcare professionals who are approachable and compassionate
- principles that honour equality, diversity and inclusion
- the prioritisation of a person's societal and personal connections
- strong communication between healthcare professionals and patients
- interventions that prioritise structurally underserved communities.

Provision of person-centred cancer care is currently limited, despite global recognition of its importance. Person-centred approaches to care are recognised as the bedrock of quality cancer control but are not being consistently utilised, particularly in low-income settings.[16] Despite the WHO adopting a framework on integrated people-centred health services in 2016,[17] health systems continue to operate based on traditional models of cancer care. These models focus primarily on biological causes and can overlook the psychosocial factors that influence illness and recovery,[18] which disempowers people with cancer and distances them from their healthcare professional(s). Such fragmented relationships can result in limited knowledge of the person's values, care needs and preferences.[19]

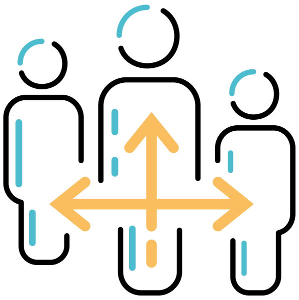
Governments must urgently invest in person-centred cancer care pathways to deliver better experiences and greater value from scarce resources. Cancer incidence and costs risk rising unless systems shift away from paternalistic care to person-centred care, ensuring that the person is at the centre of the care pathway and that their care allows them to thrive.[19] This shift requires funding; in 2023, a global analysis found only 27% of cancer plans had appropriate financing strategies.[20] National cancer control plans should also be co-designed with people who have lived experiences of cancer. Aligning national and local cancer plans with this approach, as called for in the Union for International Cancer Control's World Cancer Declaration 2025–2035, will improve service uptake, equity and system efficiency while delivering care that meets the needs of all populations.[4 5]

> Person-centred care is about having people with cancer in the driver's seat [...] As scientists, we have a role as facilitators to ensure people get the care they need in the right way, at the right time and in a way that meets their priorities.
>
> Dr Ambreen Sayani, Women's College Hospital, Research and Innovation Institute, Toronto; and Dalla Lana School of Public Health, Canada

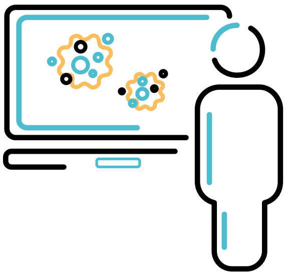
> Person-centred care is how experiences and outcomes may be maximised for that person within the constraints of the health system.
>
> Dr Susannah Morris, Health Consumer Advocate, Australia

This report presents solutions to implement better person-centred cancer care along the care pathway.* Building on the elements of person-centred and efficient cancer care identified by All.Can, these include the following steps:

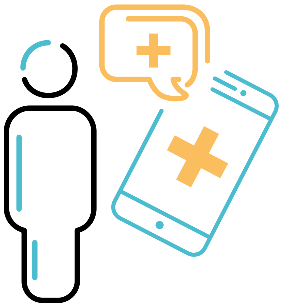
1. Enable swift and effective diagnosis with timely initiation of care



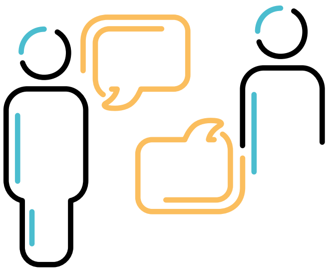
2. Provide coordinated and multidisciplinary cancer care



3. Optimise processes using digital technologies in the care pathway

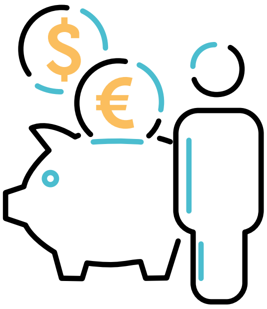


4. Incorporate remote care and telemedicine care approaches in the cancer care pathway



5. Facilitate effective communication and shared decision-making for cancer care plans

6. Incorporate supportive care and survivorship approaches in the cancer care pathway



7. Provide financial advice and support to people living with cancer and their loved ones.

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*Prevention and risk reduction strategies are not discussed due to the focus on the care pathway; however, we recognise the importance of these factors in establishing person-centred care.

Step 1.

Enable swift and effective diagnosis with timely initiation of care

Early detection, diagnosis and timely treatment of cancer are vital to improving outcomes, but late-stage diagnosis is a global problem. The earlier cancer is diagnosed, the greater the chances of survival.[21] Globally, however, some of the most prevalent cancers are diagnosed late; almost 70% of lung cancers and over 60% of cervical cancers are diagnosed at an advanced stage.[22,23] Earlier diagnosis and treatment initiation also confer healthcare efficiencies – for example, fewer invasive investigations and better treatment outcomes – which can lower healthcare costs while improving quality of life for people with cancer.[21,24]

Early detection efforts are hampered by poor health literacy, limited screening uptake and insufficient primary care support for referrals. Although many countries offer population-based and targeted cancer screening programmes, participation rates are often low.[25] Limited cancer symptom awareness – both among healthcare professionals and the public – exacerbated by poor health literacy, can reduce self-referral and delay diagnosis.[26] Even people who recognise cancer symptoms may not seek care.[21] As primary care practitioners are often key facilitators of access to care, it is vital they receive the knowledge and support they need to expand diagnostic access, and ensure a swift and effective cancer diagnosis.[27]

Opportunities for change

Making cancer information more appropriate

Understanding how general health literacy affects cancer knowledge among the public is key to ensuring information materials are appropriate and effective. Poor knowledge of cancer symptoms among the general public, low health literacy and widespread misinformation can drive possible reliance on unproven and ineffective interventions, at the expense of proven therapies.[26,28] To counter this, informative resources must be tailored, accessible and culturally safe to meet the diverse informational

> The same complaint I hear from every country is that they diagnose pancreatic cancer very late because there is no awareness among the general population or general practitioners.
>
> Professor Alfredo Carrato,
> Pancreatic Cancer Europe, Spain

needs of people with cancer and carers in a multilingual, multicultural society.[29] Patient organisations and cancer groups can help to fill this gap and dispel misinformation by directing people to high-quality, research-based information about cancer.[28]

Information materials about recognising cancer symptoms early can be more effective when they are developed in a person-centred and culturally appropriate way. Participatory methods, such as co-design and community interviews, can be used to ensure information meets the needs of its intended audience.[29] Ensuring resources are multilingual, respect cultural considerations, and are straightforward to navigate and easily accessible (e.g. on the internet) is also important to encourage engagement with health services.[29] In Lebanon, a video awareness campaign used a baker kneading bread to demonstrate how to conduct a breast self-exam; the campaign promoted awareness of breast cancer symptoms in a culturally appropriate way, avoiding cultural taboos and social media restrictions around showing breasts.[30]

Making screening for cancer more appropriate and accessible

Screening offers an opportunity to diagnose cancer early in people with no symptoms, but varied delivery and limited uptake impact its effectiveness and efficiency. There is global variation in the provision of screening programmes for cancer (breast, prostate, cervical, colorectal, lung, stomach).[25 31] When well-implemented, these programmes can be instrumental in detecting cancer earlier while also being cost-effective.[32 33] However, barriers to uptake include poor public and clinician awareness of programmes, cultural taboos around screening, socioeconomic position, costs and travel requirements.[25 34]

Involving people with lived experience in designing screening programmes, and integrating community health workers into services, can support uptake by using personalised approaches. As with communication about cancer symptoms, using tailored outreach materials which address cultural concerns around screening, as well as educating frontline and peer workers, can encourage uptake (*Case study 1*).[35] Community health workers can also facilitate outreach to different population groups, for instance, by providing direct communication about cancer screening; in one study, this approach resulted in an 82% increase in likelihood of participation.[36] Co-designing screening programmes with the target population (especially underserved communities) makes programmes more acceptable and accessible.[37 38] In Toronto, for example, cancer screening services were co-designed with target ‘equity-deserving’ populations to ensure cultural appropriateness, and that information materials were tailored to the population and available in a range of languages.[38]

Case study 1.

Increasing the uptake of breast cancer screening in rural Mongolia

Breast cancer screening uptake is suboptimal in the Arkhangai province in rural Mongolia, with only 59% of the eligible population presenting for screening in 2022.[39] This is partially attributed to poor knowledge and awareness, as 60% of surveyed women responded incorrectly to a survey on knowledge about breast cancer.[39]

Recognising this obstacle for screening uptake, the breast cancer project team at the Union for International Cancer Control collaborated with the Mongolian Department of Health, general practice clinics, community health centres and local media to develop educational materials and strategies to address knowledge barriers and improve uptake. This included:[39]

- educating 433 healthcare professionals and volunteers on clinical breast exams and effective referrals
- co-developing educational materials and strategies based on the barriers identified in surveys of the target population
- providing navigation services to ensure suspicious findings were effectively managed and followed up.

These strategies resulted in just over 98% of the eligible population undergoing screening by the end of 2024.[39] More than 115 women had suspicious findings and were navigated to secondary and tertiary hospitals for further investigations.[39] This resulted in four stage II diagnoses and two stage III diagnoses, with the average diagnosis interval being 40 days.[39]

> If we were more person-centred in our approach, people may be more likely to engage with screening or to be investigating symptoms and catching cancer earlier.
>
> Dr Susannah Morris, Health Consumer Advocate, Australia

Alternative screening models can make screening more accessible, particularly to underserved communities. Shifting away from a centralised approach can help to address barriers to screening. For example, combining multiple screenings into one visit or with other routine health services, such as vaccination programmes, can reduce the amount of travel required of people.[40] Remote screening models – such as mobile scanners and local sample collection, including self-sampling (where people retrieve their own biological samples) – can also help facilitate screening by empowering people to manage their own healthcare and by reducing cultural taboos associated with certain types of screening.[41-43]

Reducing time to diagnosis

Speed and accuracy of diagnosis significantly impact a person's experience of care but are often hindered by system inefficiencies. In its international cancer patient survey, All.Can found that obtaining a diagnosis was the most inefficient part of the care pathway, with 32% of participants reporting that their cancer was misdiagnosed when detected outside of a screening programme.[44] Delays to obtaining an accurate diagnosis can be caused by limited laboratory capability and capacity, a lack of imaging availability, limited or untrained workforce, management of referrals outside of standardised pathways, managing comorbidities, and the need for additional imaging or investigations.[45-47] Delays in diagnosis result in treatment delays, which in turn can cause deterioration in health, increased anxiety and worry as well as being subjected to additional pain and procedures.[48]

Consistent implementation of dedicated rapid investigation pathways offers an opportunity to minimise harm and achieve an accurate diagnosis. Investment in the diagnostic capability of health systems is needed to implement more person-centred approaches to diagnosis – including rapid investigation pathways. However, to be executed effectively, such pathways require a suitable workforce and infrastructure. Investments to achieve this could include:

- adequate resourcing and infrastructure to support the potential future use of molecular diagnostics (using early cancer biomarkers to detect cancer before symptoms appear)[24]
- dedicated community-based rapid diagnostic centres[†] to enable fast diagnosis in local healthcare settings and to increase system capacity: for example, a lung cancer rapid investigation clinic in Canada reduced diagnosis time by 14 days compared with people not diagnosed through the clinic (26 days vs. 40 days)[49]
- standardising radiology reporting and direct communication of results to improve follow-up of suspicious imaging[50]
- increasing diagnostic laboratory testing capacity to ensure that people receive their results in a timely manner[51]
- implementing a 'chain of custody' for diagnostic tests, including electronic tracking, to ensure timely referral, delivery and communication of results of all diagnostic procedures.[50]

[†] Specialist locations and/or programmes where people with suspected cancer undergo a variety of diagnostic tests within a set time period to achieve a fast diagnosis.

Cutting down time to treatment after a diagnosis

There can be significant delays in starting treatment, which can have devastating consequences for people living with cancer. Prompt treatment increases the availability of curative care, and improves patient satisfaction and outcomes.[52] Every four weeks that surgical treatment is delayed is associated with significant psychological distress and a 6–8% greater risk of death.[47 53]

Adequate resourcing and defined pathways can expedite effective and personalised treatment. Building appropriate health system infrastructure – including a multidisciplinary team, guideline-aligned care pathways (*Case study 2*) and localised care – can help treatment be initiated promptly. The use of innovative therapy approaches, such as precision medicine (*Box 3*), can also ensure that treatment is as effective as possible, personalising approaches to minimise adverse events and improve survival.[54]

Case study 2.

Use of care pathways to reduce time to treat in Norway

In 2015, Norway introduced cancer care pathways to reduce the delay between diagnosis and treatment.[55] The pathways also aim to increase care satisfaction while improving its quality and consistency.[56]

The pathways resulted in shorter waiting times from diagnosis to treatment, including:

- 14–50 fewer days waiting for radiotherapy for people with colorectal, lung or prostate cancers[55]
- 7–36 fewer days waiting for surgery for people with lung or prostate cancers.[55]

People with cancer reported that the pathways increased their trust and sense of safety in the health system.[57]

Box 3. Precision medicine

Precision medicine tests biomarkers (unique genetic signatures that represent how cells work and react) in a person's body and in cancer cells, to identify which treatments are most likely to work for the individual.[6] It results in better outcomes, enhances efficiency of care and improves wellbeing.[6]

Policy recommendations

To ensure swift and effective cancer diagnosis and timely initiation of care, the following person-centred approaches are recommended:

- With target populations, co-create information materials on cancer symptoms, the importance of early detection and health-seeking behaviours.
- Implement cancer screening programmes that have been co-designed with target populations and, where appropriate, utilise alternative screening methods (e.g. self-sampling).
- Ensure healthcare professionals have the resources and support to implement rapid investigation pathways for suspected cancer, with appropriate resourcing to ensure diagnostic laboratory capacity is increased.
- Prepare health system capacity for the integration of precision medicine to ensure access to innovative therapies and the selection of the most effective treatment options.
- Implement cancer care pathways that align to globally recommended standards of care to reduce time from diagnosis to treatment.

Hannah’s story: managing multiple cancer diagnoses

I received my first cancer diagnosis through a breast clinic. I had to push slightly to get a timely appointment to confirm my diagnosis of breast cancer, but after that everything moved quite swiftly. I was even offered participation in a clinical trial, which is almost unheard of that soon after a diagnosis.

After completing my treatment I was cancer free for several years – but I then had a swelling in my armpit and had to go through the arduous referral process via my general practitioner to have more investigations at the breast clinic, which didn’t show anything of concern. Fortunately, staff at the clinic gave me a direct contact to them, ensuring I didn’t have to circumnavigate the entire health system to access them.

I then found a lump in my neck, which was initially believed to be a regional recurrence. However, after a lot of scans of my whole body, I received a diagnosis of stage IV breast cancer the day before I was meant to begin chemotherapy for the recurrence.

My cervical cancer diagnosis was made through routine screening while I was undergoing treatment for the stage IV breast cancer. It was removed entirely through a biopsy, and the liaison between the gynaecology cancer clinic and my breast oncologist meant all my treatment transitions were smooth and I could continue my other cancer treatment as normal.

I was given a contact number for the cancer centre navigator hub, which I can ring up at any time to ask questions. While managing different diagnoses, I was given clear information on how new diagnoses affected my treatment. I was sometimes a bit overwhelmed with the amount of information I was provided with, but I trusted in my doctors to provide me with the best care possible.

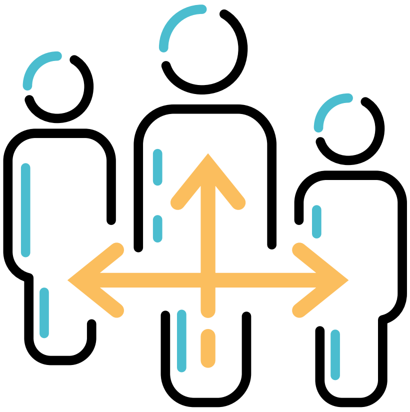
I have had some issues with having scans while I had a port (an implant with a line directly into my vein). I received mixed messages from different members of the healthcare team as to whether I would be able to have the scan while having the port.

I’ve had the same breast oncologist throughout all my diagnoses and treatments, and the relationship we have fostered has made managing my cancer so much easier. I trust him with my care, and I feel heard and listened to at every appointment. I have also been given the opportunity to change my chemotherapy times and dates to fit around mine and my loved ones’ schedules. I also regularly see and talk to the breast care nurses; they support me through every appointment, going out of their way to make sure I understand everything. I know I can always call them and they will get back to me with all the support I need.

Name and specific details have been changed to protect anonymity. This is an individual’s personal experience and not medical advice.

Step 2.

Provide coordinated and multidisciplinary cancer care



Coordinated and multidisciplinary cancer care helps people receive high-quality disease management that responds to their needs. Cancer care often requires multiple visits to different providers, settings and departments, making coordination vital. Effectively coordinated cancer care that guides and supports a person with cancer through the care pathway ideally should also include a multidisciplinary team. By not placing the onus of coordination on the person, coordinated care improves adherence to treatment plans, encourages timely referrals, reduces stressors on the health system, and positively impacts the person's physical and psychosocial health.[58] It also improves efficiency by minimising time lost due to unnecessary medical appointments and tests, resulting in economic benefits.[59]

There remain many challenges in providing effective care coordination for people with cancer, leading to inefficiencies and dissatisfaction. Despite its importance in facilitating person-centred cancer care, effective care coordination remains limited.[60] Often, people with cancer and their carers manage their own care coordination, to the detriment of their quality of life and work productivity, and leading to potentially worse outcomes.[59 60] Even in systems with formalised multidisciplinary care, care coordination is often minimal and ineffectual.[58]

Opportunities for change

Care coordination with a patient navigator

Patient navigation can improve coordination of care, with benefits extending to experience and outcomes throughout the care pathway. Patient navigation is a form of formalised support that guides a person through the cancer care pathway and minimises barriers to accessing care.[61] It improves quality of life, increases satisfaction with care and reduces hospital admissions.[62] Such services may be provided by peer navigators (non-clinical staff) or nurse navigators.[61] These roles can: signpost people to relevant resources (such as possible clinical trials to participate in); act as a point of contact and source of information and emotional support (*Case study 3*); assist with sharing and interpreting test results; and help manage side effects.[61] Patient navigators can be supported through the use of navigator software to help track, follow up and organise administrative tasks.[63]

Patient navigation enables efficient and person-centred cancer care as it:

- guides people efficiently through a complex health system; for example, by scheduling appointments across multiple departments[64]
- provides culturally sensitive health information, facilitating informed and participatory care[65]
- enhances patient and carer quality of life, through improved care satisfaction and reduced hospital admissions[62]
- provides cost savings for the health system – as seen in a Boston (US) patient navigation programme that reduced hospitalisations by 70%, saving the health system up to $30,429 per person.[66]

Case study 3.

Using peer cancer navigation to reduce health inequities in Quebec, Canada

Recognising the importance of improving the care experiences of people living with cancer and enhancing efficiency of care, the Canadian Institute of Health Research and Quebec's cancer directorate introduced the PAROLE-Onco programme in 2019.[67] This programme integrated 'accompanying patients' (peer navigators) as part of the clinical team to:[67]

- help facilitate tailored and effective communication between people with cancer, their loved ones and their healthcare team
- act as a liaison between different parts of the health system
- inform clinical teams about the unique needs of the person
- alleviate administrative workload of oncology care teams
- increase sensitivity toward the person's experiences.

A key element of the programme is that the accompanying patient is a non-clinical person with a direct experience of cancer.[67] This helps to break down communication barriers that are often experienced by people with cancer and clinical staff. Accompanying patients have been shown to reduce health inequities, especially for people from socioeconomically disadvantaged backgrounds.[67]

Championing an integrated and informed multidisciplinary approach to care

Multidisciplinary team meetings need to centre the preferences and needs of the person with cancer to ensure care recommendations are acceptable to them. Multidisciplinary care is often guided by multidisciplinary team meetings, where specialists gather to discuss and review cases, making recommendations for care management.[58] These meetings should involve a variety of healthcare professionals, such as oncologists, surgeons, physiotherapists, pathologists, radiographers, nutritionists, occupational therapists, and speech and language therapists.[68] However, the needs of the person whose care is being discussed are often overlooked,[69] despite a variety of mechanisms that can prevent this, including:

- consulting the person on their needs and preferences in advance to inform care decisions[70]
- providing a range of treatment options and recommendations to discuss with the person after an initial multidisciplinary team meeting to validate the team's recommendations.[70]

Involving primary care practitioners along the care pathway can enhance effective coordination between primary and secondary care. While primary care practitioners often initiate the first referral, they are often not involved in active cancer treatment, only stepping in again after treatment has ceased.[71] This means that many people with cancer lack a localised clinical support system, resulting in unmanaged side effects and comorbidities.[71] Involvement of an interprofessional primary care team (nurses, social workers, physiotherapists etc.) can help to provide ongoing management of complex cases (such as people with multiple conditions), increase continuity of care, and offer a consistent point of care close to home throughout treatment and beyond.[27 72 73] Primary care teams need guidance, resources and appropriate capacity planning to fulfil these roles.[27] Integrated pathways that outline the transition between primary and secondary care can also be implemented to streamline information-sharing and communication, as well as improving outcomes and satisfaction with care while minimising costs through the efficient use of resources.[74]

> The role of the primary care provider is changing, as more people are diagnosed with cancer and are living longer after their diagnosis. Primary care providers play an important role in survivorship care. The more they are involved in cancer care, the more confident they will be and the more people will benefit from holistic care.
>
> Professor Vivienne Milch, Cancer Australia

Improving access to specialist cancer care

High-quality cancer care can be made available to all through the use of specialist centres and innovative care models. People living in rural and remote areas have worse cancer outcomes, partially due to a lack of access to high-quality healthcare.[75] To address this, hospitals in rural and remote areas should link to specialist centres, and adopt models that extend access to medical expertise and resources, such as:

- expanding the number of and connectivity between comprehensive cancer centres. Comprehensive cancer centres aim to provide research-informed, person-centred, advanced treatment and care.[76] However, access can be limited; for example, in Europe only 10–20% of people receive care in such centres.[76]
- hub-and-spoke care models – where a large reference centre is used as a central 'hub' of care that provides assistance to smaller facilities – can improve care on several levels, including: consistency, efficiency, and quality and agility of care provision in rural and remote areas (*Case study 4*).[77]

Case study 4.

Use of a hub-and-spoke model of care to improve access to systemic anti-cancer therapy in Ireland

Ireland has nine designated cancer centres that provide high-quality care, but their geographic spread means many people must travel far to receive systemic anti-cancer therapies (SACTs), incurring associated travel and accommodation costs.[78] To overcome this, a person-centred SACT model of care was developed.[78]

The model uses a stepwise approach, so that people receiving low- and medium-complexity SACTs can receive care in the community or at local SACT hospitals; in more complex cases, people can be referred to designated cancer centres.[78] These transitions are supported by reorganising hospital and community services into integrated regional health areas, and developing community services.[78] A clear SACT pathway aims to limit variations in care provision so that all people with cancer, regardless of location, have access to specialist teams, high-quality care and SACT.[78]

> If you can decentralise care, it will help to provide more person-centred care because people don't have to travel as much. This will be especially helpful for people who have caring responsibilities or young children.
>
> Dr Susannah Morris, Health Consumer Advocate, Australia

Policy recommendations

To enable effective provision of multidisciplinary and coordinated cancer care, the following person-centred approaches are recommended:

- Implement patient navigation programmes, enhanced through the use of peer navigators and navigation software, to ensure people with cancer are supported and guided through complex cancer care.
- Provide all people with cancer with access to a multidisciplinary team, offering clearly explained options for treatment that respects the preferences and needs of the person.
- Involve integrated primary care teams throughout the care pathway to ensure people with cancer are fully supported and experience continuity of care.
- Where possible, implement comprehensive cancer centres to provide cancer care that is research-led, high-quality and specialist.
- Utilise hub-and-spoke models of care to ensure everyone has access to comprehensive cancer care.

Angela’s story: my treatment experience with oesophageal cancer

I was having difficulty swallowing for months and I was referred for an endoscopy (a procedure with a tube and camera to look down my throat). After the procedure, the healthcare professionals said that they thought it could be oesophageal cancer, and this was confirmed a week later after the biopsies were checked.

I was transferred to a hospital that is a centre of excellence for cancer care, and my sister or sister-in-law attended every appointment with me. From the beginning, my healthcare team were very accommodating and involved my family in my care. I had a clinical nurse specialist who was my key point of contact and answered any questions I had; they made it clear that I could ring them at any time, and I felt comfortable doing so.

I started my treatment with a feeding tube being inserted into my small intestine, and had two cycles of chemotherapy. Unfortunately, my swallow became much worse, to the point where I couldn’t swallow anything, including my tablets. My healthcare team then reviewed my treatment plan and I was switched to a different type of chemotherapy with no tablets, which was better.

The team also accommodated my schedule really well by starting my radiotherapy at the same time as my chemotherapy. When I was initially sent the schedule, I asked if there was any way to change the times of radiotherapy to fit in better with my other appointments, so I wasn’t waiting in the hospital all day. They gladly obliged and sent me through a whole new schedule.

After my chemotherapy and radiotherapy cycles had finished, I was then due to have another endoscopy. It was incredibly difficult and anxiety-inducing waiting for the appointment. Eventually, I had the endoscopy and a follow-up telephone appointment (due to COVID-19) to discuss my results. I was told the tumour had shrunk slightly, and I was given the choice: care to keep me comfortable or a surgery to remove my oesophagus.

There was no option in my mind: I had to go for the surgery.

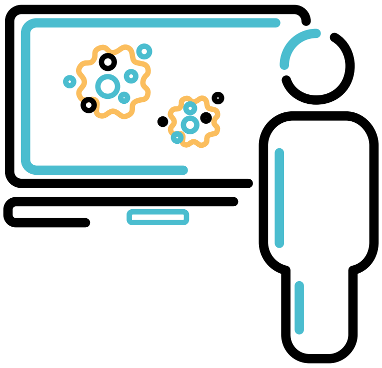
The surgery itself went well and I received comprehensive care afterwards. I did struggle with a few chest infections which led to hospitalisations. I had physiotherapy in hospital to help with my breathing, then had a six-week pulmonary rehabilitation course, and the opportunity to do another course a few years later. I also had an incredible dietitian after my surgery, who rang me every week for 18 months to see how I was getting on.

My surgery was five years ago now and I am still living cancer free. I was given the option of being discharged from my annual follow-up appointments, but I chose to keep them. My healthcare team mean so much to me, and I really felt the whole way through my journey that they listened to my worries and reassured me. They were always checking in on me and my family.

Name and specific details have been changed to protect anonymity. This is an individual’s personal experience and not medical advice.

Step 3.

Optimise processes in the care pathway using digital technologies



Provision of high-quality cancer care is restricted by capacity challenges, training, poor data collection practices and limited interoperability between systems. In many countries, insufficient workforce capacity and healthcare infrastructure lead to inequities in access to cancer care as well as worse outcomes.[2 9] In addition, quality improvement is hampered by poor data collection practices, including a lack of national audits (particularly for rare and metastatic cancers), and major data gaps for people of certain ethnicities and those of low socioeconomic position.[79] There is also a lack of training for the healthcare workforce on using new technologies: a survey conducted in 14 European countries found that almost 40% of the healthcare workforce did not have digital skills training.[80]

Health data are often siloed across systems, leaving healthcare professionals and people with cancer without access to vital information. Limited interoperability (or sharing data between systems) poses a challenge; as health data are held in different systems, it is difficult to link data between care settings.[79] A survey in Canada revealed that not all clinicians were able to access vital data to inform optimal care practices: key patient information (such as discharge notes, care plans, family history) was not readily available to 20–32% of clinicians.[81] Consequently, they were spending over an hour every day searching for these data.[81] Linking data across the care pathway can inform practices that align with patient preferences, enhance care experiences, and improve care quality and safety.[79 81]

Opportunities for change

Improving data collection and sharing processes

Improved interoperability and data collection can minimise gaps and foster collaborative and inclusive research. A key first step to improving data collection is to ensure that data can be shared between different care settings, with universal adoption of data exchange standards; this is paramount for continuity of care and to support communication between healthcare teams and people with cancer. There is also a need to invest and allocate proportionate funds towards cancer registries to collect data on different populations, particularly those for which there is less information available.[79] Sharing access to secure data between and within countries is one way to enhance data availability, especially for rarer cancers.[79]

Key initiatives in this space include:

- the Canadian Institute for Health Information Connected Care: a secure data-sharing system co-designed with the public; healthcare professionals; governments; and First Nations, Inuit and Métis communities to create standardised ways to share data across platforms[82]
- the European Network of Cancer Registries (ENCR): a collaboration between 178 population-based cancer registries in Europe to improve availability of data[83]
- European Reference Networks (ERNs) for rare cancers: aim to improve the quality of diagnosis and care, and facilitate access to cancer data across borders;[31] there are specific ERNs for rare adult cancers and children's cancers[79 84]
- the International Agency for Research on Cancer: collates global data on various cancers through its Global Cancer Observatory (GCO), to ensure that high-quality data are available to inform cancer control and research.[85]

Technologies to improve workforce capacity

Emerging technologies such as AI tools can help reduce workloads, optimise processes and act as adaptive clinical partners. AI approaches have the potential to be integrated within care pathways to support care personalisation and help address capacity issues (*Case study 5*).[86] For example, AI can automate, optimise and personalise services, providing decision support by generating care recommendations.[87 88] When applied in monitoring systems, it can alert healthcare professionals to subtle changes in symptoms and enable timely intervention while also reducing workload.[87 88] By reducing reliance on specialist resources, AI could enable more equitable access to timely diagnosis and treatment.[89] However, to ensure its safe and equitable adoption, rigorous regulatory compliance is essential, and it needs to be guided by human oversight and judgement. AI must be used in a considered way to ensure it does not reinforce paternalistic models of care.[90]

Case study 5.

Use of AI to streamline breast cancer screening in Sweden

The 'double-reading' of breast cancer screening examinations (where two trained readers independently review each mammogram) is the standard of care in European screening programmes.[91] In Sweden, the Mammography Screening with Artificial Intelligence (MASAI) trial set out to assess the potential workload reduction that could be achieved by replacing part of the double-read with AI. The trial also aimed to assess safety, ensuring that AI was able to maintain the same cancer detection rates as the current standard of care.[86]

The researchers found that using AI to triage scans detected 29% more cancers overall and reduced the radiologists' workload by 44%.[86] This indicates that using AI cancer detection tools could be a viable solution to managing workforce capacity and maintaining the effectiveness of breast cancer screening.[86]

To effectively implement technologies in cancer care pathways, training for people with cancer and healthcare professionals is essential. Improving digital literacy among healthcare professionals and managers would allow them to fully harness the potential of digital transformation in cancer care.[92] Training and education for healthcare providers is a key facilitator to increasing the adoption of digital tools.[92] Digital tool training should also be provided to people with cancer and their carers, to ensure that use of digital tools in their care is acceptable, understandable and aligns with their preferences, and that the tools are user friendly.

> AI has been used to improve diagnostic accuracy and the speed of cancer diagnosis… embedding these new technologies in the care pathway will make a big difference moving forward.
>
> Ebba Hallersjö Hult, Vision Zero Cancer, Sweden

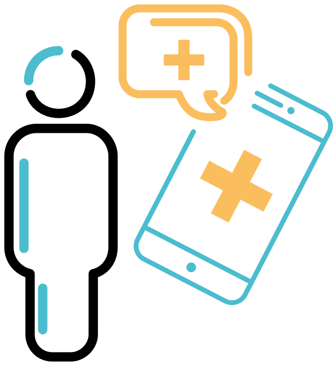
Policy recommendations

To enable optimised processes in the care pathway using digital technologies, the following person-centred approaches are recommended:

- Prioritise the development and implementation of interoperable data infrastructure (including electronic medical records), establishing and adopting universal data-sharing standards within and between countries. Standards should include data collection, analysis, reporting and governance. For care continuity, data should be securely shared with all associated primary, secondary and tertiary care services.
- Establish national cancer registries and use reference networks to link them to other registries and data sets, to enable cross-border collaboration; and work with healthcare professionals and people with cancer to ensure key data are captured and shared, such as staging and metastases data.
- Explore the integration of AI tools along the care pathway to improve workflow efficiency and workforce capacity.
- Implement digital tools training for healthcare professionals and managers, including on the importance of consulting people with cancer on their preferences regarding the use of digital tools.

Step 4.

Incorporate remote and telemedicine care throughout the cancer care pathway



Remote technologies allow people to receive care closer to their home, making it more person-centred by increasing accessibility while maintaining strong communication. This can transform delivery of care, addressing disparities in access – particularly in rural settings – and leading to better outcomes.[89] Technologies that facilitate remote care, such as wearable technologies, can enhance symptom monitoring and management, and foster shared decision-making at every stage of care.[93] They promote efficiency by delivering care in people's homes, facilitating attendance and optimising resource allocation.[94]

Technologies that facilitate access to remote care require investment in digital infrastructure. Cancer care is often complex and fragmented, which results in higher costs, particularly for rural communities.[95] At the same time, people with cancer may lack the resources to obtain technologies that facilitate access to remote care.[96] In rural and remote regions and low-resource settings, some areas lack broadband access, which requires infrastructure investment.[96] Telemedicine can also inadvertently create barriers for certain groups, including disabled people or people with diverse needs.[97]

Opportunities for change

Remote services help tackle geographical barriers to care

People in rural or underserved communities face significant barriers in accessing care, but remote care could provide a solution. Person-centred electronic health (eHealth) or telehealth platforms broaden access to care, particularly for structurally underserved communities.[98] As well as facilitating symptom monitoring, they can connect people and local providers with specialist expertise and educational resources, and bridge gaps in care delivery.[98] However, ensuring that remote care is person centred requires building equitable access to digital tools and digital literacy (*Case study 6*). It is also essential to provide the necessary equipment, infrastructure (such as broadband connectivity) and training, to ensure that these approaches enhance care experiences.

Case study 6.
The eCAN initiative in the European Union

eCAN was a project that ran from 2022 to 2024, and was funded through the European Commission's EU4Health Programme. Its mission was to advance cancer prevention and care provision through telemedicine.[99]

To help reduce cancer care inequalities, the initiative will provide a framework of recommendations for the integration of telemedicine and remote monitoring for cancer in European health systems.[100]

By improving care capacity through using these digital tools, alongside facilitating knowledge sharing between professionals, eCAN will boost preparedness among health workers.[100] In turn, this will help facilitate improved care for people living with cancer in remote areas.[100]

Remote care approaches for monitoring and care continuity

Wearable technologies and mobile apps can be used in healthcare settings to monitor symptoms through continuous data collection, provided data standards are upheld. Mobile apps and wearable devices could monitor heart rate, blood pressure, body temperature, sleep and physical activity.[93] These tools can also enable the reporting of symptoms and treatment side effects (e.g. chemotherapy), and support communication between people with cancer and their healthcare team.[101] To ensure wearables and associated technologies are acceptable for people with cancer, they must be user friendly, affordable and comfortable to wear.[102] However, issues such as variable data quality can exacerbate health inequities, which makes the implementation of data quality standards essential.[103]

> Given the distances we deal with in the US, telemedicine is incredible. It is really helpful for people with mobility and transportation problems.
>
> Dr Ronald Epstein, University of Rochester School of Medicine and Dentistry, US

Remote digital tools can also support ongoing care provision throughout and beyond the pathway. Many people affected by cancer could benefit from remote services and tools to maintain continuity of care.[97] This includes people requiring supportive and palliative care, as well as those who need to manage their long-term health, such as people who have had cancer in childhood.[97 104] Digital tools can deliver comprehensive treatment summaries to healthcare providers, helping to address care gaps and enhance the effectiveness and responsiveness of health systems over time. One example of this in practice is the Survivorship Passport (SurPass) mobile app, which aims to improve person-centred care for children across Europe.[104]

Policy recommendations

To enable remote and telemedicine care throughout the cancer care pathway, the following person-centred approaches are recommended:

- Ensure that infrastructure (such as broadband connectivity) is in place to facilitate equitable access to telehealth.
- Provide corresponding training for people with cancer to improve digital literacy.
- Promote the use of wearable technologies and apps for remote monitoring, and invest in making them available through the health service or by providing subsidies for their use.

Kelly’s story: incidental breast cancer findings

I was diagnosed with breast cancer by chance after I had an accident that resulted in bruising on my ribs that wouldn’t go away. My general practitioner referred me to the breast clinic, where I received a range of tests within three weeks. I was given a diagnosis of breast cancer almost immediately. They told me the lump was small and had been caught early – they even used the term ‘the good cancer’, as it was low risk. At the time, this phrase was encouraging, but as time progressed I felt it minimised and invalidated the serious impact of my diagnosis and treatment.

Within six weeks of my initial appointment with my general practitioner, I had a lumpectomy and the entire tumour was removed. This felt amazingly quick and I felt so supported even after such a sudden diagnosis. I was offered rehabilitation before and after my surgery, which was fantastic. I really felt like it helped make my recovery better and gave me agency and purpose at a time when my world had been turned upside down.

However, I do wish my medical team had taken the time to gain an understanding of what makes me *me*. No one asked about my home life or if I had caring responsibilities, or how my treatment and medical care were affecting my day-to-day life. I have to travel 1.5 hours on public transport to get to the hospital and no one asked about this when organising my treatments and appointments. I also live alone, but a lot of the recommendations they give are based on the assumption that you have people living with you who can care for you. There also seemed to be little consideration of the impact of my pre-existing mental health issues on my treatment experience, even though I had alerted my healthcare team to them. Support cannot be ‘one size fits all’, and getting to know me as a person could have helped to make things easier for me.

After months of having my life dictated by medical appointments, check-ups and treatments, there was suddenly nothing and I felt like I was flung into no-man’s land. I was provided with a contact for support, but sometimes I feel like I don’t want to be a bother, plus the service may call you back at any time of the day and I don’t really want to be on the phone discussing cancer in the middle of a supermarket aisle!

There are so many great charities that provide that holistic care, but it can be hard to navigate the services and know what is actually best for me. I’m a researcher and even I find all the information out there so confusing.

All the healthcare staff I interacted with have been so friendly and knowledgeable, but I wish a bit more was done to consider my specific needs and make my experience just that little bit easier.

Name and specific details have been changed to protect anonymity. This is an individual’s personal experience and not medical advice.

Step 5.

Facilitate effective communication and shared decision-making in cancer care plans

Effective communication is a key element of ensuring cancer care is centred around a person's needs and that the most appropriate care is provided. From initial engagement with healthcare providers to end-of-life care planning, high-quality communication improves healthcare efficiency by reducing errors and by making sure that interventions are tailored for each person.[105] From the patient's perspective, effective communication facilitates their involvement in care, increases satisfaction, enhances quality of life, enables treatment adherence and reduces worry.[106] When addressed to carers, it can also help them feel involved in the care of a loved one and maintain a close support network.[107]

There are consistent challenges with the effective communication of cancer-related information and support, which negatively affect care experiences and outcomes. The communication of cancer-related information is often reported to be unsatisfactory, leading to confusion and misunderstanding.[108] There are also conflicting approaches to communication, with competing clinical and patient priorities.[109] The All.Can international patient survey found that 31% of participants felt inadequately informed about their illness and treatment, and only 53% felt sufficiently involved in shared decision-making about their care.[44] The unequal power dynamic between healthcare providers and people with cancer hinders good communication, as do limited skills in providing cross-cultural communication, and a lack of translated materials and interpretation services.[110] Poor communication may result in people with cancer not adhering to treatment recommendations due to feelings that clinicians don't understand the personal factors that impact the acceptability of care, resulting in mistrust and general discontent with care provision.[106]

Opportunities for change

Shared decision-making

Use of shared decision-making models can improve communication between healthcare providers and people with cancer. Shared decision-making is the collaboration between a person with cancer and their clinical staff to ensure treatment decisions meet their preferences and values, centring around what is important to them.[111] This includes aspects such as comfort and pain management vs. continuing treatment, need to return to work, financial issues, fertility goals, and cultural practices and values.[111] Shared decision-making enhances satisfaction with care decisions and improves adherence to treatment recommendations, resulting in better clinical outcomes and care that is acceptable to the person.[109] Effective communication has multiple elements (*Figure 1*) and can be guided by communication models, such as the Integrated Oncological Decision Making (IODM) model (*Case study 7*).[112]

Figure 1. Elements of person-centred communication

Effective person-centred communication uses the following six core functions to facilitate communication between healthcare professionals and people with cancer:[113]

1. **fostering healing relationships**
2. **exchanging information**
3. **responding to emotions**
4. **managing uncertainty**
5. **making decisions**
6. **enabling self-management**

Complementary use of all of these functions can aid communication and shared decision-making.[113]

Case study 7.
Using the IODM model to make care more appropriate

The IODM model, which was developed in the Netherlands, identifies the key information that is needed to facilitate a collaborative decision-making process.[112] A key aspect of the model is that collated information is available both to people with cancer (via a digital portal) and to healthcare providers. This allows for transparency and consensus-building.[112]

The model brings together three areas of information that are essential to inform treatment decisions:[112]

1. medical technical information (tumour type and stage)
2. general health status (physical, psychological and social functioning)
3. preferences and goals of the person.

Implementation of the model in a number of hospitals across the Netherlands has resulted in more appropriate, less invasive treatments and demonstrated its potential to facilitate more person-centred care.[114]

Using patient-reported experiences to inform care provision

The use of patient-reported experiences should be an integral aspect of service monitoring and improvement. PROMs and PREMs assess health status, wellbeing, whether treatment goals have been met, and the quality of service as perceived by the person.[115] Collection and synthesis of these data ensure that the experiences of people with cancer are central to care evaluation and inform future interventions.[115] Use of data from PROMs and PREMs across the care pathway has been shown to reduce the risk of overall mortality and improve quality of life in people with cancer.[116]

Provision of culturally sensitive communication

Cultural barriers can affect communication, but providing culturally safe and appropriate information can help overcome these challenges. Structurally underserved communities often report low trust and negative experiences in health systems.[106 117 118] This is often due to healthcare professionals having a poor understanding of their specific needs and having biases related to personal characteristics such as ethnicity, gender and age.[106 118] To overcome this, healthcare professionals should have access to education and training in empathic and culturally sensitive communication (*Box 4*).[119] Effective communication that reflects the preferences of the person with cancer can increase their engagement with the health system.[29]

> The rates of satisfaction with care, measured by PROMs, have risen significantly in departments where the multidisciplinary team is considering the person in the shared decision process as well.
>
> Assoc. Prof. Dr Assia Konsoulova, Bulgarian Joint Cancer Network, Bulgaria

Box 4. Considerations for providing culturally appropriate communication

Providing culturally appropriate communication does not have a universal solution, as there is much nuance within cultures and communities.[29] For example, healthcare professionals should not only rely on an interpreter to overcome language and cultural barriers. There can be much heterogeneity in dialects and cultural practices within a language and an interpreter may not be aware of all such factors specific to the person with cancer.

To ensure their communication is effective and acceptable, healthcare professionals should:

- iteratively co-design communication materials with intended audiences through community-based participatory research
- provide alternative communication materials, such as videos, recordings of meetings and online resources, to facilitate different communication styles
- utilise peer support models to facilitate their cultural competency and humility, including the person’s loved ones and community.

Addressing carers' information needs

Carers have information needs that are sometimes ignored – but it is paramount that they are involved in care conversations. Often, carers' needs and experiences are minimised, the impact that caring has on them is not addressed, and they are left out of conversations with healthcare providers.[120 121] If clinicians lead face-to-face conversations with carers, and are able to point them to additional resources that can help contextualise clinical information, this can help reduce carers' feelings of isolation, improve their wellbeing and enhance care standards at home.[107 122]

Policy recommendations

To enable effective communication with people with cancer and their carers, the following person-centred approaches are recommended:

- Empower healthcare professionals to use shared decision-making at all stages of the care pathway (following validated frameworks/models) to ensure the needs and preferences of the person with cancer are central to all care decisions.
- Co-design the standardisation and implementation of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) based on the valued expertise of people with lived experience.
- Collect PROMs/PREMs throughout the care pathway to evaluate outcomes that matter to people with cancer and their personal experiences of care, and use these to iteratively improve cancer care services while ensuring people feel involved and listened to.
- Provide training to healthcare professionals (integrated in medical curricula, webinars, seminars) on culturally appropriate and safe communication, and involve carers in discussions, to improve trust and engagement in the health system.

> Hospitals are using a digital platform to provide information to people with cancer and to co-create a more personalised treatment plan. We also use digital questionnaires more and more – including PROMs and PREMs.
>
> Johan De Munter, University
> Hospital Ghent, Belgium

David’s story: my treatment journey with gastrointestinal cancer

My diagnosis was very quick – within a couple of weeks of seeing my primary care practitioner, I was having a colonoscopy at the hospital. Immediately afterward I was told that they thought it was cancer. The healthcare professional who delivered the news was very supportive and compassionate – I actually remember having to hold their hand and reassure them, as they seemed quite upset.

Due to COVID-19 restrictions at the time, my treatment plan changed. Instead of starting with chemotherapy and radiotherapy, treatment would begin with surgery. I think at that point, they could have explained the process in a more empathetic way. I was sent lots of information and leaflets to read, but it would probably be difficult for a lot of people to read that much material.

Ten weeks after my diagnosis, I had major colorectal surgery, which left me with a stoma bag. I had a pre-operation assessment with the surgeon, but I didn’t feel they explained things very clearly. They mentioned possible side effects, but they didn’t tell me what these were and how they would affect my life. I also wanted to know more about my surgery, like how much of my bowel they had removed, and the surgeon seemed surprised and I had to gently prompt him for an answer. I was simply curious about what they were doing to my body. I am grateful to the surgeon and the surgical team for the skill with which they removed the tumours, and the rejoining and stitching up the operation involved.

The follow-up chemotherapy care was better. I had brilliant nursing staff. They always answered any questions I had and took the time to explain everything to me. However, I did feel that the communication from the doctors was lacking – I was sent information about possible side effects from chemotherapy, such as nausea and hair loss, but I didn’t experience any of them. I then worried something was wrong with my dose and had to contact my healthcare team to confirm everything was going as expected.

Living with a stoma affected my life. I didn’t feel comfortable doing some activities, such as swimming. I was given some information on managing life with a stoma, but critical details were missing. For example, when my stoma bag started coming loose, I had to research and find adhesive rings myself, no one mentioned them or checked how I was coping. I was also told I could have surgery to remove the stoma, but no timeline or follow-up was provided. I had to push for answers for ten months before the surgery was finally arranged for two years after the first operation.

For follow-up care, I had three scans after surgery to check the cancer hadn’t returned. All were clear. A year later, I hadn’t heard from the hospital, so I contacted them about another scan. They told me I didn’t need to be seen again, but no one had communicated the next steps or the follow-up process to me. Unexpectedly, I had a follow-up colonoscopy which gave me another ‘all clear’. All the staff involved in the follow-up were caring, and carefully and clearly explained the procedure.

Name and specific details have been changed to protect anonymity. This is an individual’s personal experience and not medical advice.

Step 6.

Incorporate supportive care and survivorship approaches in the cancer care pathway

Supportive and survivorship care are essential components of person-centred and efficient cancer care that enhance quality of life during and after treatment. As more people live longer with and beyond cancer, the need for comprehensive supportive and survivorship care (*Box 5*) is greater than ever.[123] Supportive care is an essential element of overall care, as it can enhance quality of life and help people manage side effects (*Case study 8*);[124] it can also improve efficiency by reducing emergency department attendance, hospital admissions and overall healthcare costs.[125-127] Survivorship care is available to people living with cancer once they have stopped initial treatment, and aims to ensure their ongoing wellbeing, as well as providing any further treatment that may be needed.[128]

Case study 8.

Lifestyle intervention programme for people living with and beyond breast cancer in Iran

Lifestyle changes can reduce cancer recurrence and improve health and quality of life in people living beyond cancer, but care to enable this is rarely provided.[129 138]

Recognising this as an issue, a lifestyle intervention programme was implemented for people who had previously been diagnosed with breast cancer at Urmia University of Medical Sciences and Omid Charity Oncology Center in Iran.[138]

The intervention provided:[138]

- supervised moderate exercise (home- or community-based) 3–5 days per week for 24 weeks
- personalised healthy eating advice and dietary plans, with weekly follow-ups.

In comparison to people not receiving the lifestyle intervention programme, participants self-reported quality-of-life scores increased by 59%, as well as better physical, emotional, cognitive and social functioning scores.[138] Symptoms such as fatigue, nausea, pain, shortness of breath and gastric issues were also greatly reduced. The programme is a low-cost intervention that has been successful in a middle-income, resource-limited setting.[138]

Box 5. What is supportive and survivorship care?

Supportive care and survivorship care are often used interchangeably. This report uses the following definitions:

- **Supportive care** complements cancer treatment by addressing physical symptoms (pain, nausea, fatigue), social and practical needs (help at home, childcare, financial support), emotional needs, information needs, and spiritual and religious aspects of a person as they go through and beyond cancer treatment.[124]
- While a person is considered a cancer survivor from the time they receive a diagnosis, **survivorship care** is often provided once the initial cancer treatment has ceased but follow-up care is still required. It involves ongoing care to ensure quality of life.[128]

Practical examples of supportive and survivorship care services include:

- **pre/rehabilitation:** cancer rehabilitation and exercise programmes to enhance physical, psychological and social wellbeing as well as treatment tolerance and effectiveness[129 130]
- **psychosocial support:** therapy, counselling, education, spiritual support and support groups to reduce anxiety, distress and depression for people living with and beyond cancer[131 132]
- **fertility counselling:** to discuss fertility risks and preservation options before treatment, especially for adolescents and young adults with cancer[133-135]
- **palliative care:** holistic supportive care designed to improve quality of life, increase comfort and reduce the impact of side effects[136]
- **end-of-life care:** linked to better pain and symptom management, better quality of life and a greater chance of people with cancer dying in their preferred place.[137]

Provision of survivorship and supportive care globally is woefully lacking. The All.Can international patient survey found that 69% of people with cancer reported needing psychosocial support during and after cancer treatment, yet 34% said no support was available to them.[44] These types of unmet need can result in depression and anxiety; decrease quality of life; and result in poorer treatment adherence, longer hospital stays and increased suicide risk.[139] Provision of palliative care is also limited – only a third of people with cancer globally report access to these services.[140] Access to survivorship care is worse in rural and remote areas, primarily in low- and middle-income countries,[123] but even in high-income countries provision is lacking; in the US, only 41% of community oncology practices have a survivorship clinic.[141] Due to a lack of formalised provision, patient organisations and non-government organisations are often relied on to deliver these services.[142 143]

Opportunities for change

Embed survivorship and supportive care services into care pathways

> Nationally, there is an onco-freezing programme. But referral to a fertility clinic depends on the healthcare professional, the timing and availability of a fertility centre. Sometimes this is a barrier.
>
> Johan De Munter, University Hospital Ghent, Belgium

Fully embedding comprehensive supportive and survivorship care services throughout the care pathway is a key step to ensuring the person-centred provision of cancer care. Only 28% of national healthcare financing packages include palliative care services for people with cancer and only 24% of national cancer control plans had actionable objectives for the provision of psychosocial care.[8 144] Carers also often report that their emotional support needs are not met; this type of support should be included in comprehensive supportive care services, such as through tailored help and peer support groups.[107] Access to supportive and survivorship care can be improved by: including supportive and survivorship care provision in national cancer control plans; the development and implementation of guidelines for providing this care; and utilising regional partnerships for care provision where resources are limited.[145]

Advance care planning with people with cancer can reduce unnecessary suffering and hospitalisations, and this should be a defined step within cancer care pathways. In high-income countries, 77–89% of people with advanced cancer are hospitalised during the final six months of their lives to receive invasive treatments.[146] Advance care planning is the communication and planning of healthcare decisions among people with cancer and their loved ones, in preparation for a time when they may no longer be able to have these conversations.[147] It helps to increase autonomy, limit unnecessary and unwanted treatment, and reduce the rate of hospitalisation, thus leading to less stress, anxiety and depression up to the end of life.[147 148] Provision is often limited by discomfort with the topic among healthcare professionals, a lack of mentorship to enable healthcare professionals to communicate about end-of-life care, and a perception of not wanting to limit hope and affect emotional coping for people with cancer. [147]

Empower healthcare professionals to effectively and proactively provide supportive care

Targeted training and education are required to overcome persistent knowledge gaps among healthcare professionals providing supportive and survivorship care. Limited professional awareness about the benefits of supportive care (such as rehabilitation and fertility counselling), underpinned by the absence of clear clinical guidelines, creates significant barriers to access.[129 149] This is despite research showing that this type of care improves quality of life, care continuity, physical and psychosocial outcomes, and provides cost savings to health systems.[140 150 151] Incorporating dedicated survivorship and supportive care curricula into primary care training programmes can help close this gap, alongside upskilling other healthcare professionals on the importance of all aspects of supportive care.[152] Empowering healthcare professionals to provide signposting to external organisations that can deliver supportive care is also important.[153] Many patient organisations have expertise in supportive and survivorship care, and can alleviate capacity pressures on health systems that are already stretched thin.[153]

> Many people living with cancer are unaware of the supportive care available to them. Patient organisations play a vital role in bridging these gaps, and in some cases providing essential services where health systems fall short.
>
> Rosanne Lamplough, Union for International Cancer Control, Switzerland

Provide remote access to supportive and survivorship care services

Implementing remote care models could address disparities in access to supportive and survivorship care between rural, remote and urban areas. The use of digital remote care models could ease access challenges in rural and remote areas.[154 155] These models deliver services closer to people's homes, reducing the need for travel; they have also been shown to lower anxiety.[156 157] For instance, a survivorship care programme delivered via telehealth in rural Victoria, Australia, included education, exercise and wellness interventions. It resulted in improved emotional health, wellbeing and social connections, while minimising people's need to travel; it also resulted in increased workforce capacity.[156]

Policy recommendations

To enable the provision of supportive and survivorship care for people with cancer and their carers, the following person-centred approaches are recommended:

- Embed supportive and survivorship care along the care pathway, based on globally recognised recommendations, ensuring carers' needs and advance care planning discussions are included.
- Provide training opportunities for healthcare professionals to effectively deliver supportive and survivorship care throughout the care pathway.
- Invest in digital and telehealth technologies that can enable remote access to supportive and survivorship care and reduce geographical barriers to care.

Mary’s story: my treatment journey with lobular breast cancer

I was diagnosed with invasive lobular breast cancer after routine mammogram screening.

The treatment involved many lumpectomies (surgery) – and at this point, I started to advocate for myself; I work in healthcare and I am familiar with scientific literature. I pushed for a double mastectomy to avoid the endless surgery and worry about cancer not being seen in the remaining breast in mammograms (lobular breast cancer can be difficult to see in traditional imaging as it often doesn’t form a solid lump).

I was referred to a psychologist after asking for a double mastectomy, because my care team had to be sure I understood my decision to remove both breasts when cancer had only been found in one. After jumping through a lot of hoops, I was finally approved for a bilateral mastectomy. When they analysed the tissue of the second breast, they found cancer cells there too. They couldn’t be sure whether these cells would become invasive, and the cells may have otherwise gone unnoticed.

I later had surgery to remove my ovaries, which I requested as my mother had ovarian cancer and lobular metastases, meaning cancer spread to different places.

I received limited information on lobular breast cancer, and because of this, it was difficult for me to access comprehensive support. I was told ahead of having my ovaries removed that I would immediately start menopause, but I was given little information on how this would impact me. I couldn’t use hormone replacement therapy to help manage menopause symptoms, as lobular breast cancer may be more likely to be hormone positive (which means hormones could fuel the growth of cancer cells). Vaginal or topical oestrogen could have helped, but my GP refused to prescribe it because it isn’t recommended in national guidelines for people with breast cancer.

I missed so many days off work because all my medical appointments were scheduled during the working day, with little flexibility to reschedule. I would have liked more psychological help, but the only appointments offered to me were, again, during the workday and I couldn’t justify taking more time off work.

I met with women online who wanted to ensure that information and help for lobular breast cancer was more accessible to all – together, we set up our charity. This group of women has been so supportive.

Name and specific details have been changed to protect anonymity. This is an individual’s personal experience and not medical advice.

Step 7.

Provide financial advice and support to people living with cancer and their families

Many people experience barriers to accessing vital cancer care due to high costs and limited support. Costs are often cited as a key barrier to person-centred cancer care, with the substantial costs of care resulting in considerable inequities and financial toxicity (*Box 6*).[158] Globally, about 56% of people with cancer face catastrophic healthcare costs resulting from their diagnosis, leading them to delay, forgo or not complete treatment.[159] Policy responses can help; in Canada, for example, federal employment insurance sickness benefits were increased from 15 to 26 weeks due to advocacy from cancer patient organisations highlighting the financial hardship that people with serious illness, including cancer, are facing.[160]

Box 6. What is financial toxicity?

Financial toxicity is the financial burden and distress caused by a cancer diagnosis, its treatment and associated costs. It can affect people with cancer but also others in their household.[159]

Financial coverage and support for people with cancer and their loved ones are vital to ensuring wellbeing and adherence to treatment recommendations. Cancer care is expensive; treatment incurs direct costs such as medication and hospital stays, and indirect costs such as lost income, travel and accommodation.[159] Coverage of these costs improves access to cancer treatments and clinical outcomes.[159] Reduced financial strain can also help people to engage more fully with their care, focus on healing and spend more time with their loved ones.[159 161]

> Cancer makes you sick; it shouldn't also make you poor.
>
> Dr Susannah Morris, Health Consumer Advocate, Australia

Opportunities for change

Reimbursement and coverage for cancer care

Governments should ensure that cancer care is appropriately covered and reimbursed to reduce the financial burden of cancer on society. In 2021, an estimated 4.5 billion people did not have essential healthcare services covered.[162] To address this, policies that ensure the equitable access and provision of fully reimbursed and covered cancer care, including updated and transparent reimbursement structures for medicines, are needed.[163] Alongside this, managed entry agreements – arrangements between medicine manufacturers and payers – can expand access to innovative treatments while limiting payer risk.[164] Other financial approaches that can be used to increase access include budget caps, medication utilisation caps, opening up access to treatments while evidence is being fully developed, coverage with evidence-development agreements, and fixed costs per person.[164] As of September 2025, consumer taxes in India have been removed from key cancer medicines and significantly reduced on other vital medicines and medical devices.[165] This policy change aims to increase affordability of treatments, increase access to life-saving treatments, and reduce the financial burden of chronic illness on individuals.[165]

Case study 9.

Use of a financial toxicity tumour board to reduce the impact of a cancer diagnosis in the US

Over two thirds (66.5%) of bankruptcies in the US are medical-related.[168] Recognising the impact of financial toxicity on people with cancer, a Financial Toxicity Tumor Board was established in 2019 at the Levine Cancer Institute in North Carolina.[167]

The institute identifies people who are most at risk of financial toxicity and refers them to the board. The board, which meets monthly, is multi-stakeholder and includes physicians, nurses, financial counsellors, nurse navigators, social workers, pharmacy staff and administrators. It provides assistance and access to resources and is also linked to the hospital's patient assistance programme. This collaboration aims to increase access to cancer medicines by enabling appropriate analogous and unbranded treatments to be prescribed to reduce costs.[167]

A two-year evaluation of the programme found that it had saved 3,568 people with cancer $110 million to $120 million in personal expenditure (about $32,900 per person), reducing the financial strain that can lead to bankruptcy, treatment non-adherence and worse outcomes.[167]

Financial navigation services

Financial navigation can help patients overcome administrative barriers to financial support. Even when system-level financing is available, there are persistent patient-level factors that can result in financial toxicity.[166] A financial navigator or navigator programme can help people manage costs (*Case study 9*).[166 167] Social workers and nurses often provide this assistance by comprehensively assessing risk of financial toxicity, guiding people towards support resources, and referring them to financial assistance programmes.[166] The streamlining of clinical treatment and care delivery plans to reflect the financial concerns of people with cancer can also result in minimising costs in a way that reflects the preferences of the person.[166]

Support for indirect costs of cancer care

Proactively addressing financial barriers can increase access to and ongoing engagement with care. Providing direct financial support, such as travel, accommodation and care stipends (for example, reimbursing parking costs and scheduling medical appointments to ensure people can meet their workplace and family obligations) can encourage wellbeing and enable appropriate access to cancer care.[169-171] Covering prescription costs can also ensure ongoing access to medication; for example, England provides free prescriptions – including medications that are not directly related to treatment – for people with cancer.[172]

Policy recommendations

To enable the provision of financial support and advice for people with cancer and their carers, the following person-centred approaches are recommended:

- Reimburse cancer treatment and medications to ensure equitable access to high-quality cancer care.
- Use managed entry agreements to ensure access to innovative cancer treatments while limiting payer risk.
- Provide financial navigation services to reduce the financial burden of a cancer diagnosis.
- Provide support, through subsidies and stipends, to address the indirect costs of cancer.

Call to action

Policy- and decision-makers must act immediately to improve cancer outcomes and protect the health systems of the future by prioritising the delivery of efficient and person-centred care. Putting people at the centre of cancer care pathways leads to better outcomes, improves experiences of care and allows governments to make far more efficient and sustainable use of healthcare resources.

The policy priorities are clear. Policy- and decision-makers must align with the Union for International Cancer Control's World Cancer Declaration 2025–2035, and work directly with people who have lived experience of cancer to design, implement and monitor person-centred cancer care. It is through this type of care that governments can ensure timely cancer diagnoses, optimise care delivery and quality, realise the benefits of digital tools and remote services, promote high-quality communication and shared decision-making, embed support and survivorship into care pathways, and guarantee that no one affected by cancer experiences financial toxicity.

Policymakers must embed these commitments in national and regional cancer control plans to make cancer care more equitable, efficient and resilient. Doing so will future-proof health systems against the rising incidence of cancer, while saving more lives.

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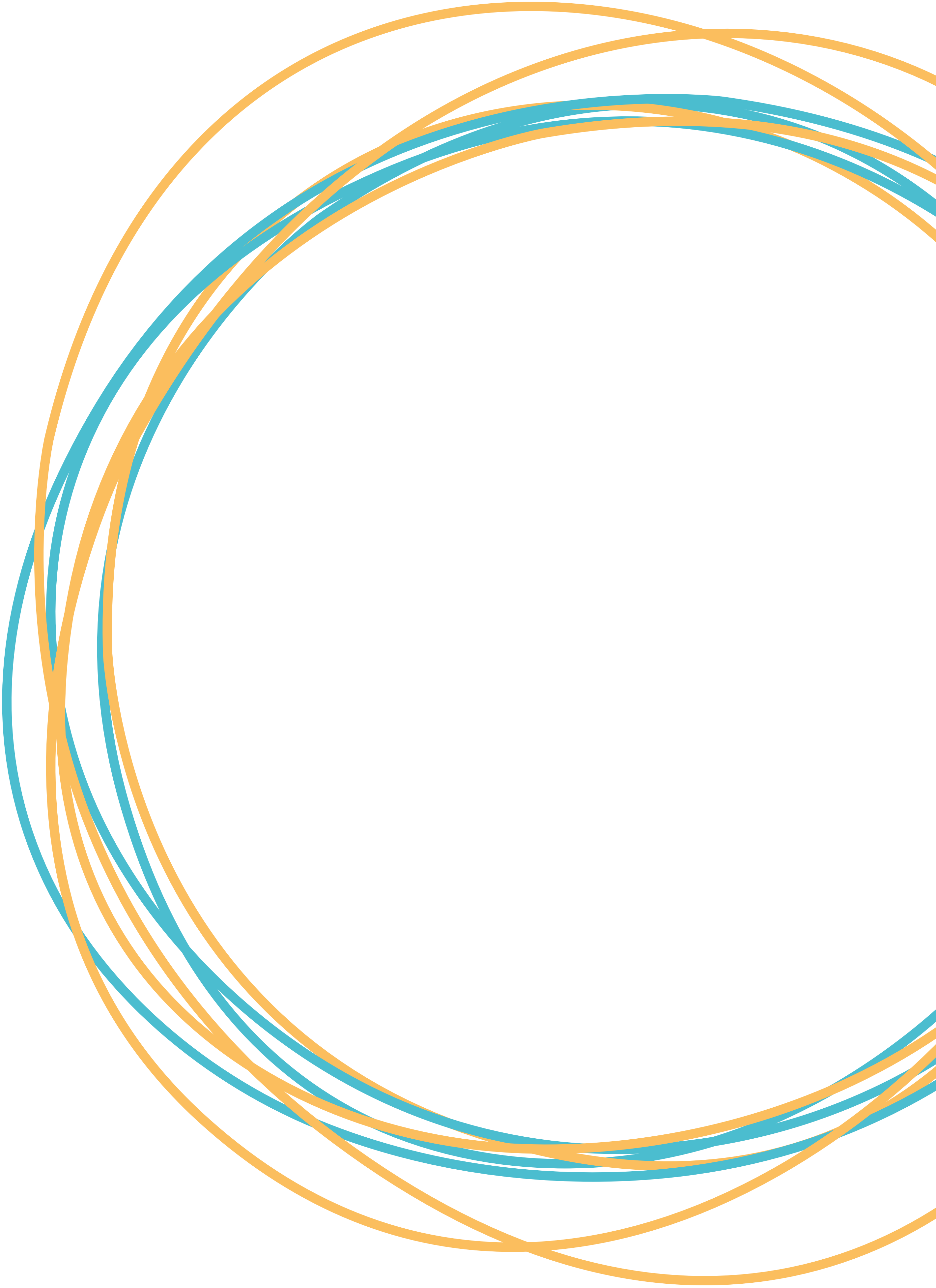

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