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Cancer Research UK's Priorities for the Health Disparities White Paper

For many of the most marginalised in our society, their chances of getting cancer, experience of care, and ultimately their chances of surviving cancer are worse because of circumstances beyond their control. These disparities impact every stage of the cancer pathway, including prevalence of cancer risk factors and access to health and cancer services. Today, these unacceptable disparities in cancer are one of the greatest and most challenging barriers to reducing cancer incidence and improving cancer outcomes in England.

With CRUK modelling estimating that around **30,000 additional cancer cases every year are linked to socio-economic deprivation,**[1] tackling cancer inequalities must be at the heart of the Health Disparities White Paper (HDWP). Now more than ever, action and investment are essential to helping the UK Government achieve its levelling up ambitions and ensuring no one is left behind in our shared mission to beat cancer.

Cancer Research UK's Recommendations

Prevention

- CRUK are calling for a **commitment to reducing disparities in smoking prevalence**, by setting a target of reaching less than 5% smoking prevalence for all socioeconomic groups by 2040 at the latest in England, and by putting a clear plan in place to reach this target.
- The UK Government should introduce **additional funding for tobacco control – for example through a Smokefree Fund**: a fixed annual charge on the tobacco industry that would use their funds, but without their interference, to pay for tobacco control measures across the UK.
- The HDWP should **commit to the UK Government exploring new ways of reducing the attractiveness of tobacco products**, such as dissuasive cigarettes, pack inserts, raising the age of sale to 21, and maximum unit pricing.
- The UK Government should ensure the **restrictions to volume-based and location promotions on products high in fat, salt and sugar (HFSS) are implemented as originally planned on 1 October 2022,** and the regulations to end TV advertising for HFSS products before 9pm and restrict paid-for HFSS advertising online are implemented as planned on 1 January 2023.

Health

- The UK Government must ensure that the HDWP provides specific funding opportunities for the development and piloting of **evidence-based interventions with a focus on reducing disparities in help-seeking**.
- NHS England and the Department of Health and Social Care must **target campaigns which aim to encourage help-seeking or inform screening programme participation to groups showing lower uptake.**
- The HDWP should commit to sharing guidance and best practice approaches to support Integrated Care Systems and Cancer Alliances to **improve data quality and availability**, alongside ringfenced resources to improve data collection.
- The HDWP must **set out targeted policies addressing disparities in capacity between cancer services**, particularly through addressing workforce disparities.

Prevention

Preventable disease and mortality continue to have a major impact on our nation's health, the NHS, and economy. The two biggest causes of cancer – smoking and overweight and obesity[2] – are more prevalent in deprived groups across the UK. **That's why we welcome the UK Government's focus on levelling up and acknowledgement of the need to tackle health inequalities through its commitment to develop the Health Disparities White Paper.** Now more than ever, action and investment are needed to tackle the biggest preventable causes of cancer, and also others like alcohol, to improve the nation's health, and to help the UK Government achieve its levelling up ambitions.

Tobacco

Priority 1: Achieving smokefree equitably

Tobacco is the biggest cause of cancer and preventable death in the UK.[2,3] Decades of Government action have meant adult smoking prevalence in the UK was at a record low at 14.1% in 2019,[4] but this masks significant inequality. There are big differences in smoking rates across the population, with **significantly higher smoking rates among the most deprived compared with the least deprived.** These differences make it one of the leading drivers of health inequalities:

- Smoking is responsible for **half the difference in life expectancy** between the lowest and highest income groups in England.[5]
- CRUK estimates show that there are nearly **twice as many smoking-attributable cancer cases in the most deprived group** compared to the least deprived in England.[6]
- People experiencing financial difficulty are **less likely** to be successful in a quit attempt.[7]
- The smoking prevalence gap between people in routine and manual occupations and those in managerial and professional occupations in England has widened significantly since 2012,[8] because smoking rates are decreasing more slowly in routine and manual workers.[9]
- Relative smoking inequalities are projected to **widen**.[10]

While the UK Government's vision for England to be smokefree by 2030 is welcome, according to CRUK analysis based on 2018 data, we are not on track to deliver this ambition until 2037. In fact, **only the least deprived group in England is estimated to be smokefree by 2030, while the most deprived group won't reach this target until the mid-2040s.**[11]

That's why we're calling for a commitment to reducing disparities in smoking prevalence, by setting a target of reaching less than 5% smoking prevalence for all socioeconomic groups by 2040 at the latest in England, and by putting a clear plan in place to reach this target. Similar targets should also be set in the devolved nations.

Priority 2: Smokefree Fund

Without additional and sustainable funding, it will not be possible to support everyone who wants to stop smoking. **Tobacco kills up to half of all users in the long term whilst being highly profitable for its manufacturers**: the four largest tobacco manufacturers make around £900 million of profits in the UK each year.[12] In comparison, funding for local, regional and national tobacco control activities in England has been significantly cut in recent years.[13] **These funding cuts have also been greatest in more deprived local authorities**[13] **– which risks exacerbating existing health inequalities**. These funding pressures mean local authorities are not only unable to deliver smoking cessation services as they should,[14] but this also threatens the delivery of local stop smoking campaigns and enforcement activity aimed at preventing underage tobacco sales and tackling illicit tobacco:

- Whilst all areas used to have a stop smoking service open to all, only 67% of local authorities in England commissioned a specialist service open to all local people who smoke in 2021.[15] Furthermore, between 2013/14 and 2019/20 total local authority spending on stop smoking services and tobacco control in England fell by 43.3% from £148.5 million to £84.2 million.[16]
- National spending in England on public education campaigns has also dropped from a peak of £23.38 million in 2008/9 to just £1.99 million in 2017/18.[17,18]

Smoking is estimated by Action on Smoking and Health (ASH) to cost society £17 billion annually in England.[19] Yet only £265.5 million of additional funding would be needed to pay for national, regional and local tobacco control activity in England, which increases to £315.2 million for UK-wide measures.[20]

That's why CRUK are calling for additional funding – for example, through a Smokefree Fund: a fixed annual charge on the tobacco industry that would use their funds, without their interference, to pay for tobacco control measures across the UK. This investment could significantly help reduce smoking prevalence, address a leading driver of health disparities across the UK, and ultimately support the vital mission of the UK Government to level up (more **here**).

Priority 3: Making smoking less appealing

Over the years, the UK has successfully implemented several regulations aimed at reducing the appeal – and therefore the uptake – of tobacco products. To maximise their impact, DHSC should rectify the loopholes used by the tobacco industry to undermine these measures.[21] However, there is also evidence to show that the effectiveness some of these successful measures, like health warnings on cigarette packs, can decrease over time as people who smoke become more used to them.

It is therefore important that the UK Government explore new legislative measures to reduce the attractiveness of tobacco products, such as dissuasive cigarettes, pack inserts, raising the age of sale to 21, and maximum unit pricing. Some of these are likely to have a particular impact on inequalities, for example maximum pricing.

Priority 4: Improving access to evidence-based cessation treatment for people who smoke

Improving the delivery of smoking cessation support in primary care

It is important to maximise the role that primary care professionals play in smoking cessation support. **Improving the delivery of smoking cessation support in primary care across the UK should get us closer to smokefree targets,** and the largest absolute benefits in health outcomes should be seen by the lower socioeconomic group given their higher smoking rates. CRUK modelling suggests that by 2039 this could lead to around 480,000 fewer cases of smoking related disease (230,000 in the most deprived groups alone). It would also save the UK around £8bn in smoking related healthcare costs and save £14bn in costs to wider society.[22]

That's why steps need to be taken to improve stop smoking support in primary care, this should include:

- **Ensuring all relevant primary care professionals have undertaken training in and are routinely delivering Very Brief Advice (VBA) on smoking in consultations with patients who smoke.**
- **Ensuring primary care professionals offer evidence-based interventions to patients to support them to stop smoking, including systematically referring them to a local stop smoking services for ongoing support where available, or prescribing pharmacotherapy for smoking cessation with brief advice.**

However, because smoking prevalence would be reduced similarly across all socioeconomic groups, our modelling suggests that by itself improving this would not narrow the socioeconomic inequity in smoking rates.[22]

That's why alongside improving smoking cessation support in primary care for all, we need research to understand what tailored interventions could effectively enhance support for those in lower socioeconomic groups and reduce inequalities.

E-cigarettes are a relatively new smoking cessation tool. They are not risk free and their long-term effects are unknown. However, the long-term harms of tobacco are indisputable, and e-cigarettes represent an opportunity for harm reduction. Evidence to date indicates that e-cigarettes are not only far less harmful than tobacco smoking[23,24,25,26,27,28] but can also help people to stop smoking [29,30,31,32,33]

and avoid relapse. E-cigarettes are a popular cessation tool for all people who used to smoke[34] **so have potential to reduce health inequalities by helping people in more disadvantaged communities to stop smoking.** This is important as smoking prevalence rates are far higher in the most deprived compared with the least deprived populations[35] and people experiencing financial difficulty are less likely to be successful in a quit attempt.[36] Smoking cigarettes costs more than two-and-a-half times as much as using e-cigarettes,[37] making e-cigarettes more financially viable. For these reasons, e-cigarettes represent a potential tool to support people from more deprived groups to stop. In line with NICE guidance in England and Wales, we therefore recommend:

Primary care professionals should discuss and recommend using e-cigarettes as one of a range of tools that can help patients to stop smoking.

Increasing the number of people accessing stop smoking services

Local stop smoking services, which provide a combination of behavioural support and treatment, offer people who smoke **the best chance of stopping successfully**. Yet they are not universally available, [15,16] mainly due to funding cuts. **It is essential that local authorities have enough resources to fund these services sustainably**, so that they can be available across the country.

CRUK modelling also suggests that **there is more to be gained from increasing the amount of people who access these services rather than improving success rates.** That's why it's crucial that there are **more mass media campaigns that motivate people to stop smoking and signpost them to these services.** These campaigns should especially **target people most at-risk of smoking** for example, pregnant women, those with mental health conditions, and the most deprived.

Service planners and commissioners of local stop smoking services should be required to proactively promote and target their service offer to people in the most deprived groups, e.g. through advertising, social marketing and media campaigns, to improve engagement and uptake of these evidence-based, effective services.

Obesity

Obesity is strongly linked to deprivation[38] and while the causes of obesity are complex, the environment around us plays an important role in guiding our choices and determining how easy it is to maintain a healthy weight. **A 9pm watershed on less healthy food and drink advertising on TV, and significantly restricting such advertising online, will help maintain healthy diets and so tackle overweight and obesity**.[39,40,41,42,43] These are a key part of a wider series of obesity measures needed to improve the nation's health, reduce disparities and relieve NHS pressure.

The UK Government should implement - in full and as planned in January 2023 - regulations to end TV advertising for products high in fat, salt and sugar before 9pm and restrict paid-for HFSS advertising online.

Additionally, the UK Government must follow through on their commitments to support shoppers to purchase healthier options, by restricting promotions of unhealthy food and drink products by volume (like buy one get one free) and location (end of aisle, checkouts) as originally planned on 1 October 2022.

Health

There are significant and unacceptable cancer disparities – in who faces barriers to accessing cancer care and NHS services, unwarranted variation in the capacity of the NHS to meet patient need, and ultimately intolerable disparities in cancer outcomes and survival.

The UK Government's HDWP must take action to eliminate these disparities and ensure no one is left behind as we drive forward innovation in cancer services, diagnosis, and treatments.

Priority 1: Tackling barriers to help-seeking

NHS England's Core20PLUS5 approach identifies priority areas for addressing health inequalities across populations within Integrated Care Systems (ICS). The 'Core20' and PLUS' element refers to target population groups: the most deprived 20% of the population and marginalised groups. The '5' refers to five clinical priorities, and it is welcome that addressing inequalities in the early diagnosis of cancer is one of these priorities.[44] Reducing disparities in access to NHS services and screening programmes will be an essential part of making progress here.

There is wide-ranging evidence of disparities in help-seeking:

- People from more deprived backgrounds report more barriers to seeking help from health services.[45] They also have lower recognition of the signs and symptoms of cancer – for example people from the mot deprived populations are almost half as likely to recognise 'unexplained lump or swelling' or 'change in appearance of a mole' as a potential cancer symptom.[46]
- The pandemic had a varying impact on how comfortable people felt when accessing help – for example ethnic minorities were significantly less likely than white adults to feel safe from COVID-19 at their GP in 2021.[47]
- There are lower screening programme participation rates for people from more deprived areas,[48] more ethnically diverse areas,[49,50] and for people with disabilities,[51] and research has found the screening system creates a number of barriers for trans men and non-binary people's access to appointments.[52]

The UK Government must ensure that the HDWP provides specific funding opportunities for the development and piloting of **evidence-based interventions with a focus on reducing disparities in help-seeking**.

NHS England and the Department of Health and Social Care must **target campaigns which aim to encourage help-seeking or inform screening programme participation to groups showing lower uptake.**

Data availability must also be a key focus of the HDWP, as this has been highlighted as a key barrier to trusts taking greater action on health inequalities.[53] Data on cancer which is broken down by sexual orientation, people with mental health conditions, and people with a disability are all very limited, and whilst there is data and evidence regarding cancer and ethnicity, population estimates have not been routinely available. There are also particular health settings where data collection is poorer, such as primary care, and data across services is not routinely linked,[54] which limits monitoring and analysis of trends in cancer disparities.

The HDWP should commit to sharing guidance and best practice approaches to support Integrated Care Systems and Cancer Alliances to **improve data quality and availability**, alongside ringfenced resources to improve data collection.

Priority 2: Addressing regional variation

Regional disparities in capacity and performance between cancer services means cancer patients currently face a postcode lottery in their cancer diagnosis and treatment:

- **Workforce**: Whilst workforce shortages impact all parts of the country, the most deprived areas are worst affected by shortages in the primary care workforce.[55,56]There is also substantial variation in the clinical oncology workforce. Growth in the clinical oncology consultant workforce over the last 5 years has averaged around 3%, but it has been minimal in the East and North West of England.[57]
- **Cancer Waiting Times**: CWTs data consistently show major geographical variation in the performance of cancer services. For example, in September 2021, the National Audit Office found that patients living in the worst performing ICS were more than twice as likely as patients in the best-performing ICS to wait longer than 62 days for treatment.[58] A significant contributory factor to this is geographic variation in capacity across cancer services.

Outcomes: There's also concerning evidence of geographical variation in cancer outcomes.

- The proportion of lung cancer cases diagnosed at stage I and II ranged from 25% to 35% across Cancer Alliances in 2016-2018.[59] Whilst this may in part be due to differences in socio-demographics, it's also likely that some variation is avoidable and could be reduced or removed with existing early diagnosis interventions.

Without addressing disparities in the capacity of cancer services, people affected by cancer will continue to face unacceptable inequalities in their access to care, and ultimately may face poorer outcomes due to where they live.

The HDWP must set out **targeted policies addressing disparities in capacity between cancer services**, particularly through addressing workforce disparities.

For primary care, financial incentives have been used to attempt to attract GP trainees to areas that have been historically struggled to fill training places – with the Targeted Enhanced Recruitment Scheme, which gives trainees a £20,000 salary supplement, in place since 2016.[60] In 2018/19, the scheme filled all 265 of its posts, suggesting it has had some success in recruiting GPs to hard-to-recruit areas.[61]

For more information or any questions, please contact Olivia Cheek, Prevention Policy Advisor or Rani Govender, Health Policy Advisor.

Other resources

- Making Conversations Count for All report (2021)
- Tobacco and Health Inequalities briefing (2021)
- Cancer in the UK 2020: Socio-economic deprivation report (2020)
- Staying Healthy in a Fast-Changing World report (2022)

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