Cancer and ageing:
Policy responses to meeting the needs of older people
Contents

2 About this briefing paper

3 Executive Summary

5 Chapter 1: Introduction: Setting the scene

11 Chapter 2: Patient journey: the continuum of care for older people living with cancer

23 Conclusion

24 Key policy take-aways
About this briefing paper

Cancer and ageing: Policy responses to meeting the needs of older people is an independent briefing paper written by the Economist Intelligence Unit and sponsored by Sanofi. The briefing paper examines the syndemic of an ageing population and rising incidence of cancer to better understand how countries could provide more customised service provision to older people living with cancer.

The briefing paper is informed by extensive desk research and expert insight. It explores the policy framework around cancer and the older person, drawing on experience and findings from Europe, Japan and the US.

The paper aims to identify opportunities to improve both integration and co-operation between gerontologists, oncologists and other specialists and to provide takeaways for policymakers, patient advocates and healthcare providers around cancer and ageing. We would like to thank the following individuals (listed alphabetically) who have generously contributed their views and insights for this briefing paper:

- **Matti Aapro**, oncologist, member of the Board of Directors, Genolier Cancer Centre, Switzerland and president-elect of the European Cancer Organisation (ECCO)
- **William Dale**, Arthur M. Coppola Family chair in Supportive Care Medicine at City of Hope cancer centre, Duarte, California, US
- **Lydia Makaroff**, vice-president of the World Bladder Cancer Coalition and former director of the European Cancer Patients Coalition
- **Hitoshi Nakagama**, president, National Cancer Centre Japan, Tokyo, Japan
- **Kirsten Sloan**, vice-president of public policy, American Cancer Society Cancer Action Network, Washington, DC, US

The Economist Intelligence Unit bears sole responsibility for the content of this briefing paper. The findings and views expressed in the briefing paper do not necessarily reflect the views of the sponsor. This report was written by Andrea Chipman and led and edited by Elizabeth Sukkar of The Economist Intelligence Unit.

May 2020
Executive summary

Cancer is a global public health threat that is increasing as populations age and life expectancies increase around the world. More than half of all new cancer cases occur in those aged 65 and older, and this age group accounts for 70% of cancer deaths. It is therefore incumbent on governments to address the particular challenges that older people with cancer face.

Yet, even in advanced states such as the US, Japan and countries within the EU, health systems are not always identifying the specific needs of older people living with cancer or defining individualised care pathways for them. This is especially notable at a time when developments in personalised treatment, such as immunotherapies, have the potential to improve outcomes and make cancer treatment less toxic for even the frailest older patients.

The absence of adequate evidence on the best ways of managing and treating older people living with cancer is one clear challenge. The lack of sufficient geriatric expertise within the oncology specialty is another. Compounding these issues is the lack of multidisciplinary treatment pathways in the regions looked at in this briefing paper alongside the limited ability of patients and their carers to contribute to the development of better service provision.

Ultimately, healthcare workers and policymakers are frequently failing to see older people living with cancer as individuals. Better geriatric training and understanding of the special health issues facing older people could help elderly cancer patients make informed decisions with their doctors that will aid them in their cancer journey. At the same time, there are good examples of efforts to help older people better navigate the process—from more organised guidance in larger health systems in the US to pilot projects that train laypeople to help cancer patients access sources of support in the US, UK and elsewhere in Europe.

Exacerbating matters, as the covid-19 pandemic progresses, cancer services are being prioritised according to patient needs, where priority may go to those with active disease while follow-up care, such as screening for recurrence may be postponed as health systems struggle to manage resources and capacity.

The key findings of the research are:

Older people are not always treated fully for cancer: Experts say that there is intermittent bias against screening and treating older people for cancer in some health systems. This can range from upper age limits on mammography to a tendency to avoid aggressive treatments such as chemotherapy even when patients might be able to tolerate a moderate dose.

Need to treat older cancer patients as individuals: By undertaking geriatric assessments, clinicians and healthcare systems are better placed to provide personalised cancer management that meets the needs of older people. Clinicians

---

2 For the purpose of this paper, we have defined older people as those aged 65 years and over, a limit used by the UN and the American Society for Clinical Oncology (ASCO), among others. See https://www.un.org/en/sections/issues-depth/ageing/ and https://www.cancer.net/navigating-cancer-care/older-adults/aging-and-cancer
3 This briefing paper acknowledges that the covid-19 pandemic will affect cancer services for older people, especially as these are the same group of people mostly affected by covid-19. See “Covid-19: supporting oncology professionals”, ESMO, 2020. https://www.esmo.org/covid-19-and-cancer/supporting-oncology-professionals

© The Economist Intelligence Unit Limited 2020
sometimes have a tendency to exclude older patients from treatment as they are assumed to be too frail to tolerate. Healthcare providers can better support cancer patients with additional co-morbidities if they introduce a wide range of preparative measures before the initiation of therapy, such as physiotherapy to improve balance or memory aids.

**More and better data is still needed to support clinical decision-making:** The lack of clinical studies involving older cancer patients, especially those with co-morbidities, is feeding into clinical hesitance to prescribe more ambitious therapies (which can include radiation, chemotherapy and immunological and biological treatments). Better use of real-world evidence and more incentives for researchers to include older people in studies could expand the information available to healthcare professionals and providers and help to create a smoother patient journey. In addition, better geriatric knowledge on the part of oncologists would inform screening, diagnostic and treatment decisions as well as post-cancer care.

**Multi-disciplinary teams are vital to improving outcomes:** Integrated teams of oncologists, surgeons, general practitioners, palliative care staff, psychologists, nutritionists and physiotherapists are key to providing a more seamless cancer care pathway for patients. But multi-disciplinary approaches that seek to cover a range of needs appear weak or absent in many healthcare systems. Providing joined-up care is not only important during diagnosis and treatment but also after cancer treatment has completed in order to ensure adequate follow-up care. Better understanding of potential medical interactions and resulting side effects on the part of all clinicians treating patients would also ease the patient journey. This is especially relevant as the increased vulnerability of older cancer patients to covid-19 creates an additional set of considerations for medical teams.  

**Better support services can help those with cancer and their carers navigate the patient journey:** In addition to joined up medical care, patients need psychosocial support, education and customised advice during the whole care pathway. While there are few such programmes in place, a number of pilot programmes seeking to engage patients are under way.

---

Chapter 1
Setting the scene

As life expectancy increases in most parts of the world, many people are continuing to work, care for others and continue active lifestyles well into what used to be considered old age. It is especially important, therefore, to help older people (defined here as those aged 65 years and over)5 to live as many healthy years as possible so they can continue to contribute to their families and to society.

Older people make up 9% of the global population6 but account for a far greater proportion of the population in developed countries. In the OECD, which comprises around 35 countries, the proportion of the population aged 65 and over is expected to continue increasing in the coming decades, jumping from 17.4% in 2017 to 27.1% by 2050 (Figure 1).7

In addition, older people play an important role in the economy as consumers, earners, caregivers and participants in local community organisations. By 2050, one report estimates that the 55 years and over group will account for 86% of spending growth in Germany, 67% in Japan and 51% in the US.8

Others forecast that the number of economically active 65 to 69 year-olds in the UK will rise from 10% in 1992 to 50% in 2067.9 Research in the US and the UK has revealed that older people also make other significant contributions to their national economies.10

People aged 65 years and over are often diagnosed with cancer while they are confronting a number of other health conditions, with the risk of developing cancer reaching a peak when people are in their

---

The rapid growth of this age group will increase demand for cancer services and will put significant pressure on healthcare resources. In addition, the covid-19 pandemic raises new fears about the risks for older cancer patients. Although data is still being gathered, there are provisional indicators that older people with underlying health conditions and active cancer—including those undergoing treatments that affect the immune system—

Figure 1: Share of the population aged over 65 and 80 years, 2017 and 2050

Source: OECD

are more vulnerable to complications from the virus.13

The raw numbers backing up this syndemic of an ageing population and cancer are straightforward. The global population aged 60 and over rose from 382m in 1980 to 962m in 2017 and is expected to double to 2.1bn by 2050.14 At the same time, cancer rates continue to rise. In the UK, the number of older people living with cancer has grown by 23% in the five years to 2015. By 2040, older people are expected to make up 77% of all people living with cancer, an increase from 66% in 2015.15

As the global burden of cancer in this age group continues to grow, addressing the special circumstances of older patients and providing sufficient support along their cancer journey has never been more important.

The rising global burden of cancer by age and region

Cancer is the second leading cause of death globally, according to the World Health Organisation, and was responsible for just under 10m deaths worldwide in 2018.16 It also places a heavy burden on global health systems, the economic impact of which is increasing. In the US in 2017, estimated cancer healthcare spending was US$161.2bn, while productivity loss from morbidity and premature mortality amounted to US$30.3bn and US$150.7bn respectively. In the EU, cancer healthcare spending was €57.3bn while productivity losses due to morbidity and premature death were €10.6bn and €47.9bn respectively.17

Older people have the highest incidence of cancer as a whole, rising substantially as people age. It ranges from 731 per 100,000 population for the 55-69 age bracket up to 1,486 per 100,000 population for the 70-plus bracket, according to data from GLOBOCAN (see Figure 2).

When looking at the burden of cancer regionally in people aged 65 years and above, the highest incident cases appear in Asia, followed by Europe and North America (see Figure 3).

In future, the cancer burden is projected to increase substantially in older people over the next 20 years. According to data from

GLOBOCAN, incident cases in North America for those aged 70-plus is expected to rise from 1.7m in 2030 to 2.2m in 2040. In Asia, the burden is much higher, with incident cases expected to rise from over 4.3m in 2030 to 6.3m in 2040 (see Figure 4).
According to an *International Journal of Cancer* study,\(^\text{18}\) published in 2019, the overall number of new cancer cases is expected to double from 7m new cases among older adults in 2012 to 14m in 2035. The study projected that the greatest increase in cancer cases will be in developing regions, partially due to the higher rate of infection-related cancers in those regions, as well as a shortage of disease control and screening systems.\(^\text{19}\)

---


According to GLOBOCAN, the top cancer types affecting older people by incidence rates in 2018 were seen in the prostate, lung, breast and the colon (see Figure 5).

When assessing cancer types by gender, a Cancer Epidemiology study (which relied on 2012 data) found that among older males, prostate cancer had the largest incidence globally in all regions except in Asia, where lung cancer exceeded all other forms. Among older females, breast cancer had the highest incidence globally and in most world regions except Asia and sub-Saharan Africa.

Mortality rates for older people living with cancer are also higher than for younger generations. While data on survival differences between countries are not easy to come by, a 2018 study found that the five-year relative survival for patients at or over 65 years old in the US was 59.3% compared with 73.9% for younger patients. This is due in part to the greater prevalence of co-morbidities in older patients, which can both increase sensitivity to more toxic treatments such as chemotherapy and interfere with the effectiveness of the treatment dose. Other studies suggest that the difference in mortality statistics can be attributed to undertreatment of older cancer patients, something we will discuss in the next chapter.
Chapter 2
Patient journey: the continuum of care for older people living with cancer

Ensuring that older patients living with cancer have a smooth and streamlined care pathway during screening, treatment and after care is crucial. It is also particularly challenging for this demographic given the greater likelihood of additional co-morbidities, prolonged exposure to multiple pre-existing medications (polypharmacy) and the heightened risk of sensitivity to standard therapies.

Co-morbidities—such as cardiovascular and respiratory diseases and diabetes—are far more common among older people, so when they also are diagnosed with cancer their care requirements need special consideration. For instance, nearly 60% of adults aged 65 or over reported living with two or more chronic diseases compared with 24% of people aged less than 65 years in OECD countries.25

The presence of co-morbidities also increases the risks from polypharmacy, including adverse drug events, drug interactions and medication non-adherence. An elderly patient with just two conditions—heart failure and chronic obstructive pulmonary disease—is likely to be taking more than five medications. Older people on multiple medications are also more prone to functional decline, cognitive impairment and falls, all of which can complicate cancer treatment.26

While there are some guidelines for certain cancers relating specifically to the needs of older people, these are largely academically based, and gaps exist, given the paucity of research on older cancer patients. Nonetheless, these guidelines act as the backbone of ensuring healthcare providers and healthcare staff follow best practice, especially around integrated care and ensuring geriatric assessments take place (see Box: Providing a framework for cancer care).

Screening in the older person: improving the patient journey by catching cancer early

Within the world’s wealthier economies, the extent of screening for cancer among older patients is not consistent across countries or populations.

---

In some cases, says Dr Matti Aapro, a medical oncologist and president-elect of the European Cancer Organisation (ECCO), this is due to the fact that patients have other health conditions that are more likely to curtail their life sooner. Indeed, one recent study suggests that those at risk from colon cancer should only be screened and monitored if they have a life expectancy of ten years or more.27

Most European countries have an upper age limit of 70-75 years for routine mammography for breast cancer, given insufficient data showing that preventative exams for patients above that age can make a difference in long-term outcomes, Dr Aapro says.

Further factors are at play in Europe, including regional inequalities and differences in the ease and overall cost-effectiveness of screening for certain cancer types. According to the European Commission’s directorate general for health and food safety, rates of population-based breast cancer screening were just 0.2% in Romania, but 82.1% in Denmark.28

“We do have fairly good screening systems throughout most of Europe for breast, cervical and colorectal cancer,” says Lydia Makaroff, vice-president of the World Bladder Cancer Coalition and a former director of the European Cancer Patients Coalition.

She notes that colorectal cancer screening has a tendency to lag behind others due to the need for patients to produce faecal samples, something that still faces “social acceptability” barriers. Lung cancer screening is still undergoing cost-benefit analysis due to its dependence on more expensive scans rather than pathology screening. For other tumours, such as bladder cancer, the lack of a diagnostic test is the main obstacle to population screening.29

In Japan, where there has been a complete universal health insurance system for the entire population since the 1960s, there is no clear age discrimination for cancer screening and treatment. However, with the oldest population in the world, policymakers are confronting serious concerns about how sustainable the funding system will be in the future, says Hitoshi Nakagama, president of Japan’s National Cancer Centre in Tokyo.

---

The country has a nationwide screening system for five major cancers: stomach, cervix, lung, colon/rectum and breast, Dr Nakagama says. But, as he explains, physicians are increasingly starting to look at the cost-effectiveness and harm of screening for older, frail people whose mortality will not be modified by early diagnosis of cancers by screening.

In the US, which has a level of health insurance coverage gaps (8.5% lack insurance) often not seen in other developed countries, older patients looking for screening for certain cancers can come up against affordability issues, according to Kirsten Sloan, vice president for public policy at the American Cancer Society’s Cancer Action Network. By contrast, recommended screening programmes are covered by Japan’s universal insurance system and by some EU countries.

While mammography and some other forms of screening are generally free from co-payments, a “glitch” in Medicare (the federal insurance system for the over 65s) can see some older people charged as much as US$300 if a colonoscopy screening detects a polyp that is later removed, changing it from a screening to a diagnostic procedure, she explains.

“We are getting more and more screening tools, and what we want to make sure is that we get rid of the financial barriers,” she says.

Researchers have been studying whether there is age bias against older people in healthcare systems. A 2019 Lancet Public Health study found older patients with cancer are less likely than younger patients to receive treatments considered definitively or potentially curative. It is also noted that older patients might not be diagnosed with conditions such as cancer as early as younger people are, even when there are population-wide screening procedures in place. The study highlighted the importance of clinicians maintaining an awareness of possible age-related bias when treating elderly patients and

---


© The Economist Intelligence Unit Limited 2020
noted the importance of making evidence-based decisions.

There is also evidence that survival rates among older patients with cancer differs to those of younger patients. A 2019 study suggested that despite the banning of age discrimination in the provision of health services in 2012, age-related discrepancies in the prevalence, treatment and outcomes of people with breast cancer indicate that unconscious bias could affect policy. The study found that while breast cancer mortality rates had decreased by 44% since the 1970s among those aged 65-69, the drop was just 27% for those aged 70-79 and mortality rates had increased by 6% amongst those over 80.\(^34\) Part of the problem is likely to be the fact that some clinicians have concerns about prescribing more aggressive treatment for older patients, as we will see later in this chapter.

**Multidisciplinary care often lacking**

Multidisciplinary care is an integrated team approach to cancer care in which medical and related healthcare professionals agree on evidence-based clinical decisions and co-ordinate the delivery of care for each patient. Given the complexity of cancer care, a recent study estimated that the use of best practice—with multidisciplinary care at the centre—could improve long-term survival to 70% by 2035.\(^35\) A recent policy statement from ECCO called it an "ethical priority".\(^36\)

The literature and those interviewed agree that multidisciplinary care teams are vital for all cancer patients, including older ones, to ensure the best possible outcomes.\(^37\) While the multidisciplinary approach to cancer is becoming common in many parts of Europe, regional disparities exist—it is rarely seen in Japan and is generally only present in larger US health systems.

"Regrettably, we see patients coming in for a second opinion who have never seen their case being discussed in a multidisciplinary team meeting," says Dr Aapro.

Having a team that includes multiple specialties is especially relevant where a

---


© The Economist Intelligence Unit Limited 2020
patient has co-morbidities—such as diabetes, functional losses or neutropenia, which makes them more vulnerable to infections, he adds.

In the US, such integrated approaches—uniting internal medicine specialists, oncologists, geriatricians, surgeons, palliative care specialists and mental health professionals into a single team—are more often seen in larger integrated cancer centres, universities or healthcare networks such as the Kaiser system. These include primary care, specialists and supportive care teams under the same umbrella and emphasize value-based healthcare, says Dr William Dale, Arthur M. Coppola Family Chair in Supportive Care Medicine at City of Hope, a comprehensive cancer center in Duarte, California.

By contrast, he says, independent primary care or oncology practices find it more difficult to provide this sort of integrated care.

Ms Sloan agrees that while a team-based approach to cancer treatment is more likely to be a feature of large managed care systems such as Kaiser in the US, the majority of older patients still receive care from traditional fee-for-service arrangements, under which health care providers are paid for individual treatments or procedures, and where there is little integrated care. With elderly patients already having a unique set of needs to begin with, she says, cancer adds more complexity to their care and underscores the importance of a joined up patient journey.

“For a cancer patient that’s important because they start in cancer care, then may have surgery and chemotherapy and end up transitioning back into the primary care system,” she says. “They are so well cared for in the oncology bubble, but once they move back primary care doctors don’t know how to treat them—for example, whether they need to have special nutrition programmes or further screening. Cancer patients are so relieved when their active treatment completes but fail to be vigilant for cancer for the rest of their life as it can return.”

The actual provision of multidisciplinary care is also patchy in Japan, where primary care is less developed and hospitals often coordinate cancer care, Dr Nakagama says, although he acknowledges that a team approach is especially important as it relates to social support and daily care at home. Efforts to introduce the concept of team-based cancer care have been increasing over the past few years.

---

“At present, cancer treatment is very specialised and not many other physicians, especially primary care doctors, are familiar with it,” he says. “Some adverse reactions [to therapies] need to be closely monitored and this is not always appreciated by primary care doctors, so we need to extend their knowledge in this area.”

A team approach is as important to post-cancer care as it is to the initial treatment, agrees Ms Makaroff, given the need to follow up on the after-effects of treatment, the possible effects of co-morbidities and to monitor patients for cancer recurrence.

Optimal treatment is personalised treatment

A key part of selecting the correct care pathway for patients involves using a standardised, but brief geriatric assessment, a process that allows clinicians to identify any health concerns and select the appropriate interventions for improving outcomes.

These assessments can provide a fuller understanding of the functional and physiological age of an older person living with cancer. It is a multidimensional tool that evaluates several areas, including physical function, cognition, nutrition, co-morbidities, psychological status and social support.40

“Geriatric assessments give you information about who is likely to have toxicity from cancer treatment, underlying frailty, or a tendency to fall, for example,” says Dr Dale.

Both the International Society for Geriatric Oncology (SIOG) and the American Society for Clinical Oncology (ASCO) have issued guidelines41 for performing a geriatric assessment of older cancer patients.

Cancer plans and the extent to which they cover the needs of older patients vary between regions (see Box: Providing a framework for cancer care).

Providing a framework for cancer care

The most detailed guidelines relating to cancer in older people come from the leading academic organisations for geriatric oncology in Europe and the US:

The International Society for Geriatric Oncology (SIOG) has published guidelines for the best standards of care for elderly patients with breast, prostate or renal cancer, as well as broader recommendations addressing the quality of life needs of older cancer patients.42

The American Society for Clinical Oncology (ASCO) has a range of guidelines for treating specific cancers in older adults as well as recommendations around geriatric assessments for oncology patients,43 but there are no national guidelines that specifically refer to older patients.

The European Society for Medical Oncology (ESMO) also has a handful of guidelines relating to specific cancers as well as specific recommendations on supportive and palliative care. Its 2019 congress presented research on the progress of a Geriatric Oncology Liaison Development (GOLD) service to improve outcomes for older people with cancer.44

National cancer guidelines vary widely within Europe and do not always address the specific needs of older patients. Two leaders in this field are France, where the 2014-2019 national cancer control plan spells out the country’s approach to coordinating care for older cancer patients,45 and the UK, where the Cancer Strategy for England includes a recommendation to develop a comprehensive care pathway for older patients.46

The EU is in the process of developing new guidelines, known as Europe’s Beating Cancer Plan, and which cover prevention, diagnosis and screening, treatment and care and quality of life for patients and caregivers. It is unclear whether the guidelines will specify recommendations for elderly patients specifically.47

Japan’s Plan to Promote Cancer Control Programmes was last revised in 2012 so clinicians tend to use guidelines from the National Clinical Cancer Network (NCCN), a non-profit alliance of 30 leading cancer centres focusing on patient care, research and education. The guidelines spell out ways of assessing chemotherapy toxicity and other screening measures.48

47 From written answers to questions from the EU DG SANTE Cancer team.
Geriatric assessments and determining the best possible approach

Another key challenge regarding geriatric assessments is the shortage of specially trained geriatricians or oncologists with specific knowledge in this area, according to experts we interviewed. While many oncologists may not be as skilled in undertaking a full geriatric assessment, other providers and even non-clinicians can be trained to perform a basic one, Dr Dale says.

Free online tools, such as the CARG Toxicity Tool or ePrognosis, can also help screen patients with a history of falls, sensory deficit or cognitive problems, all of whom would be considered high-risk for certain chemotherapy treatments.

Too often, Dr Dale and Ms Makaroff agree, more vulnerable older oncology patients may not receive standard treatments such as radiotherapy and chemotherapy, due to concerns about their ability to tolerate them. They point out that health care providers have a number of options for these patients, including choosing treatments with less toxicity, such as newer biologic or immunotherapies, or using lower dosages. In 2015, UK cancer charity Macmillan developed a geriatric assessment questionnaire and found that cancer patients aged 70 and older who had completed it were more likely to finish their cancer treatment as planned, without needing any treatment modifications.

In addition, an oncology health team can put what Dr Dale refers to as a “prehabilitation” plan in place ahead of treatment. This might be physiotherapy to combat balance problems for patients prone to falls or a system of reminders and labelled medicine pillboxes for patients with cognitive or memory problems. This helps “optimize” patients for upcoming treatments and minimizes toxicities.

“The most extreme thing is to tell someone we are not going to treat them; our job is to

William Dale, Arthur M. Coppola Family Chair in Supportive Care Medicine at City of Hope cancer center, Los Angeles, US


50 See http://www.mycarg.org/SelectQuestionnaire and the ePrognosis website https://eprognosis.ucsf.edu/


© The Economist Intelligence Unit Limited 2020
identify risks, modify our approach and help manage patients,” says Dr Dale. “We talk a lot about personalised treatments in other ways, such as those related to genetics and choosing therapy. This is also personalised medicine: geriatric assessments aren’t any harder, and in many ways are a lot easier and less expensive than other testing we do.”

Oncologists can try different approaches to help older patients tolerate treatment, he observes, from starting at a full dose and reducing it gradually over time or initiating therapy at a lower dose and recalibrating upwards. More individualised treatment would also help to counteract the perceptions of ageism in treatment that we have already discussed.

All older patients need to be treated as individuals, Dr Aapro says, noting that although some treatments might be riskier for an 85-year old with cancer, they might be curative and extend the life of a patient who has no other major health problems. He recalled a recent encounter with a 92-year-old patient with advanced ovarian cancer with severe digestive problems for whom chemotherapy was seen as the most logical treatment. “She asked us to go ahead and try, saying, ‘you might learn, and I might survive.’ And indeed she did tolerate the treatment, saw her quality of life come back with her cancer in remission and she died from other causes 18 months later.”

Recent advances in immunological therapies and other personalised treatments have the potential to improve outcomes for older patients as they are generally less toxic than traditional chemotherapy and other anticancer drugs. Dr Dale notes that former US President Jimmy Carter, who lives with metastatic melanoma that has spread to his liver and brain, was successfully treated with immunotherapy at the age of 91.53

In Japan, medical oncologists still generally use approved cancer drugs for many older patients. But many are increasingly prescribing molecular targeted treatments to elderly patients, which are fully covered under Japan’s health insurance system. This is especially likely to be the case for patients over the age of 80, or those with renal function problems, who find these treatments easier to tolerate, Dr Nakagama says.

In the US, Ms Sloan explains, affordability can be a particular issue given that many new treatments are very expensive.

**Filling the research gap**

Meanwhile, a major challenge is the lack of data on the kinds of treatments that work in older patients, and this is more often due to the relative weighting of clinical trials toward younger and healthier people. Just a third of those participating in standard research for cancer drugs are over the age of 65, Dr Dale notes, despite the fact that 60% of cancer cases occur in this age range.54

“Even those people who are over the age of 65 in trials are, by and large, the most robust and fit older people, so even the information about older patients is a different set of information than you [would] get from older patients with cancer who have co-morbidities,” he adds.

---


In the US, there are efforts by the Food and Drug Administration (FDA) to broaden the criterion defining eligibility for clinical trials, but it is still in the public comment stage. In addition, the endpoints sought in research may not be serving older people well. While most drug trials focus on extending survival, many older cancer patients may prioritise improved function, independence and quality of life at least as much.

In Europe, approaches such as the European Medicines Agency’s Adaptive Pathways, which were piloted between 2014 and 2016, aim to use real-world evidence to supplement clinical trial data, as well as allowing for approval of treatments in phases, starting with a restricted group of patients and then expanding to a wider patient population.

Japan’s National Cancer Centre has introduced the Centre for Cancer Genomics and Advanced Therapeutics. This aims to build up the cancer genome knowledge database for cancer treatment and diagnosis, and consequently helps physicians select the most effective treatments for individual patients and to avoid unnecessary treatments, while also contributing vital research data, Dr Nakagama says.

**Widening the care net: support for the patient journey**

Older people who are living longer with cancer need healthcare systems to adjust and support them, not only during therapy but also throughout the post-treatment phase.

“Part of cancer is survivorship, and a lot more people are being diagnosed with cancer and surviving,” Ms Makaroff says. “The system was set up assuming people would die, and now they aren’t.”

Indeed, survivors have as much need for coordinated care after their cancer treatment as they do during it, according to studies which suggest that the experience of post-treatment health complications, and a continued need for emotional support, underscores the need for a “patient-centred” pathway that can provide navigation and guidance.

---


56 For an example of research that has looked at this issue, see video interview with Dr Enrique Soto from the National Institute of Medicine in Mexico City, SIOG 2019 meeting: https://ecancer.org/en/video/8438-do-older-patients-prioritise-survival-or-quality-of-life


© The Economist Intelligence Unit Limited 2020
This is most evident in the gaps in social support for patients. Waiting lists for psychosocial care remain long, and there are few public health systems in Europe, Japan or the US that provide sufficient services for post-cancer care, according to our expert interviewees. An article last year in the British Journal of Family Medicine found that one in three cancer patients do not get the psychological support that they need.\(^59\)

Current examples of best practice in the UK include Maggie’s Centres, which tend to exist on sites next to hospitals, and Macmillan, which offers financial support to patients, yet there is little in the way of organised national or EU support for cancer patients, and very little for the elderly in particular, Ms Makaroff observes.

The role of specialised cancer nurses who can communicate with both patients and their families is especially vital.\(^63\) Macmillan’s cancer information nurse specialists can provide patients with advice about living with cancer, including cancer risks, information about side effects and prognosis for individual types of cancer.

In the US, a pilot project offering psychological support over the phone to older cancer patients is still being assessed, but initial results suggest that it has helped to alleviate depression in frail, older patients with cancer.\(^64\) The US has a range of specialists dealing with cancer care in some health systems. These include case managers who co-ordinate patient care throughout diagnosis, treatment and recovery, including working with insurance companies and connecting patients and families to helpful resources.\(^65\)

Healthcare providers and patients are supportive of programmes that recognise the need to help patients navigate the care system, Ms Sloan says, given the challenges facing cancer patients when they are at their most vulnerable.

“Once treatment is completed, many cancer patients will have to take drugs for the rest of their lives to prevent recurrence, and these come with side effects. If someone is co-ordinating care, someone can take care of that drug regimen, and that is really at the heart of some of the US [health delivery] models,” she adds.

---

60 See https://www.maggies.org/
A lot of policymakers are making space for consultation with older people and with patient organisations, but we need to support these.

Lydia Makaroff, vice-president of the World Bladder Cancer Coalition

For instance, in the US a Patient Care Connect Programme uses specialised community health workers (or “navigators”) to help patients, especially those in underserved communities, to navigate the health system, including older people with cancer. Navigators use an assessment tool to score patients, and those with worrying scores will see a member of a clinical team.66 Similar models have been used elsewhere in the US and in the UK and Denmark, with studies suggesting that the presence of such navigators is beneficial to cancer care.67

The process of encouraging patients to contribute to the development and shaping of guidelines and services remains a work in progress, especially outside of developed countries. Patient involvement in this process is more likely to occur in Europe and the US, which have a longer tradition of patient activism, than Japan.68 Organisations such as Macmillan continue to solicit patient input, including information from the UK’s National Cancer Patient Experience Survey, to help make elderly cancer patients more active participants in their care.69

“We’ve seen the rise of professional patient organisations and the rise of professional patients,” says Ms Makaroff. “A lot of policymakers are making space for consultation with older people and with patient organisations, but we need to support these.”

More needs to be done to communicate adequately with patients, Dr Aapro says, such as establishing better support during and after therapy, including networks of support for cancer patients and their families and/or friends.

---


© The Economist Intelligence Unit Limited 2020
Conclusion

As global populations age, cancer cases are likely to continue to rise, putting greater pressures on clinicians treating more elderly patients and health systems trying to serve them. This briefing paper has suggested a number of policy recommendations that can improve care for these patients, but as a first step, there must be a realisation that older patients, like younger ones, are individuals and that their management, support and care should reflect their individual needs.

Ensuring a more personalised care pathway for older people living with cancer will require the use of geriatric assessments. These multidimensional tools help clinicians take fully into account the potential impact of co-morbidities, nutrition, psychological status and frailty of patients when considering different treatments and actions. At the same time, the continuing covid-19 pandemic will also have an impact on policy and clinical decision-making where older cancer patients are concerned given the increased risk factors for many in this group. Both the American Society of Clinical Oncology (ASCO) and the UK National Institute for Health and Care Excellence (NICE) have issued recommendations that physicians strongly consider interrupting cancer treatment for patients with active covid-19 infections.70

Yet, for clinicians to choose the best cancer path for each individual patient, they also need better evidence on what is effective. This will require improved information, including “real world” evidence from patient experience and more age-appropriate data from clinical trials. Efforts to encourage researchers to expand their inclusion of older patients in clinical trials should therefore continue.

Once healthcare providers have decided on the best individual course of management, they are likely to see better outcomes if they can establish more multidisciplinary teams that include all of the medical and psychosocial support that patients will need during their cancer care.

Finally, additional support is required for both patients and caregivers to assist with navigation of complex cancer pathways and the post-cancer journey. In combination these recommendations can provide the best chance of a high quality of life for cancer patients across the globe.

Key policy take-aways:

As societies brace to address the syndemic of cancer and ageing, our analysis highlights several key take-aways that governments, policymakers and medical institutions should consider when addressing the rising cancer burden of older patients:

- Ensure older patients are treated fully for cancer as per their needs and be aware of the intermittent bias against screening and treatment these patients may face in some health systems.
- Encourage the use of geriatric assessments so clinicians and healthcare systems are in a better position to meet the needs of older people when considering cancer management and personalised care.
- Make better use of real-world evidence to help manage older cancer patients and advocate for their inclusion in clinical trials.
- Work with patient groups as they have developed resources and special services to meet the needs of older patients undergoing the cancer journey.
- Provide a multidisciplinary team approach as best cancer care practice for older patients, not only during the initial part of the patient journey through diagnosis and treatment, but also after the completion of care to ensure patients are followed up effectively.
While every effort has been taken to verify the accuracy of this information, The Economist Intelligence Unit Ltd. cannot accept any responsibility or liability for reliance by any person on this report or any of the information, opinions or conclusions set out in this report. The findings and views expressed in the report do not necessarily reflect the views of the sponsor.