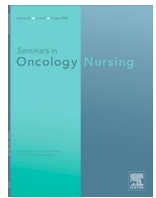




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## The Australian Cancer Plan through a Caring Life Course Lens: Moving from *Cancer* to *Care* by Placing the Person at the Center of Care

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## ABSTRACT

**Objective:** We propose the Caring Life Course Theory (CLCT) as a lens that can inform and enrich national cancer policy and clinical practice. The purpose of this discussion paper is to highlight how a CLCT lens can inform the implementation of a national cancer control plan, using sections of the Australian Cancer Plan as examples—Optimal Care Pathways and the Australian Comprehensive Cancer Network.

**Methods:** This discussion paper presents novel suggestions by drawing on CLCT concepts—care biographies, care networks, and self-care. Contrasting “current state” and “future state” vignettes are described to demonstrate how CLCT can help cancer policy move from *cancer* to *care*. Based on a robust theoretical lens, recommendations for policy and practice have been made at the micro, meso, and macro levels, with reflection on the nurses’ role, and application to other national cancer control plans.

**Results:** Optimal care pathways should include holistic assessments that incorporate broader histories at key clinical time points. The Australian Comprehensive Care Network should consider the holistic needs of people affected by cancer, and harness innovative approaches for how these needs can be met in a networked approach. In addition to clinical considerations, understanding of an individual’s care biography, care network, and self-care can inform the delivery of high-quality cancer care. Implementation of these aspects of care will be led by nurses, supported by a multidisciplinary team.

**Conclusions:** A CLCT lens can help support implementation of the aspirational person-centered objectives described in the ACP. The potential exists for application of the CLCT approach to other national cancer control plans, including those in low-resource settings.

**Implications for Nursing Practice:** Nurses play a vital role in leading the implementation of person-centered dimensions of cancer control plans and core aspects of the CLCT approach.

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### Plain language summary

#### What we investigated and why

Cancer impacts all aspects of a person's life. Cancer policy has traditionally focused on treatment of the disease, rather than care of the whole person. Cancer policy, including national cancer control policies, is beginning to focus on all aspects of care (holistic) that are important to people affected by cancer. Challenges exist in implementing holistic objectives described in various national cancer plans across a number of health care systems.

#### How we did our research

This discussion paper discussed how concepts in the Caring Life Course Theory approach (understanding people's life stories, experiences, social connections, ability to care for themselves, and care responsibilities) can inform two key objectives from the Australian Cancer Plan (use of standardized care pathways for people with cancer, and the provision of a networked approach to cancer care).

#### What we have found

Incorporating concepts of Caring Life Course Theory into personalized care pathways and using this information to draw on a networked approach to cancer care can enable more effective, equitable, and sustainable cancer care and better experiences of care—across Australia.

#### What it means

Using concepts from Caring Life Course Theory can help to implement holistic care that is focused on people, which is a key objective of the Australian Cancer Plan. A Caring Life Course Theory lens may also be useful in countries with fewer resources. Further work is needed to explore the broad application of the theory to cancer policy.

#### Current State

The young woman scrolled through her phone, waiting for the oncologist to call her name—flicking through photos of happier times with her children. She wondered if she would make it home tonight to tuck the youngest into bed. The long course of chemotherapy and radiation had left her exhausted and desperately trying to maintain dual roles as a mother and “patient”—relying on help from family and friends to keep daily life running. The hope of attending school events, hosting birthday parties, and playing in the park again kept her going.



(continued)



In the adjacent seats, a man with his wife of 50 years drank coffee while they waited—his large, thin hand trembling from advancing Parkinson disease. The man wondered how much longer he could make the twice-weekly journey to the hospital with his wife for her much-needed blood transfusions. He worried about the future—how could they stay together, living in the home they had raised their family in, and shared a life together over many decades? He smiled, warmly thinking about the young couple next door, who mowed his lawn and took his rubbish bin out.

On the other side of the waiting room wall, health care teams bustled through the day—working through a long list of people to be seen. Each “patient” had a checklist, protocol, or clinical pathway for their disease to guide best-practice, evidence-based care delivery. Within the outpatient unit, a nurse reviewed blood results in preparation for the next “patient”—she knew them both well—a young mother with breast cancer and an older woman with acute leukemia. The nurse hoped she would have time between starting infusions to sit with each of them briefly and check how life was going at home. She wondered what they were worried about on the other side of the waiting room wall. Infusion pumps alarmed and interrupted her thoughts—she rushed to attend to them.

#### Burden of Cancer

Cancer is a major cause of morbidity and mortality worldwide, with nearly 20 million new cases occurring globally in 2022.<sup>1</sup> Almost 170,000 new cancer diagnoses occurred in Australia in 2024,<sup>2</sup> with over 2 million estimated in the USA in 2025.<sup>3</sup> Globally, cancer burden is projected to increase by 77% by 2050 (from 2020), due to an aging population and exposure to risk factors.<sup>4</sup> Advances in detection and treatment have markedly improved survival rates in high-income countries such as Australia,<sup>2,5</sup> with significant disparities in care access and outcomes in low-resource settings and countries.<sup>4</sup> In high-income settings, advances in treatments and supportive care mean that many cancers are now managed as chronic, complex conditions rather than acute illness, with people living for years with ongoing treatment-related effects and care needs.<sup>6</sup> Improvements in cancer care internationally are heavily influenced by fiscal constraints, with corresponding inequities between and within countries.<sup>4</sup>

With the rising importance of survivorship internationally in high-income settings due to improved survival rates and control of recurrent disease, coupled with cancer care moving closer to home, the traditional acute episode model of cancer care has evolved. Instead of being experienced as a time-limited biomedical crisis, the impacts of cancer can unfold over time, with fluctuating remissions and recurrences, leading to profound life-course disruptions. Such disruptions include, but are not limited to, ongoing role interruption, identity shifts and losses, caregiver burden, and structural disadvantage.<sup>6,7</sup> People affected by cancer must navigate the impacts of cancer alongside parenting and family roles,<sup>8–11</sup> employment and finances,<sup>12</sup> aging, or caring for others,<sup>13</sup> while adjusting to relying on spouses, children, other family, and friends.<sup>14</sup> Experiences such as bereavement, caring for others, or job loss have been identified as determinants of quality of life—sometimes even exceeding the direct impact of cancer itself—for some people living with cancer.<sup>4</sup> Carer

demands, such as parenting young children or providing care to others, significantly increase the psychological distress of people with cancer.<sup>14-16</sup> Of note, people affected by cancer in low-resource settings and countries have fewer available resources, leading to profound life-course disruption, including impacts to employment, independence, financial security, and education.<sup>17,18</sup>

### Cancer Policy

Cancer policy (also known as oncopolicy) outlines the strategies, guidelines, and framework for managing cancer, and has traditionally evolved through the lens of epidemiology, biomedical innovation, and health system efficiency.<sup>19-21</sup> While such approaches have achieved significant gains in early detection, treatment access, and survival outcomes, they may underrepresent the lived, relational, and longitudinal realities of those affected by cancer. International agencies, national governments, professional organizations, and academic institutions support the development of cancer policy, including cancer control plans, government policy, best practice guidelines, and white papers. Although cancer policies such as cancer control plans strive to improve comprehensive care experiences, people with cancer have reported that current cancer care remains narrowly focused on tumors and treatment protocols, without fully addressing their broader psychosocial and practical needs.<sup>22,23</sup> There is often a limited focus on the integration of cancer care into primary care. A description of optimal cancer care across the cancer continuum, in various resource settings, is needed in consensus-based, future-oriented cancer policies co-designed by clinicians, researchers, consumers, and policymakers.

In recent years, cancer policy has begun to evolve to consider the comprehensive needs of people at risk of, and affected by cancer, with a focus on providing better, more accessible, and equitable cancer care. The first internationally endorsed roadmap, the recent Multinational Association of Supportive Care in Cancer (MASCC) Supportive Care 2030 Movement<sup>24</sup> statement, describes consensus-derived ambition for supportive care by 2030. This policy framework champions self-care and self-management—and calls for coordinated and individualized care, partnerships between patients and health professionals, evidence-informed patient education, and meaningful and authentic collaborations between consumers, researchers, care providers, and institutions.<sup>24</sup> The MASCC Supportive Care 2030 Movement collectively transforms supportive oncology from a series of isolated interventions into a policy architecture that is experiential, collaborative, and spanning the whole cancer trajectory, thereby aligning health system actions with the real-world journey of people affected by cancer.<sup>24</sup>

Despite advances in some areas of cancer policy, evidence suggests that many national cancer control plans have not yet fully adopted a truly holistic approach to cancer care.<sup>25</sup> Additionally, psychosocial needs, caregiving responsibilities, identity disruptions, and cultural care expectations are often acknowledged in national cancer control policies but insufficiently implemented and embedded into service design and performance frameworks.<sup>25</sup> Nurses can play a unique role in the development of cancer policy through their expertise in direct patient care, focus on holistic aspects of care, and role in patient advocacy. Effective approaches are needed to support the implementation of national cancer plans and the delivery of optimal, person-centered cancer care. In many countries, nurses are the largest group of health care providers and significantly impact the implementation of cancer plans.

### Australian Cancer Plan

In Australia, the 2023 Australian Cancer Plan (ACP) describes the ten-year national policy ambition for person-centered, equitable, and world-class cancer outcomes and experiences for all Australians.<sup>26</sup>



Fig. 1. Six strategic objectives of the Australian Cancer Plan.<sup>26</sup>

The ACP outlines strategic goals (Fig. 1) that span prevention, diagnosis, treatment, survivorship, and end-of-life care.<sup>26</sup> The foundational aim of the ACP is to reduce cancer-related morbidity and mortality, and improve experience, through integrated, equitable, and sustainable national strategies.

The ACP demonstrates strengths in several areas identified in a recently published global cancer policy review<sup>25</sup> as essential to effective cancer control, including its articulation of strategic goals addressing each stage of the cancer care continuum, and its focus on principles of person-centered care, equity, and system integration. Consistent with the global trend toward holistic strategies, the ACP describes clear ambitions around early detection, integrated care, and survivorship—domains that remain unevenly addressed in many cancer control plans worldwide.<sup>25</sup>

The ACP explicitly aims to improve outcomes for those most affected by disparities, including but not limited to Aboriginal and Torres Strait Islander peoples, individuals in rural and remote areas, and culturally and linguistically diverse communities. This focus is noteworthy given that only 14% of cancer control plans globally include a dedicated health equity goal.<sup>25</sup> The ACP represents a major national effort to drive equitable, person-centered, and coordinated cancer care across the continuum. However, like many cancer control plans analyzed in the 2025 global policy review, its ultimate impact will depend on the health care workforce's ability to operationalize these ambitions.<sup>25</sup>

Nurses are recognized in the ACP as vital members of the cancer care team for providing comprehensive, person-centered care across the care continuum. Nursing roles within the ACP include (but are not limited to) assessment and management of physical and psychological symptoms, care coordination, specialized roles, navigation, education and support, survivorship care, quality improvement, advocacy, policy and planning, workforce development, and research.<sup>27</sup> The ACP notes that nurses must be well-supported and educated to be leaders addressing inequities and improving patient outcomes.

As national cancer control plans such as the ACP move towards a more coordinated and individualised approach to cancer care, tension may develop between the integration of experiential, biographical, or relational dimensions of care and more traditional biomedical

systems and processes. Opportunities exist to support the implementation of the strategic aspirations of the ACP through approaches that understand the lived experience of cancer as a deeply disruptive life-course event.

### Purpose

This paper introduces the Caring Life Course Theory (CLCT) as a lens that can inform and enrich national cancer policy and clinical practice. The CLCT conceptualizes care as a universal human need that unfolds across the lifespan, situated within interdependent processes, such as personal biographies, social networks, and structural contexts.<sup>28</sup>

The purpose of this discussion paper is to highlight how a CLCT lens can inform the implementation of the ACP, drawing on Optimal Care Pathways (OCP) and the Australian Comprehensive Cancer Networks (ACCN) as examples. We offer novel suggestions using a robust theoretical lens to make recommendations for policy and practice at the micro, meso, and macro levels. Using the ACP, as one example of cancer policy in a high-income country, we provide an example “future state” (contrasting the “current state”) and discuss how CLCT can help move from *cancer* to *care*—by aligning a cancer control plan with the holistic needs of people affected by cancer. We also reflect on the potential application of CLCT to cancer policy in resource-limited settings.

### Caring Life Course Theory

Despite being a fundamental need for care across the life span, the theoretical understanding of care needs and care provisions has been relatively neglected in scientific discourse.<sup>28</sup> To address this gap in understanding, Kitson and colleagues developed the CLCT (first published in 2022). The theory defines care as a lifelong human necessity,<sup>28</sup> not merely as a service delivered during moments of biomedical crisis to meet clinical needs. Caring Life Course Theory foregrounds the dynamic interplay between individuals, their relationships, and the systems in which they live, work, and age. In doing so, CLCT extends the scope of policy discourse beyond health interventions to include the broader emotional, relational, and social architectures that shape people’s experiences of illness and care.

The CLCT approach offers a vocabulary and logic for understanding how care experiences evolve over time and are shaped by intersecting social roles and vulnerabilities. Caring Life Course Theory can inform cancer policy as it moves away from disease-focused clinical interventions, towards supporting people across the life course. An innovative framework, CLCT adopts a longitudinal, person-in-context view, linking micro-level experiences to macro-level structures: it compels greater attention to individuals’ historical and lived experiences of illness and the complex ecosystem of formal and informal care that surrounds them. Kitson and colleagues developed CLCT to reconceptualize and provide a stronger theoretical foundation for care that could transcend disciplines.<sup>28</sup> Several key concepts are central to CLCT (Box 1).

#### Box 1 Caring Life Course Theory Key Concepts

##### Care biography

A personalized history that captures an individual’s self-care and care-for-others capabilities, capacities, and their understanding of the care they have received and should receive

##### Care network

An interconnected web of formal and informal relationships that provide care and influence a person’s life journey

##### Self-care

The ability of individuals to manage their own health and well-being, including promoting health, preventing disease, maintaining health, and coping with illness

### Care Biography

The *care biography* is the first core construct in the CLCT—described as a longitudinal narrative that traces how individuals give and receive care across the life course.<sup>29</sup> Not limited to clinical records, CLCT emphasizes that an individual’s health trajectory is deeply influenced by their care biography—the cumulative history of care experiences, relationships, and social context throughout their life.<sup>29</sup> In the context of cancer, care biographies allow for a richer understanding of how a diagnosis intersects with existing responsibilities, such as parenting, elder care, work, and community obligations, and how these intersections compound vulnerability or resilience.

### Care Networks

Another key CLCT construct is the *care network*.<sup>28</sup> Recognizing that people are rarely passive care recipients, this concept highlights that people are embedded in reciprocal networks of care involving family members, peers, and community actors. This has particular relevance for cancer policy, where people with cancer often serve as carers themselves, or where care is shared across extended relational systems. CLCT thus challenges biomedical ways of thinking and instead positions people within interlocking webs of responsibility, support, and obligation that shift over time.

### Self-Care

The third key construct is *self-care*, or how a person with cancer is empowered or feels empowered to live their best life as a cancer survivor. In their recent publication, Kitson and Lawless<sup>30</sup> argue for a reconceptualization of self-care and self-management not as discrete behavioral tasks, but as interconnected, socially embedded processes that span individual (micro), relational (meso), and systemic (macro) levels. In this model, effective self-care is not reducible to personal autonomy or medical compliance; rather, it depends on access to stable care networks, emotional continuity, and system-level supports. This has direct implications for the ACP’s emphasis on navigation services, survivorship planning, and equity goals—suggesting that nurses, especially those in boundary-spanning roles such as nurse navigators, must be empowered to bridge individual capacities with social and structural enablers. A care-integrated approach to self-management would recognize not only the person with cancer’s role but also their caregiving responsibilities, mental health, and social determinants of engagement. Embedding this expanded understanding of self-care into the ACP could help avoid reinforcing inequalities and support more sustainable, equitable outcomes across the cancer continuum.

### Nurses’ Role

Nurses provide care at every point across the lifespan.<sup>31</sup> As caregivers, educators, advocates, core members of the multidisciplinary team, and leaders in health service delivery, nurses play a vital role in CLCT.<sup>32</sup> Core aspects of the nursing role are aligned with, and can enable genuine integration of a CLCT approach, including provision of fundamental care; a holistic approach; promotion of person-centered care; broad collaboration across health care teams and settings; advocacy for the patients, families, and caregivers; and focus on equitable access to care.<sup>32</sup>

### How CLCT Can Enrich Cancer Policy: Applications to the ACP

The CLCT approach was generated to fill the gaps identified in policy and practice around persistent failures in delivering high-quality,

safe, holistic person-centered fundamental care,<sup>33</sup> generating systematic responses to missed care,<sup>34–36</sup> and to generate opportunities for policymakers to consider how they reframe care in the face of the recognized demographic and economic changes affecting all countries.<sup>37,38</sup> It is the organizing conceptual framework for the Caring Futures Institute, a research institute dedicated to the systematic study of self-care and caring solutions across multiple clinical conditions (cancer being one of them). The CLCT has been used as an analytical, interpretative framework to shed light on how evidence-based interventions can be implemented into policy and practice. As a recently developed theory, CLCT is yet to be integrated into social and economic policy and clinical practice. This discussion paper serves as one of the first applications to cancer.

Using theoretical constructs to strengthen particular aspects of supportive care within the ACP could provide alternative, more person-centered perspectives or novel ways of addressing particularly challenging and complex care issues. These include addressing the improvement of cancer care navigation across psychosocial needs, caregiving responsibilities, identity disruptions, and cultural care expectations that are often acknowledged in national cancer control policies but insufficiently implemented, and embedded into service design and performance frameworks.<sup>25</sup>

Current approaches to health care are unsustainable due to a range of factors, including increasing demand, cost, and expectations of care. The CLCT approach supports sustainable health care as it champions self-care within care networks, based on an understanding of a person's care biography.

This discussion paper offers novel interpretative ways to find solutions to care challenges that are consistently experienced across the world. Its novelty is that it has created a robust theoretical lens to address care at the individual (micro), relational, and network level (meso) and at the system, organizational, and policy (macro) level. This means that policy and practice frameworks developed in jurisdictions can scaffold their integrated cancer care responses equally, connecting clinical excellence with an explicit person-centered approach that keeps the individual and their care network at the center.

Authentic integration of a relational and biographical understanding of cancer can support the ACP to fully realize its goal of equity and person-centeredness—this requires a fundamental shift in how cancer policy and services are conceptualized, coordinated, and experienced. CLCT can support this transformation. Across its key strategic objectives, the ACP can be enriched by applying CLCT to shift the focus from *cancer* to *care*. In the following subsections, we apply this framework across two core components of the ACP that support World Class Health Systems for Optimal Care—OCPs and ACCNs. These sections serve as examples of how CLCT can inform the design and delivery of more responsive, relational, and equitable cancer care.

### *Reimagining Optimal Care Pathways*

Embedding OCPs into everyday cancer care is a central objective of the ACP.<sup>26</sup> The OCPs serve as guides for best practice care across the cancer continuum (starting at “prevention and early detection”) for various tumor streams and priority groups.<sup>39</sup> Similar clinical pathways are used internationally to outline the critical steps required for consistent, safe, high-quality, evidence-based cancer care.<sup>40</sup> The intended purpose of OCPs is to improve outcomes, promote equity and accessibility, support health care professionals, and improve efficiency.<sup>41</sup> The current formulation of OCPs contains key elements of care coordination, centered on diagnosis, treatment, and follow-up milestones, but not reflecting the impact of broader life concerns. The OCPs have been criticized for being largely biomedically driven rather than person-centered or culturally appropriate<sup>42</sup> and prioritizing standardization and efficiency at the risk of potentially overlooking

the needs and preferences of individuals.<sup>43</sup> It is also unclear how a care pathway can commence before the diagnosis of cancer is made, as found in the OCPs.

Recognizing that “optimal” care is not defined solely by clinical efficiency but also by coherence with a person's identity and lived experience allows oncology teams to provide care that is meaningful and relevant. Consequently, this could support the multidisciplinary team to provide effective and efficient holistic care—focusing on psychosocial, financial, emotional, and relational aspects of life. We suggest that updates to existing OCPs and the development of new OCPs include recommendations for holistic assessments that incorporate broader histories, including care biographies, care networks, and self-care, at key clinical time points. To enable this, core constructs of the CLCT approach would have to be integrated into new or modified assessment tools.

Additionally, digital technology could be used to support the creation of co-designed, personalized care plans that integrate CLCT concepts of care. Such plans should have a high level of adaptation to a person's life and predictive adaptation to a person's care plans, which can be enabled by harnessing technology. The inclusion of structured reviews for emotional distress, caregiving status, or relational strain at the diagnostic and survivorship phases would reflect a more holistic understanding of optimal care. Completion of such activities could be included as key performance indicators, the same as clinical steps within the OCPs.

Taking a CLCT lens to OCPs could help to address health inequities by supporting deep and genuine co-design of personalized care plans for priority populations, incorporating their unique needs. Taking a person-centered approach, differing OCPs can be integrated together when a person fits multiple categories (eg, a tumor stream pathway and an Aboriginal and Torres Strait Islander pathway). Personalized cancer plans can ensure that people affected by cancer are treated as individuals, while still ensuring best practice care is provided for clinical conditions.

### *The Australian Comprehensive Cancer Network Driving Person-centred Care*

A networked approach to the delivery of comprehensive cancer care across Australia is another core goal of the ACP.<sup>26</sup> The ACCN aims to ensure the delivery of high-quality cancer care closer to home, through connectivity and the sharing of expertise between Comprehensive Cancer Centres (CCCs) and other cancer centers/services, regional hospitals, and community and primary care.<sup>44</sup> This approach supports more equitable and accessible cancer care across all geographical regions of Australia. Within a networked approach, CCCs serve a pivotal role as hubs, centers of excellence in cancer care, research, and education.<sup>44</sup> We propose that models of comprehensive cancer care can be informed through a CLCT lens—taking into consideration the holistic needs of people affected by cancer, and developing innovative approaches for how these needs can be met in a networked approach. In addition to clinical considerations, understanding of an individual's care biography, care network, and self-care can inform delivery of high-quality cancer care within the ACCN.

CLCT acknowledges that people affected by cancer will have a care history predating their diagnosis and will require lifelong care post treatment. The ACCN can be more effectively operationalized by understanding and working within care networks—extending cancer services into the community. Shared care models between cancer care services and primary care providers have been shown to be acceptable and effective<sup>45,46</sup> at providing survivorship care in the community.<sup>47</sup> Potential exists for shared care models with other primary care providers, including, but not limited to, Aboriginal Community Controlled Health Organisations. Community-based care is especially relevant for priority populations to enable culturally appropriate care, self-determination/agency, and a strengths-based

approach. As priority populations experience barriers accessing CCCs, the ACCN can provide personalized, high-quality cancer care closer to home, informed by the CLCT.

A CLCT lens advocates for psychology and peer-led services such as family counseling, navigation, family support, and identity recovery programs to be resourced and integrated, as core elements of comprehensive cancer care. Additionally, embedding lived experience representatives in the governance structures of CCCs—through advisory boards, service design committees, and research panels—can ensure that institutional priorities are informed by those most affected. Furthermore, a CLCT lens on the ACCN can also drive social prescribing, a non-medical approach to improve the health and well-being of people by connecting them to community resources and activities.<sup>48</sup>

The ACP highlights experience and outcome data as critical to improving cancer services and outcomes.<sup>27</sup> A recent systematic review highlighted that although CCCs internationally may be effective in the delivery of superior biomedical outcomes, they may often fall short in domains relating to equity and accessibility.<sup>23</sup> The academic literature highlights limitations in the way in which success is defined within CCCs—largely focused on mortality and survival, and quality of clinical care.<sup>22</sup> This narrow focus can lead to a lack of attention to patient-reported experience and outcome measures, such as quality of life, communication, access to care, comfort, emotional well-being, and psychosocial support. A holistic approach to measuring the success of CCCs and the ACCN is needed—incorporating care experiences and satisfaction, equitable access, and location of care, in addition to mortality, survival, and quality of clinical care. We propose that incorporating CLCT principles into OCPs and how care is accessed across the ACCN would improve the experience and satisfaction outcomes of people affected by cancer. A collection of such data, such as key performance indicators for CCCs and across the ACCN, could send a clear message regarding the importance of the lived experience of people affected by cancer. CLCT provides a pathway to inform CCCs and the ACCN as institutions that are not only clinically excellent but also embedded in the social and relational contexts of those they serve.

## Implications and Recommendations

### Future State

In a future state, where the ambitions of the ACP have been realized, the mother with breast cancer waits for a call from her oncologist from the comfort of her home. She is close to her children and supported by home nursing services and a care coordinator. After completion of treatment, she plans to spend time at her mum's rural property, regaining her strength while spending time with family. Her survivorship care will be delivered through a small regional hospital—supported by her cancer care team. Her nurse care coordinator will help her self-manage recovery, well-being, and symptoms in the community.



(continued)



The man with Parkinson disease, and his wife with acute leukemia, can access care closer to home, in their local health clinic—transported via a community shuttle. The couple is supported to maintain their independence for the time being through home-based palliative care, and have their evolving needs assessed as the leukemia progresses. A care coordinator ensures seamless communication between care providers within cancer care and out into the community.

In the cancer center, the nurse in charge and the multidisciplinary team prepare for an acute admission—a man on a refugee visa with newly diagnosed, rapidly progressing, metastatic cancer. The man has been working on a farm in a rural area, providing financial support to his large family awaiting visas in a refugee camp. The nursing team and cancer care team are poised for the complexity of the man's needs and depth of distress the diagnosis may bring. After receiving a handover from the transferring regional hospital, a medical officer and nurse care coordinator gather culturally appropriate, evidence-based assessment tools to be completed in a dedicated time, with support from a translator and the multidisciplinary team.

In the coming days, representatives from the local cultural community are contacted and rally around the man to support his well-being and guide the health care team on his cultural needs. While palliative chemotherapy begins, an emergency application is made to the Australian government to expedite his family's immigration to Australia on compassionate grounds. The cultural and language barriers that exist between the health care team and the man are bridged by a genuine desire to care for him as a whole person, rather than as a "cancer patient."

In this future state, the health care team working to provide cancer care services, policymakers, and the people affected by cancer in waiting rooms, hospital rooms, or homes and communities across Australia, have a shared goal—focused on care over cancer.

We describe how a CLCT lens can inform Australian cancer policy in the "future state" vignette above, which is aligned to the aspirations of the ACP. However, the benefits are far wider ranging than this reflection. We make several recommendations at the micro, meso, and macro levels to support the operationalization of the ACP using a CLCT lens (Table 1).

### Limitations

As a novel theoretical lens, the CLCT approach has not been previously applied to health policy. We acknowledge some potential limitations in the application of a CLCT lens to cancer policy. The CLCT approach may be criticised for emphasizing certain dimensions such as person-centeredness and individual experience of care, while overlooking other important dimensions such as social structures, economic feasibility, and clinical effectiveness. We propose that a CLCT lens adds value to cancer policy by emphasizing previously undervalued dimensions to create a more person-centered and equitable approach to optimal and sustainable care. We acknowledge that a CLCT approach may be hard to implement in under-resourced (i.e., aged care) or isolated (i.e., rural and remote areas) settings with persistent challenges in formal care provision. We propose that a CLCT approach can adapt to such challenges through informal care networks and a person's ability to self-care. This paper focused on the application of the CLCT lens to the implementation of a national cancer control plan in a high-income country, with known inequities in access to care and outcomes for certain populations. To date,

**Table 1**  
Recommendations at the Micro, Meso, and Macro Levels

Level	Focus of care	Recommendations
Micro and meso	Care of people and models of care	<p>Assessments of care biographies, care networks, and self-care are conducted at key clinical time points and on an ongoing basis.</p> <p>Expanded interventions and roles (i.e., navigators and care coordinators) that consider and support caregiving biographies, such as additional supports for people in dual care roles (e.g., parents of young children, those caring for elderly parents).</p> <p>Psychosocial and peer-led services to be regarded as core elements of comprehensive care.</p> <p>Continued push for cancer care provisions closer to home or at home – informed by understanding of care biographies, care networks, and self-care.</p> <p>Greater focus on shared care and primary care–led models in the community.</p> <p>Social prescribing (health care professionals connecting people with cancer with non-clinical services) to improve health and wellbeing and provide culturally appropriate care.</p>
Macro	Education, policy, and research	<p>Introduce and cultivate a culture that nourishes the CLCT—setting this approach as the standard of practice for optimal cancer care.</p> <p>Updates to existing OCPs, and development of new OCPs, include recommendations for holistic assessments that incorporate care biographies, care networks, and self-care, at key clinical time points and life events.</p> <p>Development or modification of assessment tools that incorporate core constructs of CLCT.</p> <p>Use of digital technology to support the creation of co-designed, adaptable, personalised care plans that integrate CLCT concepts into the critical clinical steps outlined in the OCPs.</p> <p>Draw upon CLCT concepts to provide holistic cancer care across systems and sectors—to operationalize the ACCN.</p> <p>Completing CLCT-informed activities to be included as a key performance indicator—the same as clinical activities in OCPs.</p> <p>Embedding lived experience representatives in the governance structures of CCCs—through advisory boards, service design committees, and research panels.</p> <p>Measurement of success of the ACCN incorporating care experiences and patient satisfaction, equitable access, and location of care.</p> <p>Collection of nationally consistent data incorporates life stages and care responsibilities of people affected by cancer to understand need.</p> <p>Future research to explore and predict need based on life stage or care responsibilities.</p> <p>Future research to explore the application of CLCT with priority populations.</p> <p>Principles of CLCT are incorporated into role descriptions of care coordinators and navigators.</p> <p>Nursing education and training around CLCT concepts.</p>

limited focus has been placed on the application of CLCT in countries with fewer resources.

#### *International Application of Caring Life Course Theory*

The CLCT is likely transferable (either in its current form or in a refined version subject to further testing) to other high-income, Western-style health care settings with similar national cancer control plans to Australia. As a framework, it can inform (or guide) the provision of comprehensive cancer care and person-centered care.

Disproportionately high rates of cancer incidence in low-resource countries<sup>1</sup> mean that people with the fewest resources will “bear the brunt of the global cancer burden” in the coming decades.<sup>4</sup> Although not yet explored, we propose that a CLCT lens may be valuable in informing cancer policy and national cancer control plans in low-resource countries. The impact of a cancer diagnosis in a low-resource country may have a profound impact on the life course of individuals, families, and communities. In many low-resource countries, health infrastructure, access to care (detection and treatment), universal health care, and social welfare may be limited or not available at all.<sup>49,50</sup> Cultural barriers, stigma of cancer, and practice of traditional medicine may also impact the experience of cancer.<sup>51</sup> In such settings, people with cancer and their families experience high out-of-pocket costs, loss of income, and lost productivity,<sup>18</sup> not only impacting the ability to access treatment but also the quality of life, safety, education, and well-being of the entire family.<sup>17,18</sup>

Understanding how care biographies and self-care intersect is of utmost importance in such contexts to adequately support people affected by cancer in the context of scarce resources. Availability of effective care networks to support the provision of cancer care, including families and local communities, non-government organizations, and the non-cancer workforce, may also play an important role

in low-resource countries. A CLCT lens positions the person with cancer as the central point of care but reaches out to focus on care responsibilities and care networks—extending to families and communities. This approach may be of particular relevance in the provision of cancer care in low-resource settings. Future work is needed to explore the application of CLCT in such settings to support equitable optimal cancer care globally.

#### **Conclusion**

This discussion paper has highlighted how taking a CLCT lens can inform cancer policy, drawing upon sections of the ACP as examples, specifically the OCPs and the ACCN, of how the approach can support the delivery of optimal care. This paper has offered novel suggestions using a robust theoretical lens to describe practical approaches to meet aspirational person-centered objectives, as described in many national cancer control plans. Potential exists for application of the CLCT approach to cancer policy in low-resource settings—to equitably support the holistic needs of all people affected by cancer.

#### **Declaration of competing interest**

The authors declare they have no conflicts of interest.

#### **CRediT authorship contribution statement**

**Elise Button:** Writing – review & editing, Writing – original draft, Conceptualization. **Angela Rong Yang Zhang:** Writing – review & editing, Writing – original draft, Conceptualization. **Carla Thamm:** Writing – review & editing, Conceptualization. **Raymond J. Chan:** Writing – review & editing, Supervision, Conceptualization. **Andreas Charalambous:** Writing – review & editing. **Carolyn Ee:** Writing –

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