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Collaboration or a systemic gap? Relations between oncology coordinators and representatives of patient support institutions

Współpraca czy luka systemowa? Relacje koordynatorów onkologicznych z przedstawicielami instytucji wspierających pacjenta

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ABSTRACT

INTRODUCTION: Despite the reforms being implemented in the Polish health system, the situation of oncology patients remains difficult. The health system is unable to meet the challenges on its own, which generates the potential for cooperation with other sectors. Coordinators can serve as a link between hospitals and other patient-oriented institutions.
MATERIAL AND METHODS: The aim of the article is to assess the degree of cooperation between coordinators and representatives of social, rehabilitation, palliative care and non-governmental organizations (NGOs). The article is based on selected results of the project: "Oncological patient coordinators. Profile, experiences and opinions of persons performing the functions of coordinators in Polish hospitals", the results of which will be described in the emerging dissertation of the author of the article. The survey was conducted in 2023. It involved 149 coordinators from Polish hospitals implementing rapid oncology therapy (*szybka terapia onkologiczna* – STO). The study used a survey questionnaire and individual in-depth interviews (IDI). The program IBM SPSS Statistics (29.0.0.0) was used as the main statistical analysis tool.
RESULTS: The results indicate that cooperation between coordinators and representatives of the above-mentioned institutions is marginal; 77.9% of coordinators had never cooperated with NGOs and 62.4% had no contact with social assistance. Only 12.1% frequently collaborate with palliative care, and 7.4% with rehabilitation specialists. The review also took into account oncology Unit structures used in hospitals and participation in the pilot project of the National Cancer Network (NCN; Krajowa Sieć Onkologiczna – KSO). The lack of differences in inter-institutional cooperation suggests that even in more organized models, mechanisms for coordinators to cooperate with representatives of social welfare, rehabilitation, palliative care and NGOs have not been put in place.

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CONCLUSIONS: There is a lack of systemic action and cooperation between coordinators and representatives of institutions that can support oncology patients. Strengthening intersectoral relationships can benefit patients and ease the burden on medical staff by implementing shared care.

KEYWORDS

organization of oncological care, oncological patient coordinators, lack of cooperation, cooperation with representatives of NGOs, cooperation with social welfare representatives

STRESZCZENIE

WSTĘP: Pomimo reform wdrażanych w polskim systemie ochrony zdrowia sytuacja pacjentów onkologicznych pozostaje trudna. System zdrowotny nie jest w stanie samodzielnie sprostać tym wyzwaniom, co stwarza możliwość współpracy z innymi sektorami. Funkcję łącznika pomiędzy szpitalami i innymi instytucjami zorientowanymi na pacjentów mogą pełnić koordynatorzy.

MATERIAŁ I METODY: Celem artykułu jest ocena stopnia współpracy koordynatorów onkologicznych z przedstawicielami opieki społecznej, rehabilitacyjnej, paliatywnej i organizacji pozarządowych (*non-governmental organizations* – NGOs). Artykuł bazuje na wybranych wynikach projektu: „Koordynatorzy pacjentów onkologicznych. Profil, doświadczenia i opinie osób pełniących funkcje koordynatorów w polskich szpitalach", którego wyniki zostaną opisane w dysertacji doktorskiej autorki artykułu. Badanie przeprowadzono w 2023 r. Uczestniczyło w nim 149 koordynatorów z polskich szpitali, realizujących szybką terapię onkologiczną (STO). W badaniu zastosowano kwestionariusz ankiety oraz indywidualne wywiady pogłębione (*in-depth interview* – IDI). Jako główne narzędzie do analizy statystycznej wykorzystano program IBM SPSS Statistics (29.0.0.0).

WYNIKI: Wyniki wskazują, że współpraca koordynatorów z przedstawicielami wspomnianych instytucji jest marginalna; 77,9% nigdy nie współpracowało z NGOs, a 62,4% nie miało kontaktu z opieką społeczną. Tylko 12,1% regularnie współpracuje z placówkami opieki paliatywnej, a 7,4% ze specjalistami rehabilitacji. Podczas przeglądu uwzględniono również występujące w szpitalach rozwiązania typu Unit (tzw. centra narządowe) oraz udział w pilotażu Krajowej Sieci Onkologicznej (KSO). Brak różnic w zakresie kooperacji międzyinstytucjonalnej sugeruje, że nawet w bardziej zorganizowanych modelach nie wprowadzono mechanizmów współpracy koordynatorów z przedstawicielami opieki społecznej, rehabilitacyjnej, paliatywnej i NGOs.

WNIOSKI: Brak systemowych działań oraz współpracy między koordynatorami i przedstawicielami instytucji mogących wspierać chorych onkologicznie. Wzmacnianie relacji międzysektorowych może przynieść korzyści pacjentom i odciążyć personel medyczny poprzez wdrożenie opieki współdzielonej.

SŁOWA KLUCZOWE

organizacja opieki onkologicznej, koordynatorzy pacjentów onkologicznych, brak współpracy, współpraca z przedstawicielami NGOs, współpraca z przedstawicielami opieki społecznej

INTRODUCTION

For more than a decade, changes in the organization of oncology care in Poland have focused mainly on improving diagnosis and treatment. Areas related to comprehensive patient support have remained largely unchanged. Strengthening these activities is sought primarily by patient organizations [1]. Institutions such as non-governmental organizations (NGOs) and social welfare entities can play an important role in meeting non-medical needs of patients. Currently, however, they are rarely invited to collaborate by hospitals [2]. In many countries, their participation in oncology care is much greater [3]. Polish regulations allow hospitals to formally cooperate with patient organizations and social welfare institutions. An example is the regulation enabling representatives of these entities to participate in meeting of the oncology medical team (*konsylium*) in hospitals implementing Comprehensive Oncological Care (Kompleksowa Opieka Onkologiczna – KON) centres[1] [4]. The special requirements for these facilities indicate that the conferences may be attended by people other than the staff, for example social care workers or representatives of patient organizations [5]. In practice, however, hospitals rarely use this option. One of the few solutions that integrate the health and social welfare system is the function of the social nurse. Her task is to organize support for patients in difficult life situations [6]. These nurses mainly take care of

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[1] Oncology centres in Poland offering Comprehensive Oncological Care (KON) are specialized facilities that must meet strictly defined meet high requirements. Unlike traditional oncology centres, they provide comprehensive care at all stages of the disease. They also offer the latest treatment methods. KON are dedicated to specific cancers, e.g. breast or colon. It is profitable for the hospital to treat at KON. The procedures are better priced.

chronically ill and dependent people. However, their activities are ad hoc and are not part of a long-term strategy of intersectoral cooperation. The Polish social welfare system lacks programs dedicated to oncology patients. Assistance is provided on the basis of general criteria, such as degree of disability or material situation. This limits the possibility of targeted support, especially after treatment ends [7]. In the context of these challenges, it is worth understanding the role of oncology patient coordinators employed in Polish hospitals implementing rapid oncology therapy (*szybka terapia onkologiczna* – STO)[2] [8]. In Poland, the oncology coordinator function was introduced in 2015 with the Oncology Package. Currently, it is implemented in various models – within the framework of the STO, Unit structures or the National Cancer Network (NCN)[3] [9]. Care coordination is a key element in the organization of services for patients with chronic diseases, especially in oncology. The role of coordinators is to provide continuous, planned and tailored support to the patient – from diagnosis, through treatment, to the aftercare stage. This includes, among other things, keeping the patient informed, organizing services, monitoring the pathway and fostering communication between members of medical teams. They are the only professional group in the healthcare system whose responsibilities include broad-based organizational and informational support for patients. Assessing the extent of their cooperation with representatives of institutions that can support hospitals in key areas can provide valuable information on possible changes in the support system for cancer patients.

MATERIAL AND METHODS

The study, a fragment of which is presented in this article, was conducted in 2023. The results presented in this article are based on selected results of a broader research project: “Oncological Patient Coordinators. Profile, experiences and opinions of persons performing the functions of coordinators in Polish hospitals”. The full results of this study will be presented in the author’s upcoming doctoral dissertation. The aim of the study was to assess the position, characteristics and scope of activities of oncological coordinators. In the context of this study, the focus was on identifying medical and non-medical entities that cooperate with coordinators. The study involved 149 coordinators employed in hospitals implementing STO.

The respondents came from all provinces and had diverse education and professional experience. The triangulation method was used, combining quantitative and qualitative approaches in order to increase the reliability of the results. Data were collected using a survey and individual in-depth interviews (IDIs). Triangulation allowed for the analysis of the problem from different perspectives and reduced measurement errors. The survey consisted of 54 closed and open-ended questions. The entire survey generated 16 research questions, two of which were relevant to this study: 1) What medical and non-medical entities do coordinators work with? 2) Are there networks of intersectoral relationships supporting cancer patients? In the quantitative analysis, a set of crosstabulations was developed and the chi-square test and Fisher’s exact test were used to assess the statistical significance of differences between groups. In the qualitative part, 12 IDI interviews were conducted, and their content was subjected to thematic analysis. The aim of the article is to assess the degree of cooperation between coordinators and rehabilitation and palliative care facilities, and to identify coordinators’ relationships with NGOs and social services. The assessment also takes into account the impact of implementing certain organizational solutions in hospitals. A comparison was made between the level of cooperation in facilities that have implemented models such as Cancer Unit (e.g. Breast Cancer Unit) [10] and KON (e.g. KON-Breast)[4] [4] or participated in the pilot of the NCN, and those that have not. It was hypothesized that facilities using higher organizational standards may be characterized by greater integration with external institutions, fostering better collaboration with NGOs, social care, rehabilitation and palliative care. After collecting the data in a spreadsheet, they were imported into IBM SPSS Statistics (version 29.0.0.0), which served as the primary tool for statistical analysis. Additionally, Microsoft Excel 2021 (MSO) was used to support data processing.

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[2] Rapid oncology therapy (STO) is an organizational solution aimed at efficiently and quickly guiding the patient through the next stages of oncological diagnostics and treatment. STO is intended for all patients in whom doctors suspect or confirm the occurrence of malignant tumors. STO was introduced to Polish hospitals in 2015. This was the first major oncological reform in Poland. It had not existed in Poland before. In the same year, oncological patient coordinators were also introduced to hospitals. Not every hospital implementing STO employed a coordinator.

[3] National Cancer Network (NCN) is currently being introduced to Polish hospitals. Only specific facilities are included in the NCN, and only they can treat cancer patients. These hospitals must cooperate with each other. These facilities must meet high requirements and have different levels. The first level has only the surgical ward. The second level has the surgical ward and radiotherapy. The third, highest level has the surgical ward, radiotherapy and systemic treatment.

[4] Some hospitals in Poland treat according to the procedures in force in Units and KON. These are more highly specialized units. They are considered higher level hospitals and specialize in the treatment of e.g. breast cancer, colon cancer and lung cancer.

RESULTS

To better understand the context of the analyses, the presentation of the results began by determining the frequency of cooperation between oncology coordinators and representatives of various entities, both medical and non-medical (Figure 1).

The data show that oncology coordinators most often cooperate with other hospitals. Frequent contacts with these facilities are reported by 57.7% of respondents. IDIs show that the cooperation is mainly related to cancer diagnosis and treatment card (*karta diagnostyki i leczenia onkologicznego – karta* DiLO)[5] and patient transfer. It is much less common for coordinators to cooperate with primary health care (PHC)[6]. Not even half of the respondents (38.3%) consider this cooperation to be limited, and 20.8% say it does not occur at all. Statements from the interviews confirm these results. The coordinators emphasized that their contacts with PHC are mainly limited to matters related to *karta* DiLO (*K6: It's mainly about closing or improving these cards, if at all possible*). Some coordinators admitted that they do not send *karta* DiLO back to PHCs, despite current regulations. The survey results indicate a lack of real cooperation between these sectors. Coordinators' contacts with outpatient specialty clinics and diagnostic laboratories outside their hospitals are also not common. Frequent contacts with such facilities are reported by 40.9% of respondents. Qualitative interviews revealed that a structured network of cooperation between outpatient specialist care (OSC)[7] and cancer hospitals is lacking (*K10: I, in my professional work, have not encountered something like this, that a coordinator from OSC called me (...). And in my opinion, outpatient clinics that diagnose breast cancer in the OSC should have coordinators responsible for contacting administrative and substantive coordinators, if I remember their names correctly*). The least developed is cooperation between representatives of NGOs and employees of social welfare institutions. As many as 77.9% of oncology patient coordinators have never worked with foundations and associations, and 62.4% have had no contact with social welfare institutions. In interviews, coordinators stressed that patients rarely ask if they can contact NGOs. In their opinion, this reduces the need to establish cooperation with this sector (*K1: Foundations? In general, patients don't ask about foundations. I'll be honest, at least not us, and so I don't have any contact with foundations*). Some coordinators also pointed to a lack of procedures to integrate NGOs into the oncology system and a reluctance towards such organizations (*K6: No, we don't cooperate. Hardly, for example, amazons – when the boss sees them or hears about them, he is sick. Patients don't ask on their own either*). Similarly, cooperation between oncology coordinators and palliative care representatives and rehabilitation staff is limited. Only 12.1% of coordinators report frequent contact with palliative care staff and 7.4% with rehabilitation staff. Oncology patient coordinators emphasized that patients are mainly referred to hospices and rehabilitation centres by family doctors or specialists. Their own role in this regard is marginal (*K10: Most of the time it's like palliative care, the patient goes to a family doctor or a specialist makes a referral to a home or inpatient hospice. And it's totally out of the coordinator already*). Table I presents data on the impact of implementing the Unit/KON models on the level of cooperation between oncology patient coordinators and representatives of external entities.

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[5] Cancer diagnosis and treatment card (*karta* DiLO) is a key document in Poland. Patients suspected of having cancer receive this *karta* DiLO Card. The card facilitates their access to rapid diagnostics and then treatment. And the rapid deadlines specified in the regulations must be maintained here. Everyone who has a *karta* DiLO receives their own coordinator. This document was implemented in Poland as part of the STO reform in 2015.

[6] Primary health care (PHC) is understood in Poland as the care of a general practitioner. The advice of a PHC doctor is paid for by the state, not the patient. The PHC doctor is the primary physician who (if necessary) refers the patient to a specialist.

[7] Outpatient specialist care (OSC) is a group of specialist doctors.

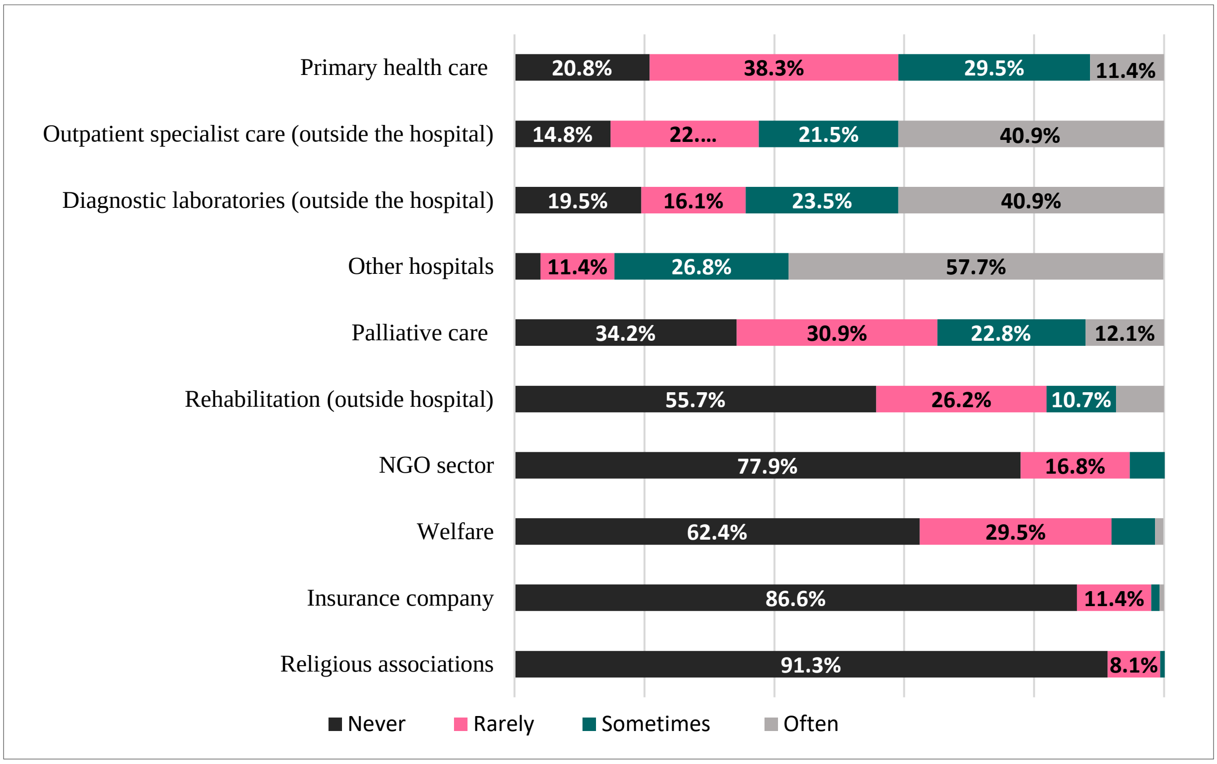

Fig. 1. Cooperation of oncology coordinators with representatives of external institutions supporting oncology patients (N = 149; author's own study); NGO – non-governmental organization.

Table I. Collaboration of oncology coordinators with representatives of other institutions, with a division of facilities with Units/KON vs facilities without Units/KON (N = 149)

Inter-institutional cooperation	Implementation of Unit/KON organizational solutions in the hospital (%)		Statistical significance tests
	implemented	not implemented	Fisher's test
Cooperation with palliative care/hospices			
Never	35.20%	33.70%	p = 0.311
Rarely	33.30%	29.50%	
Sometimes	25.90%	21.10%	
Often	5.60%	15.80%	
Cooperation with rehabilitation (outside the hospital)			
Never	46.30%	61.10%	p = 0.088
Rarely	25.90%	26.30%	
Sometimes	18.50%	6.30%	
Often	9.30%	6.30%	
Cooperation with patient support organizations (NGOs)			
Never	72.20%	81.10%	p = 0.046
Rarely	20.40%	14.70%	
Sometimes	7.40%	4.20%	
Often	0.0%	0.0%	
Cooperation with social welfare			
Never	57.40%	65.30%	p = 0.299
Rarely	31.50%	28.40%	
Sometimes	11.10%	4.20%	
Often	0.0%	2.10%	

Author's own study. KON – Kompleksowa Opieka Onkologiczna (Comprehensive Oncological Care); NGOs – non-governmental organizations.

The data collected suggest that the implementation of Unit/KON models had no significant effect on coordinators' collaboration with palliative and hospice care (p = 0.311, Fisher's test). The percentage of coordinators who never collaborated with these units was similar in both groups (35.2% in facilities with Unit/KON vs 33.7% in facilities without these structures). Frequent cooperation was slightly more common in hospitals without Unit/KON (15.8% vs 5.6%). In the case of out-of-hospital rehabilitation, the data show a greater lack of cooperation in facilities that have not implemented Unit/KON. As many as 61.1% of coordinators from these units have never cooperated with employees of rehabilitation clinics, compared to 46.3% in facilities with such structures. There are also differences in occasional cooperation. Coordinators from facilities with Unit/KON were more likely to report occasional contact with specialists rehabilitation (18.5% vs 6.3%). Although Fisher's test showed no significant differences (p = 0.088), the noticeable trend may suggest that more integrated organizational models favor more frequent cooperation with representatives of rehabilitation facilities. The survey results indicate a low level of cooperation with NGOs in both groups. 72.2% of coordinators from establishments with Unit/KON and 81.1% from establishments without these structures never collaborated with NGOs. The chi-square test did not show any significant differences (p = 0.438), but the Fisher test suggests some correlation (p = 0.046). This may indicate the beginning of cooperation between oncology coordinators employed in hospitals where a Unit/KON was implemented and representatives of patient support organizations. As with NGOs, cooperation with social welfare institutions remains low. There are no significant differences between groups (p = 0.299, Fisher's test). More than half of the coordinators reported no cooperation with this sector (57.4% in facilities with Unit/KON vs 65.3% in facilities without these structures). However, facilities with Unit/KON were more likely to have occasional contacts with social welfare institutions. The percentage of coordinators declaring occasional cooperation was 11.1% vs 4.2% in the other units. The review of the data included in Table I indicates that the implementation of Unit/KON did not significantly affect coordinators' cooperation with palliative care, rehabilitation, NGOs and social welfare institutions. However, some trends suggest a slightly higher (though still low) involvement of coordinators from facilities with comprehensive care models, especially in the areas of rehabilitation and NGOs. It is worth analyzing whether and to what extent the participation of facilities in the pilot of the NCN has affected the level of cooperation between coordinators and other institutions. NCN is a new model for organizing oncology care. It is important to examine whether coordinators from facilities participating in the pilot cooperate more often with representatives of medical and non-medical entities than those who did not participate in the pilot. Detailed data are presented in Table II.

Table II. Collaboration of oncology coordinators with representatives of other institutions, and participation of hospital in pilot program of NCN vs no participation of hospital in pilot (N = 149)

Inter-institutional cooperation	Hospital participation in pilot of NCN (%)		Statistical significance tests
	participated	not participated	Fisher's test
Cooperation with palliative care/hospices			
Never	38.30%	32.40%	p = 0.554
Rarely	23.40%	34.30%	
Sometimes	23.40%	22.50%	
Often	14.90%	10.80%	
Cooperation with rehabilitation (outside the hospital)			
Never	63.80%	52.00%	p = 0.325
Rarely	17.00%	30.40%	
Sometimes	12.80%	9.80%	
Often	6.40%	7.80%	
Cooperation with patient support organizations (NGOs)			
Never	78.70%	77.50%	p = 0.845
Rarely	14.90%	17.60%	
Sometimes	6.40%	4.90%	
Often	0.0%	0.0%	

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Cooperation with social welfare			
Never	57.40%	64.70%	p = 0.634
Rarely	31.90%	28.40%	
Sometimes	8.50%	5.90%	
Often	2.10%	1.00%	

Author's own study. NCN – National Cancer Network (Krajowa Sieć Onkologiczna); NGOs – non-governmental organizations.

In the facilities participating in the NCN pilot, cooperation with palliative and hospice care was slightly more frequent (14.9% vs 10.8%). At the same time, coordinators from these units more often declared a complete lack of cooperation with this sector (38.3% vs 32.4%). The results indicate that the participation of the hospital in the NCN pilot had no significant effect on the cooperation of oncology patient coordinators with palliative and hospice care representatives (p = 0.554, Fisher's test). The lack of cooperation with rehabilitation facilities outside the oncology centre was declared by 63.8% of coordinators from NCN pilot facilities and 52.0% from non-pilot units. Occasional cooperation ("sometimes") and frequent cooperation ("often") in both groups was at similar level. In piloted units it was 12.8% and 6.4%, respectively, and in non-piloted units 9.8% and 7.8%. Fisher's test did not show any significant differences (p = 0.325). These data indicate that the cooperation of coordinators with representatives of rehabilitation workers remains marginal, regardless of participation in the NCN pilot. A similar relationship was observed in the case of NGOs. The lack of cooperation with NGOs was declared by 78.7% of coordinators from facilities participating in the pilot and 77.5% from other units. Fisher's test did not show any significant differences (p = 0.845), which may suggest that participation in the pilot did not influence the development of this cooperation. Cooperation between coordinators and social welfare institutions also remains low. More than half of coordinators reported its complete lack (57.4% in facilities participating in the NCN pilot vs 64.7% in non-pilot units). These differences were not statistically significant (p = 0.634, Fisher's test). In summary, the review of results did not reveal significant differences in the extent to which oncology coordinators cooperate with medical and non-medical institutions depending on the participation of the institution in the NCN pilot. The lack of statistical differences suggests that implementation of the NCN model will not intensify intersectoral cooperation.

DISCUSSION

The results of the study indicate that the implementation of the Unit/KON organizational models and participation in the NCN pilot did not have a significant impact on the cooperation of oncology patient coordinators with representatives of external entities. Although some positive trends were observed in the case of coordinators' contact with NGOs and rehabilitation facilities, among coordinators employed in facilities using comprehensive care models (Unit-type), these differences were not significant. Cooperation of coordinators with representatives of palliative care and the social care sector remains at an equally low level, regardless of the implemented organizational solutions. Of particular concern is the almost complete lack of cooperation between coordinators and the social care sector and NGOs. The data show that eight out of ten oncology coordinators have never had contact with employees of NGOs, and an equally low level of cooperation applies to social care workers. Coordinators indicate a lack of tools for identifying non-medical needs of patients, and hospitals lack mechanisms for regulating intersectoral cooperation. Foreign studies of coordinated care emphasize the importance of the concept of "shared care", in which different sectors work together for comprehensive patient support [11]. It is crucial to include representatives of non-medical professions in the coordination process. In many coordinated care systems, the role of coordinators is played not only by nurses, but also by representatives of other professions [12]. Experts stress that effective care requires the involvement of multiple institutions, which should be aware of the challenges patients face during treatment. It is also important to have a better understanding of the roles and responsibilities of all parties involved and to support patients in making informed use of the available resources of the health and social welfare system [11]. In some countries, coordinated care systems involve close integration of hospitals with other entities. In many foreign models, up to 90% of coordinators maintain contact with patients after treatment, helping to organize follow-ups and long-term care [13]. Meanwhile, in Poland, the role of coordinators mainly focuses on the diagnostic stage, organizing consiliums, and often ends when treatment begins. Further interventions are usually initiated by patients. The limited role of coordinators means that their potential is not fully realized. Patient support could also include areas beyond the scope of the *karta* DiLO. Oncology rehabilitation, which, despite its important role, is rarely treated as a standard component of comprehensive care, remains a particular challenge. Expert reports indicate unequal access to rehabilitation facilities [14]. Although oncological coordinators play a key role in organizing the diagnostic and therapeutic path, their involvement in referring patients to rehabilitation centres outside their home hospitals is very limited. More than half of the surveyed oncological patient coordinators have never cooperated with rehabilitation facilities outside their centre. The involvement of coordinators in referring patients to palliative and hospice care units is similar – more than one third of the oncological coordinators participating in the study claim that they have not had contact with this sector, and another third report only occasional cooperation.

Foreign reports indicate that coordinators' activities should include not only optimization of the diagnostic and therapeutic pathway, but also psychological, social and professional support, which significantly affects the quality of life after treatment [15]. In Poland, coordination usually ends with the therapeutic process. As a result, patients are often left without formal support during the period of recovery and return to daily functioning. In many countries, it is noted that effective coordination should include integration with the social security system and training of medical personnel in cooperation with social organizations [11]. In Poland, such integration is still marginal, and intersectoral cooperation is neither structured nor widespread. Although training for oncology coordinators includes elements on cooperation with NGOs, systemic solutions that would realistically strengthen such cooperation are lacking. The introduction of such mechanisms could significantly improve the quality of life of oncology patients by minimizing barriers to accessing support both during and after treatment.

CONCLUSIONS

1. It cannot be stated that the implementation of organizational models such as Unit/KON and participation in the pilot of the NCN contributed to the strengthening of cooperation between oncological coordinators and representatives of external institutions. The lack of significant differences in inter-institutional and inter-sectoral cooperation suggests that even in more organized Unit-type models, effective mechanisms for integrating the healthcare system – oncological patient coordinators with the non-governmental sector, social care, palliative or rehabilitation – have not emerged.
2. There are grounds to believe that the Polish oncological care system has still not reached a level at which the need for close inter-sectoral cooperation is widely recognized and implemented. The lack of integration of activities of the healthcare sector, social care and NGOs is one of the key systemic challenges. The lack of such cooperation may negatively affect both patients and healthcare facilities that do not use the potential of other entities.
3. Coordination of oncology care in Poland is still mainly focused on the diagnostic and treatment stages. It is necessary to introduce mechanisms to enable earlier and more effective integration of patients into rehabilitation programs and to ensure a smooth transition to palliative care when necessary.
4. Organizational reform measures are worth supplementing with mechanisms that integrate the health care system, especially oncology coordinators with broader social support. Only then will it be possible to provide oncology patients with comprehensive and holistic care.

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