Our cancer and health inequalities strategy 2025–2030

November 2024

CANCER RESEARCH UK

Together we are beating cancer

Contents

Foreword

We exist to beat cancer.

But the burden of cancer isn't distributed equally across the population. We have a responsibility to ensure no one gets left behind in our progress, because beating cancer means beating it for everyone.

Health inequalities are driven by the conditions into which people are born, grow, live, work and age. Not everyone has the same pressures and opportunities in life, meaning it's harder for some people to live healthily, while others face more barriers to seeking healthcare.

Cancer inequalities, specifically, exist in all aspects of public health and cancer care. There are differences across the cancer pathway beginning with the risk of developing the disease all the way through to differences in outcomes.

Our commitment to tackling inequalities is woven throughout our organisational long-term strategy, from championing a more diverse and inclusive research community to reducing the inequalities in access to proven cancer interventions. However, there's a need for focus and prioritisation.

Our cancer and health inequalities strategy provides a clear and actionable plan to tackle inequalities, within the broader health system.

We know we can't address the problem of inequalities alone, so we'll utilise our proven ability to collaborate with people affected by cancer inequalities and partner with communities and organisations to amplify our impact.

Together we'll:

- deepen our understanding of cancer inequalities and what works to tackle them
- drive impact through influence
- engage and inform the public in ways that are inclusive, relevant and accessible

We have the tools, the knowledge and the opportunity to make significant improvements. This strategy is more than just a plan – it represents hope and a future where everybody lives longer, better lives, free from the fear of cancer.`

Dr Ian Walker
Executive Director of Policy, Information and Communications

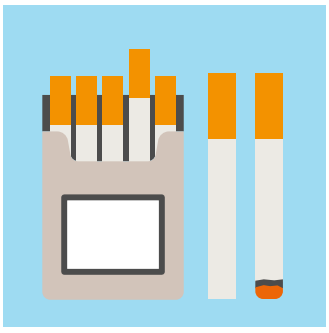
Introduction

At Cancer Research UK, our vision is a world where everybody lives longer, better lives, free from the fear of cancer.

As research delivers insights and innovation in the prevention, diagnosis and treatment of cancer, and as policies change for the better and services improve, we've seen huge advances in survival from the disease over the last 50 years. However, we know that improvements are not experienced consistently across the population. This strategy sets out our approach to ensuring that no one is left behind by improvements in cancer outcomes.

▸ Cancer and health inequalities

Health inequalities are unfair and avoidable differences in health outcomes across the population. In cancer, we see inequalities across the cancer pathway. These differences arise from a complex interplay of factors, including [1] [2]:



exposure to cancer-specific risk factors, such as smoking

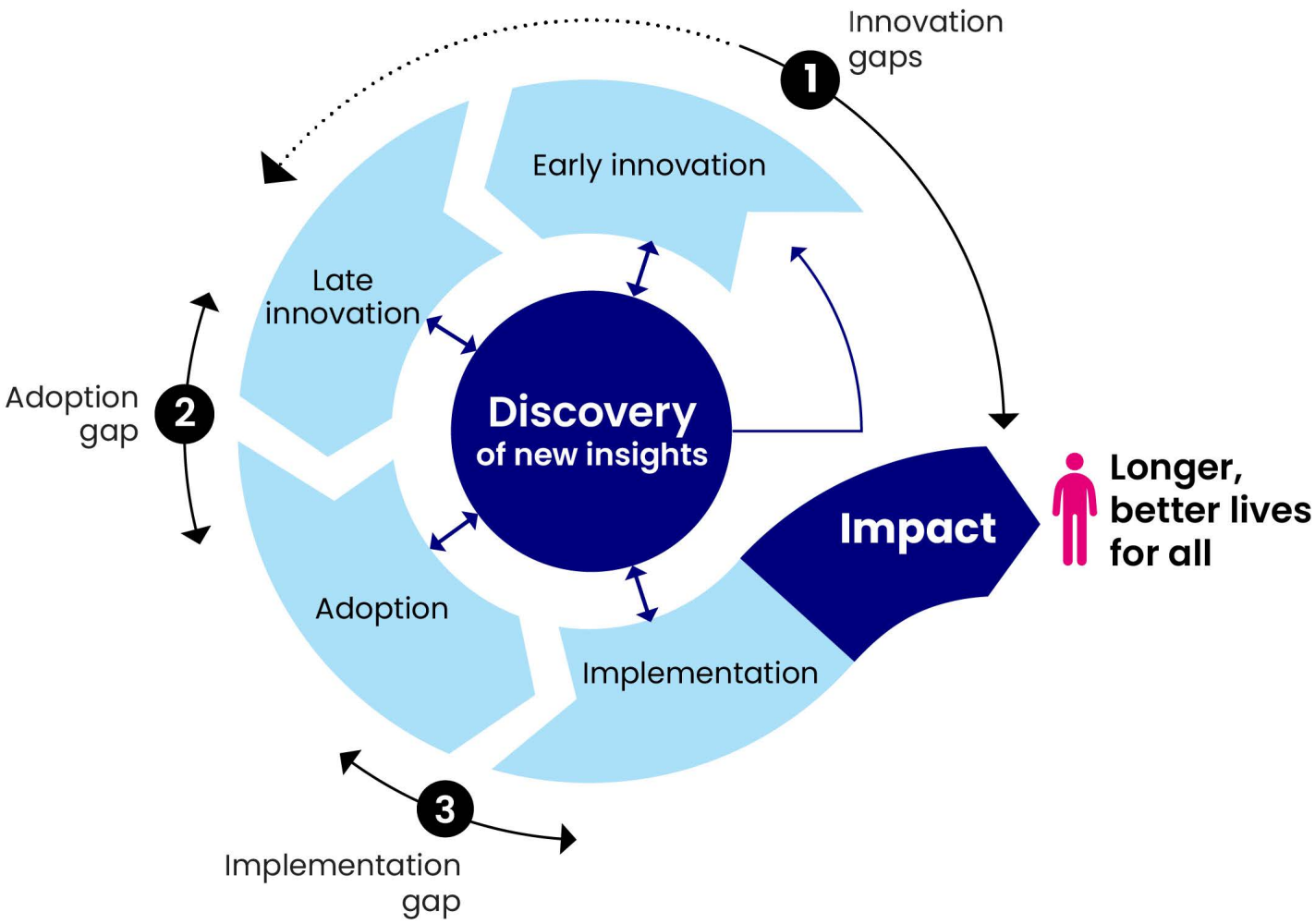
variation in access to healthcare

a range of wider determinants of health, such as economic deprivation, housing or education

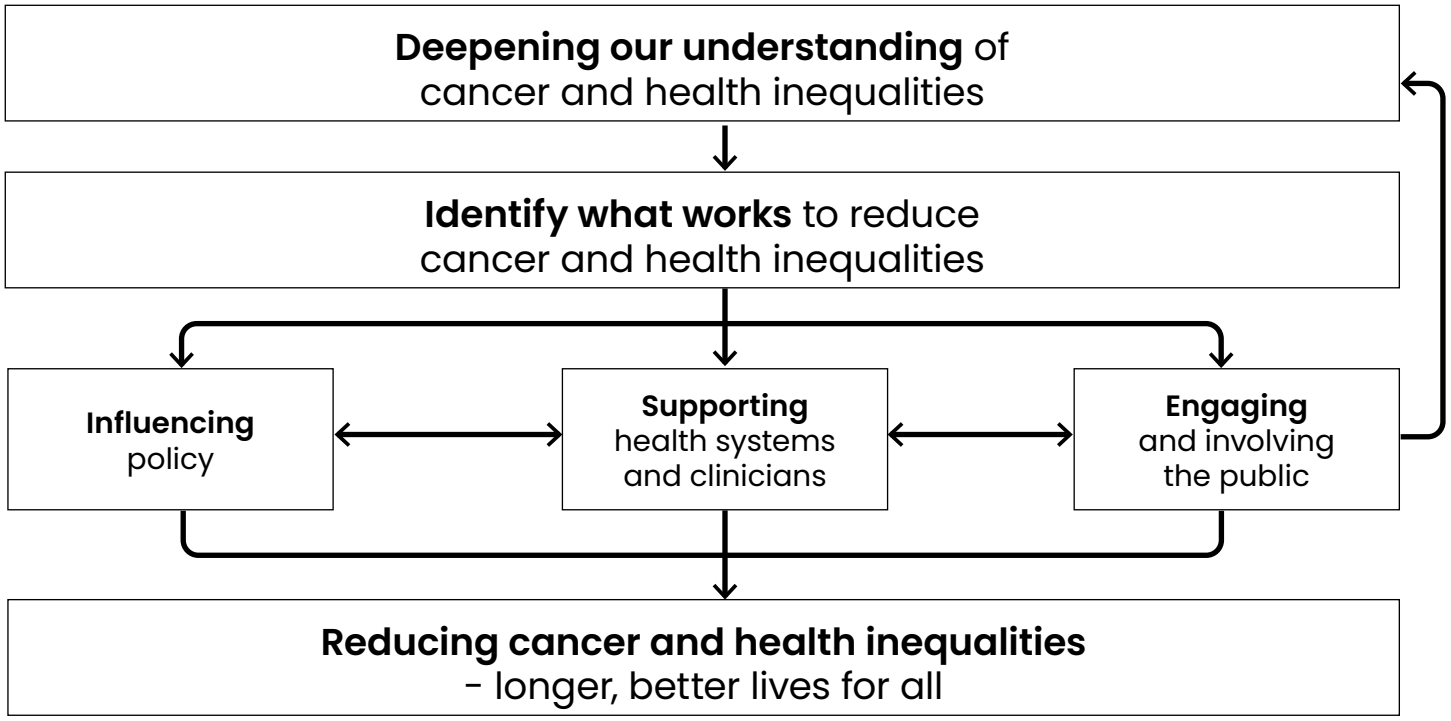
a complicated interaction with biological risk factors

▸Targeted action

and changes in policy and service provision have been shown to reduce inequalities.



Three of the core objectives in our long-term organisational strategy are pertinent to this work: 'Discover', 'Translate' and 'Engage'. Through the discovery of new insights and by translating those insights into public and patient benefit, we seek to accelerate positive impact [3]. This strategy sets out how we'll deepen our understanding of how those impacts are felt inconsistently across the population, and how we'll influence policymakers and health systems, and engage the public, to reduce cancer and health inequalities.



This five-year cancer and health inequalities strategy sits within our long-term organisational strategy and our equality, diversity and inclusion strategy, and alongside our research strategy [3], which has reducing cancer inequalities as one of its three core principles [4]. Our research strategy focuses on reducing and preventing cancer inequalities through research, and it includes a strategic approach that seeks to understand, for example, the biological factors underpinning how and why cancer affects people differently.

A key part of delivering our cancer and health inequalities strategy will be to evaluate how our work affects the whole population across all four nations of the UK.

We'll focus and prioritise work that:

- **leads to the largest absolute improvements in cancer outcomes**
  Since the 1970s, cancer mortality rates have fallen by 21% [5] and 10-year survival has doubled [6] thanks to improvements in cancer prevention, diagnosis and treatment, which have been driven by insights and innovation from research.
- **ensures that no one is left behind by improvements**
  We know that innovation and service provision can sometimes be driven by demand from higher socioeconomic groups or benefit the least disadvantaged first, and we seek to mitigate this effect. We can influence the design or implementation of interventions, so innovations benefit all, or we can ensure that compensating mechanisms are put in place to support the most disadvantaged.
- **deepens our understanding of inequalities**
  Inequalities are complex and interlinked. There are still many unknowns about the causes and impact of health inequalities and what we can do to tackle them. As a research charity, we play a critical role in informing research, policy and practice with evidence. This should include greater prominence of the voice of people affected by health inequalities.
- **enables us to be greater than the sum of our parts**
  Our scale and presence across multiple routes to impact – biological, behavioural and social research, influencing policy, working directly with health systems, and informing and engaging the public – creates opportunities to increase our impact through coordinated action across the organisation.

The inequalities challenge

- Cancer survival
- Cancer incidence
- Risk factor prevalence
- Stage at diagnosis
- Symptom awareness
- Help-seeking and accessing services
- Screening uptake
- Assessing treatment

The inequalities challenge

Tackling inequalities in health has been an ambition for all UK nations for decades [7] [8] [9] [10], but the data we have shows little progress. People experiencing health inequalities can be from marginalised or socially excluded groups who have been underserved, leaving gaps in evidence. Wherever we do have robust data, we see inequalities in cancer. Here are just a few examples of how inequalities manifest across cancer survival and incidence, and prevention, awareness, help-seeking, diagnosis and treatment of the disease.

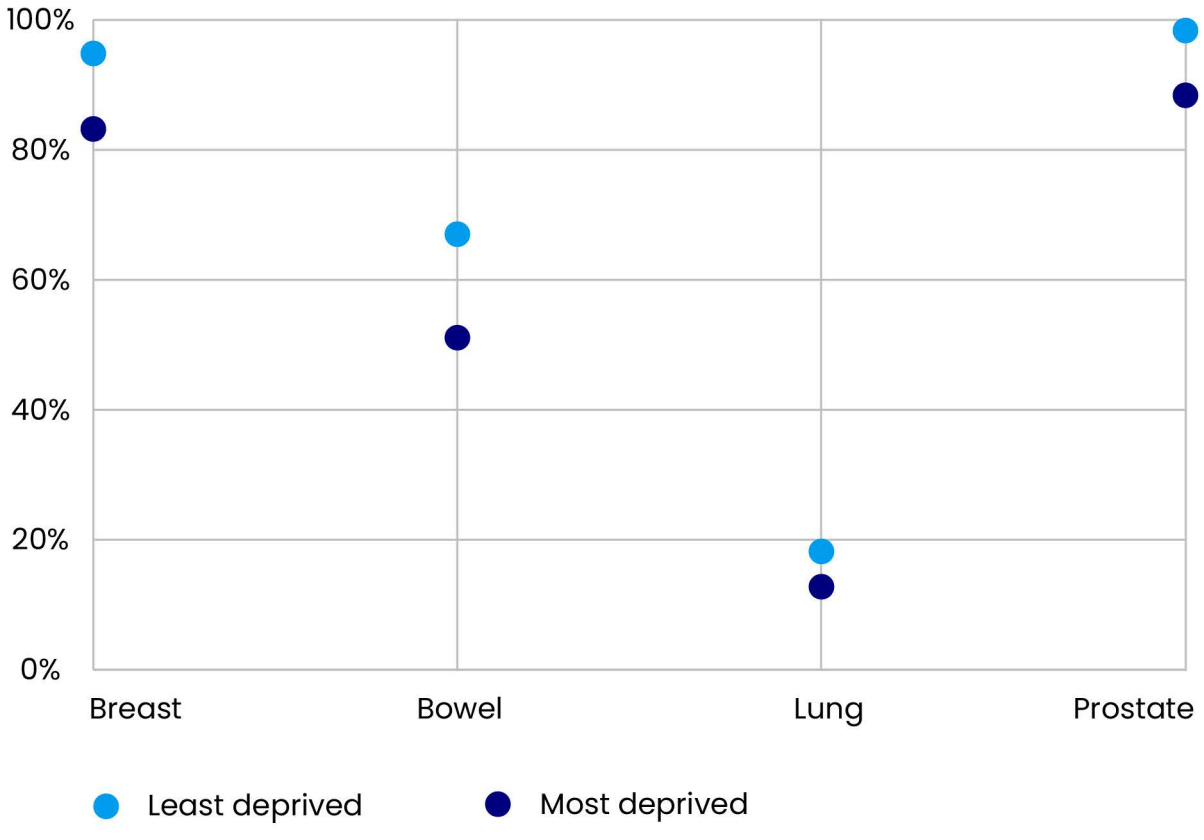
1. Cancer survival

Ultimately, inequalities along the cancer pathway result in variation in outcomes. While there are many factors that contribute to an individual's chance of survival, there is evidence of lower survival among more deprived patients and geographical variation between and within the four UK nations [11] [12] [13].

Data on variation by socioeconomic status in five-year survival for the four most common cancers in Wales shows that the most deprived group is up to 10 percentage points lower than the least deprived [14].

▸ Five-year cancer survival (net)

by socioeconomic deprivation, Wales, 2012-2016

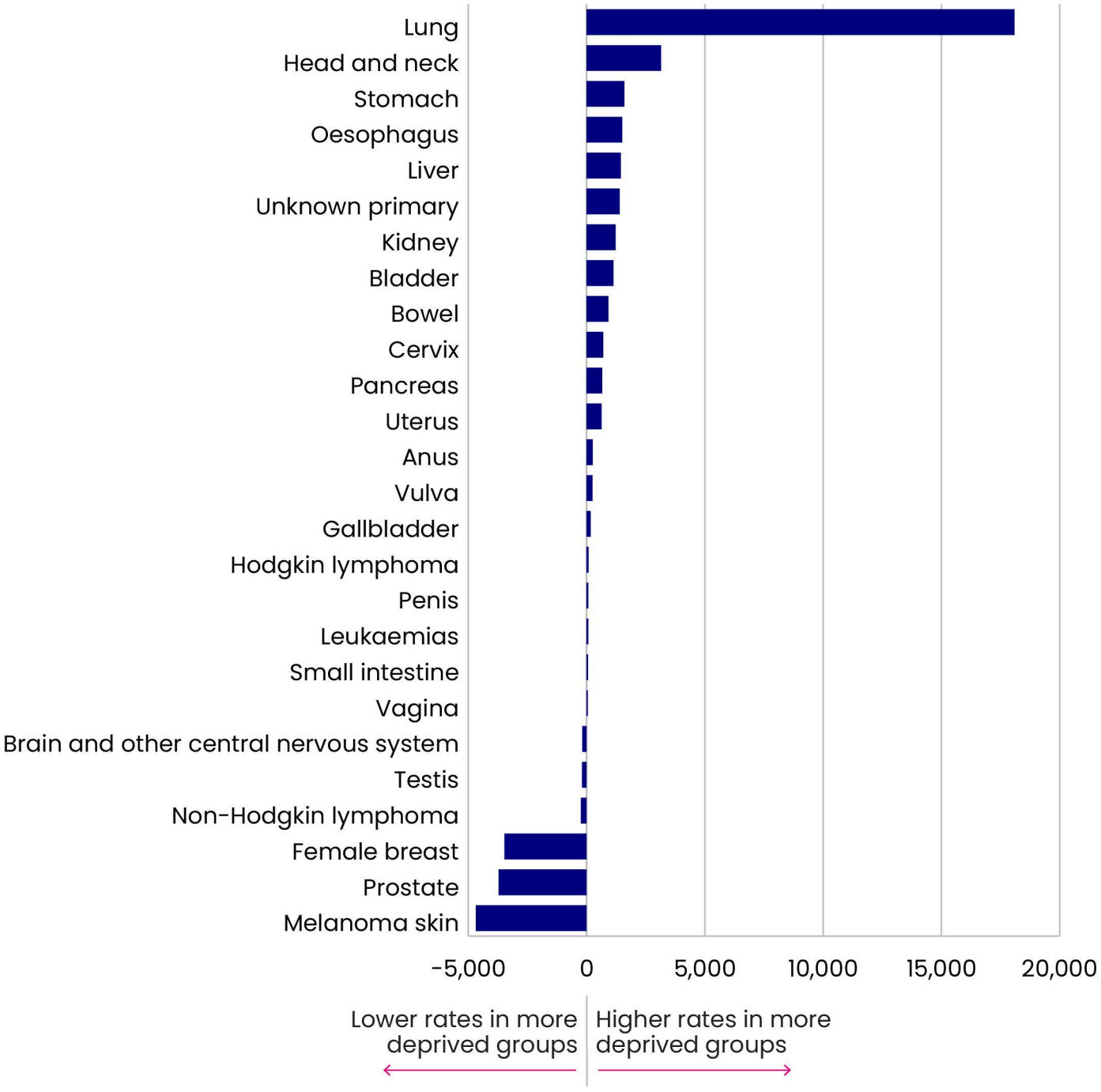


2. Cancer incidence

There is substantial evidence linking cancer incidence rates and inequalities. Cancer incidence rates are predominantly higher for people from more deprived areas, with an estimated 33,000 extra cases each year across the UK attributable to socioeconomic deprivation [15]. This is mostly due to variations in the prevalence of smoking by deprivation level, and could mostly be prevented if no one smoked [16].

▸ Cancer cases attributable to deprivation

UK, 2013-17

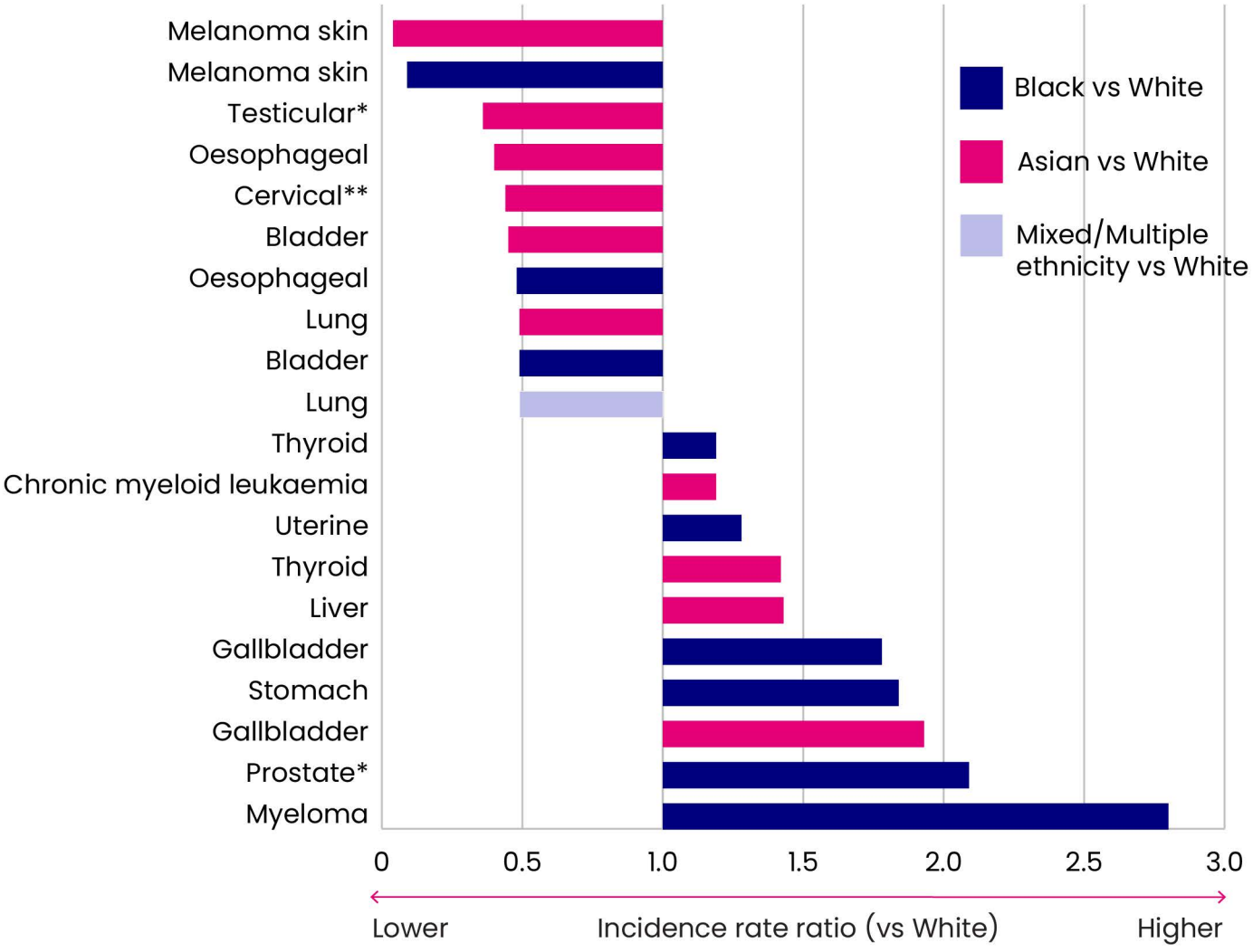


2. Cancer incidence continued

There is also evidence of cancer incidence being lower for certain groups. For most cancer sites, age-standardised cancer incidence rates are generally lower across non-White ethnic groups as cancer risk factors, especially smoking, have been historically lower in these ethnic groups. Higher rates are only evident where there are known genetic risk factors, such as for prostate cancer among Black men and myeloma among Black men and women, and where there are specific risk factors among an ethnic group, such as for several gastrointestinal cancers [17].

▸ Cancer incidence by broad ethnic group

selected cancers, England, 2013-17



Figures are for all persons except * = males only, ** = females only.
10 highest and 10 lowest significant rate ratios are presented.

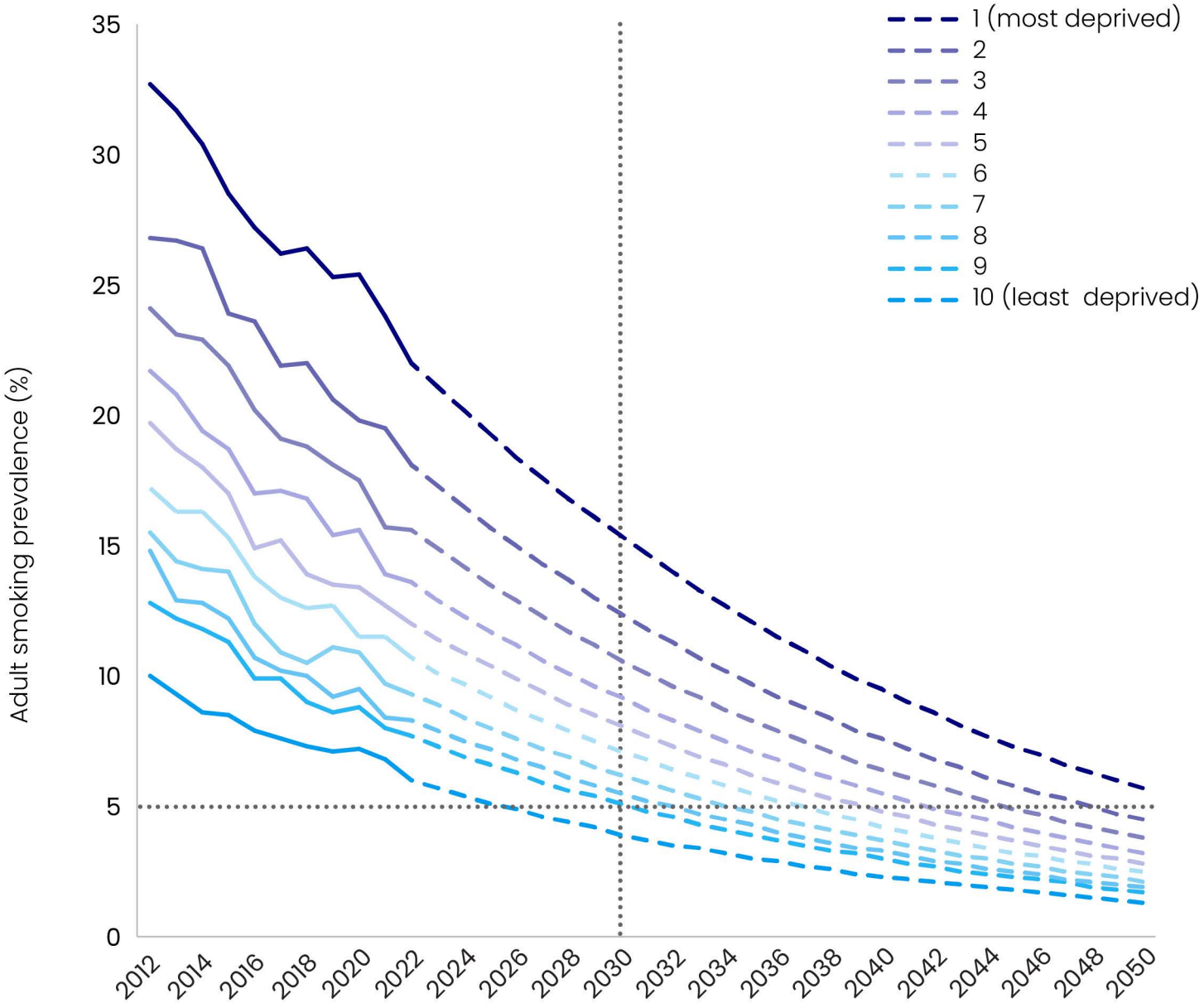
For nearly every cancer site that occurs in both sexes, there is higher incidence of cancer among males compared to females [18]. While historically higher rates of smoking, overweight and obesity, and alcohol consumption among males compared to females accounts for some of the variation, there are other causes of increased cancer incidence rates among males that we need to understand more about.

3. Risk factor prevalence

When we look at the prevalence of the two largest modifiable risk factors for cancer in the UK – smoking, and overweight and obesity [19] – there are stark differences between many groups. Smoking is the largest modifiable risk factor for cancer [18] and the biggest driver of health inequality [2] [20]. There are differences in prevalence by sex, age, socioeconomic deprivation, ethnicity, sexual orientation and experience of mental illness [20] [21]. Smoking rates are three times higher in the most deprived populations compared to the least deprived. Without intervention, this is projected to continue for the next 30 years [22].

▸ Smoking prevalence projections

by deprivation decile for adults (aged 18+) in England

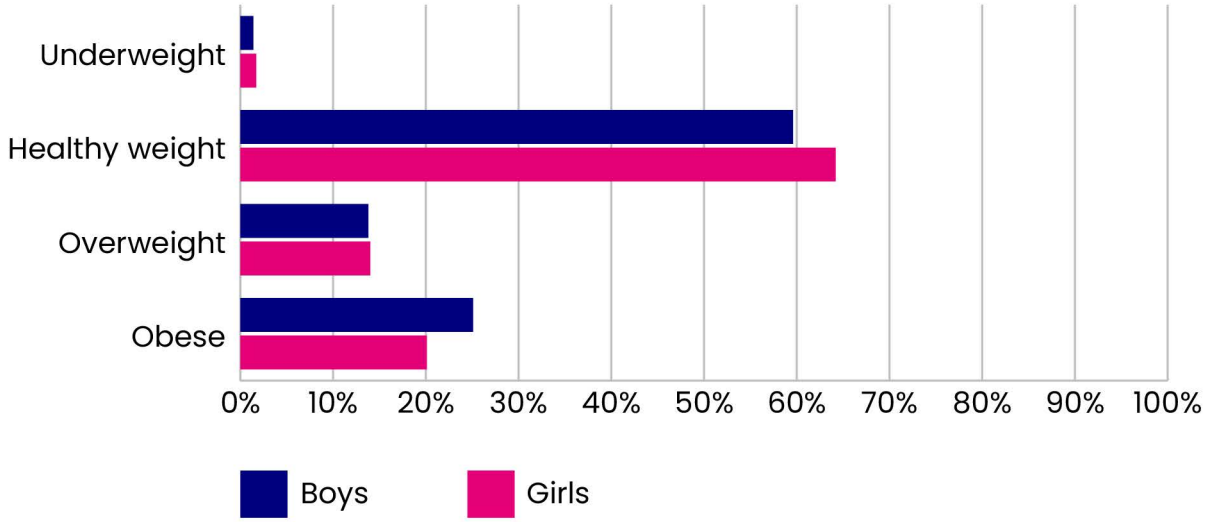


3. Risk factor prevalence continued

Overweight and obesity is the second largest modifiable risk factor for cancer, and on current trends will become the largest risk factor in the coming decades [23]. Evidence shows that children who are overweight or obese are around five times more likely to be overweight or obese as adults [24]. And almost 4 in 10 children in England leave primary school overweight or obese, with the proportion of children leaving school overweight or obese over 70% higher in the most deprived areas compared to the least deprived [25].

▸ Overweight and obesity

prevalence by sex for children in Year 6
England, 2022/23

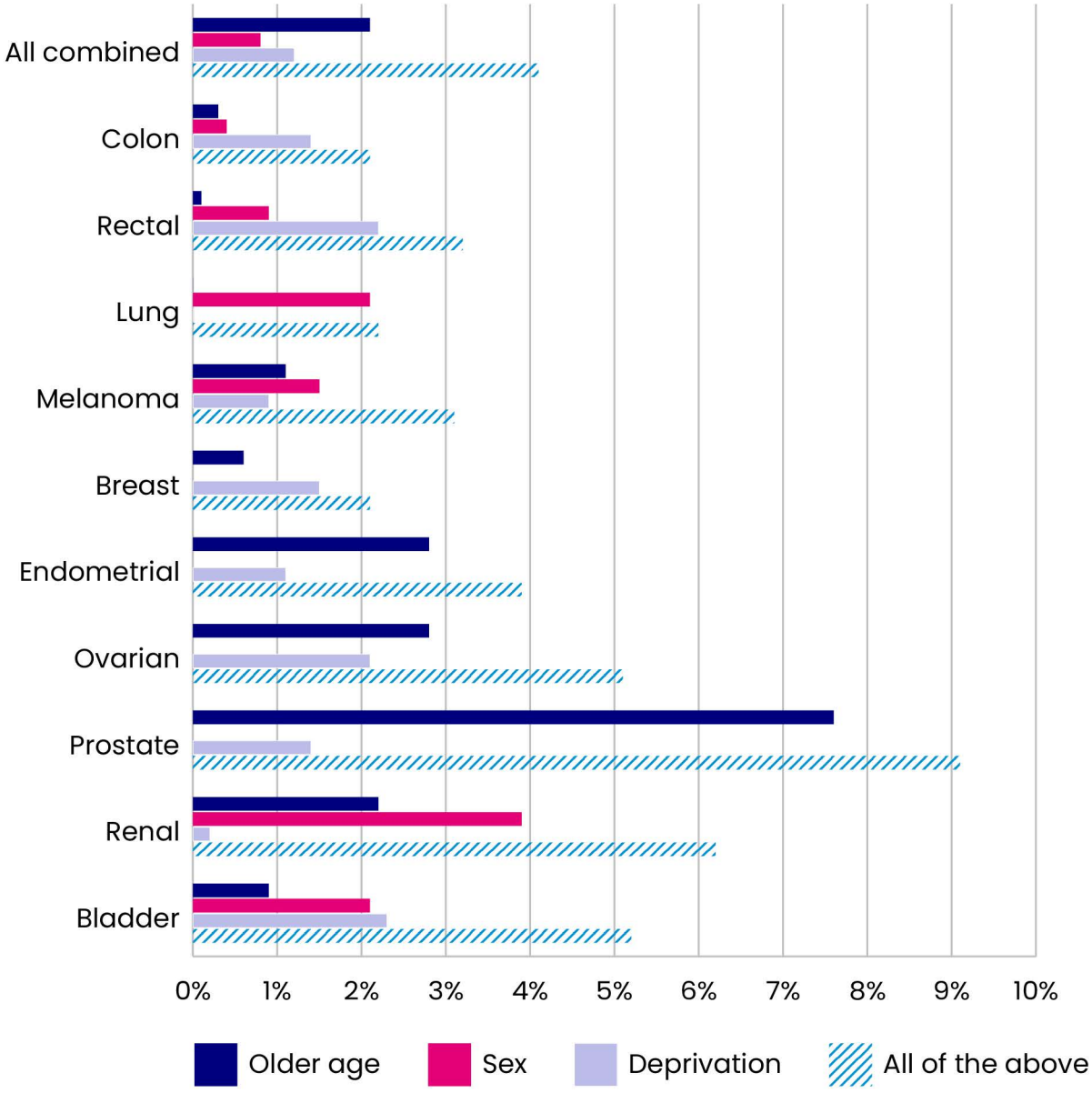


4. Stage at diagnosis

Inequalities are evident in stage at diagnosis of cancer. For example, a recent study across 10 solid tumour sites showed an increasing likelihood of being diagnosed with late-stage disease with age [26]. The study suggests that by eliminating age, socioeconomic and sex inequalities in stage at diagnosis, the overall proportion of patients diagnosed 'early' would increase by 4 percentage points across these 10 cancer sites, which could translate into more than 10,000 fewer patients every year diagnosed at stage 3 and 4 across the UK.

▸ Estimated impact of removing inequalities

in older age (among individuals ≥65 years), sex and income deprivation



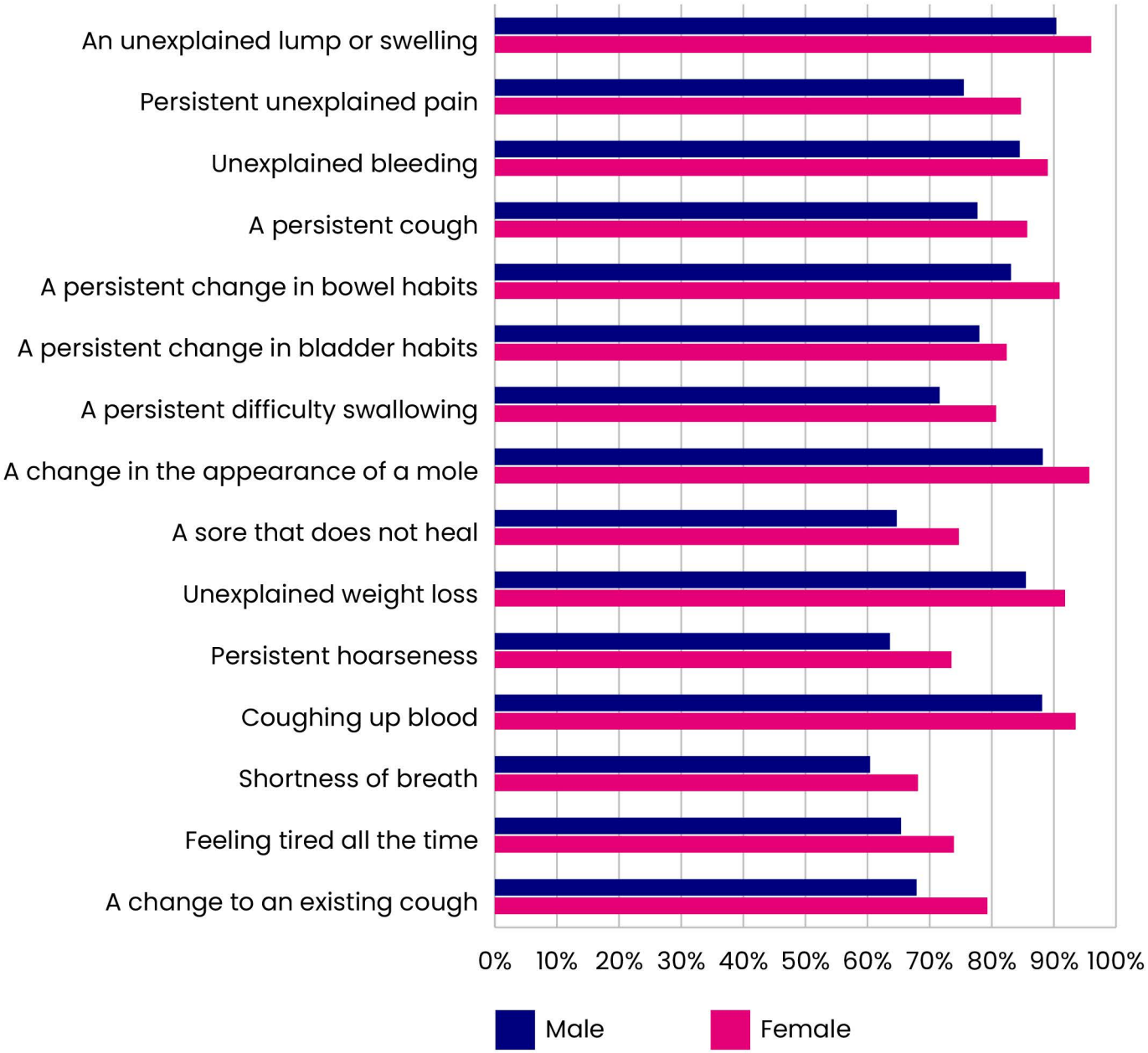
Adapted from Barclay et al (2021). Impact is shown as the reduction in the number of tumours diagnosed at stage 3/4 as a percentage of total diagnoses of each cancer site, and of all sites combined.

5. Symptom awareness

Our Cancer Awareness Measure 'Plus' survey consistently shows that men, people from lower income groups and people from Black and Asian ethnic minority groups are less likely to recognise cancer symptoms [27]. What's more, people can be aware of cancer signs and symptoms, but if they don't think their own symptoms are serious or think they are caused by something other than cancer, they may not seek help [28]. Our research found that women and people from Asian ethnic minority backgrounds are less likely to think that their own symptoms could be cancer [27].

Percentage of people

who recognise common signs and symptoms of cancer



6. Help-seeking and accessing services

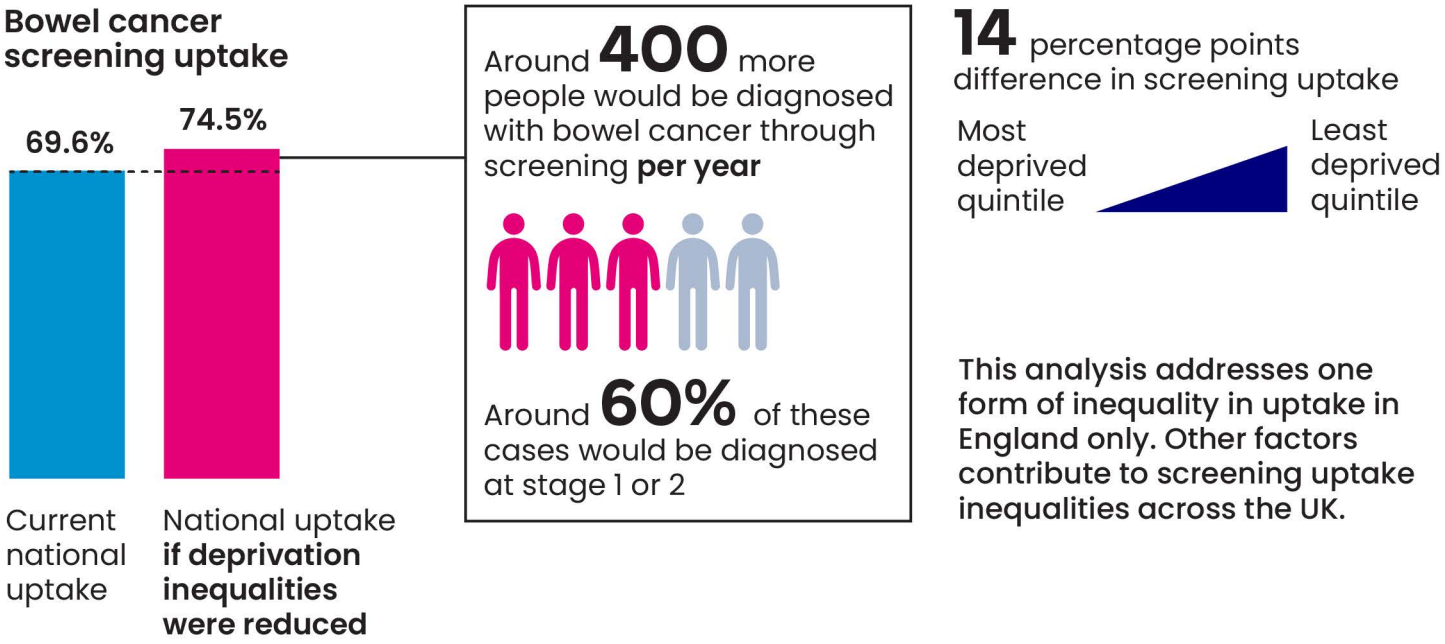
There is wide evidence relating to the barriers that different groups face in seeking help from primary care [29]. People are more likely to put off or delay seeking help because of difficulties getting an appointment if they are females or from Mixed, Asian and Black ethnic groups. People with disabilities report that they are less likely to get an appointment within a week [27]. For older people, remote consultations are less likely to address concerns adequately [27] [30]. And when people do have potential cancer symptoms, younger people and people who identify as LGBTQ+ are less likely to contact their GP [27]. Inequalities also exist after people have sought help, with research showing that a younger age and Black, Asian or Mixed ethnicity are associated with a higher number of GP visits before a cancer diagnosis [31].

7. Screening uptake

Evidence suggests that across the UK, participation in cancer screening is lower in more ethnically diverse communities and among people living in deprived areas [32] [33] and people with learning disabilities [34] or severe mental illness [35]. For bowel and cervical cancer screening, this variation doesn't only exist in who is more like to attend an initial screening appointment, there are also inequalities in attendance when a follow-up appointment is required [35] [36] [37] [38].

▸ The impact of reducing deprivation

inequalities in bowel cancer screening



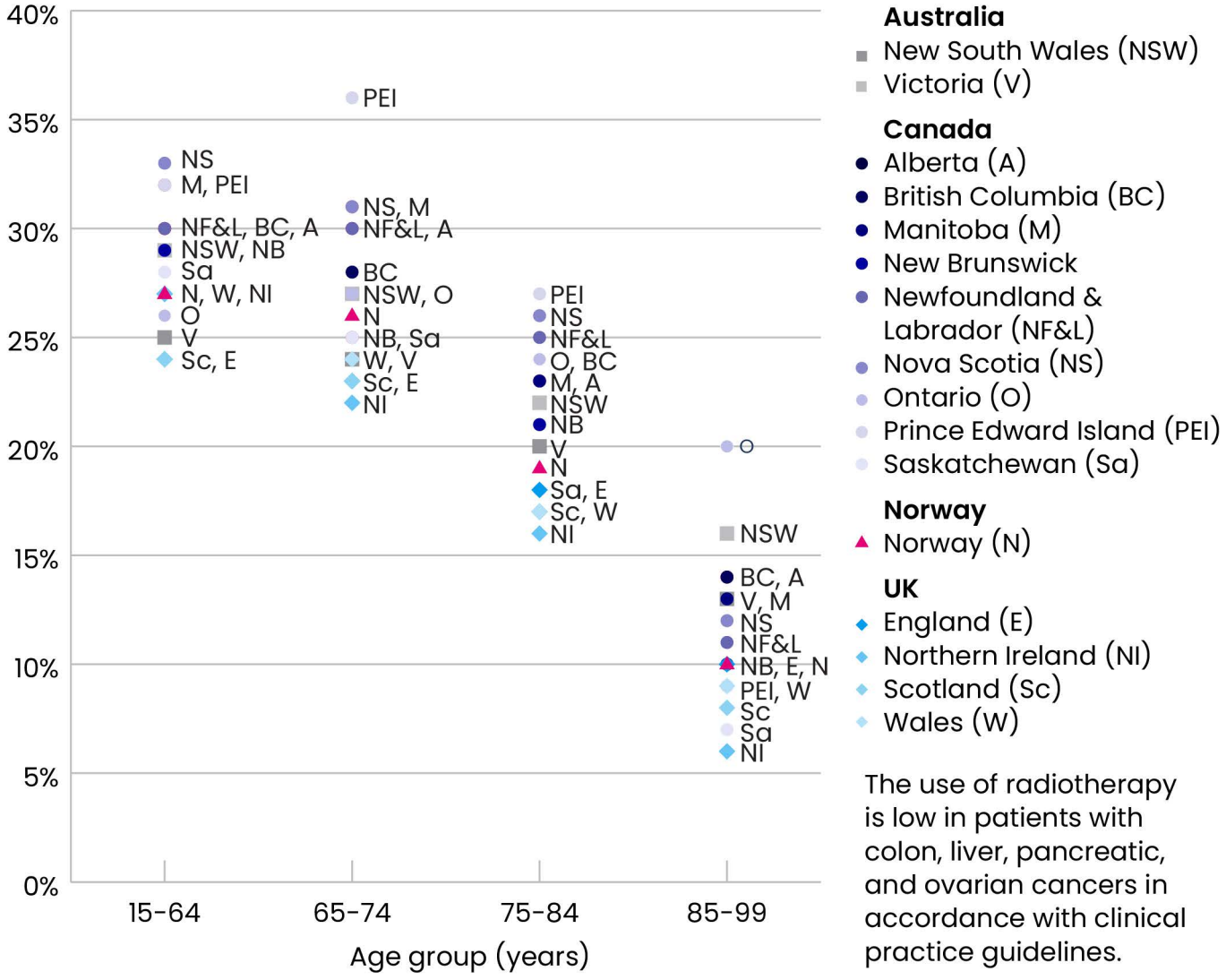
Analysis for England by Cancer Research UK using data sources from DHSC Fingertips and NHS England [39].

8. Accessing treatment

Many of the barriers people face in seeking help continue throughout the treatment journey. Different studies have shown that access to the main treatment modalities of surgery, radiotherapy and chemotherapy diminish with age. International comparisons for chemotherapy and radiotherapy show that across the UK, access to these treatments is lower than in other countries, especially in the oldest age group [40] [41]. Higher rates of frailty and comorbidities may be a factor, but more research is needed to understand this issue fully.

▸ Radiotherapy use by age group

for all cancer sites



The use of radiotherapy is low in patients with colon, liver, pancreatic, and ovarian cancers in accordance with clinical practice guidelines.

Inequalities in access to health and cancer information due to language, cultural and literacy barriers, and digital exclusion also contribute to inequalities along the cancer pathway [1] [2]. Many groups can experience these barriers to accessing information, including low-income households, people with disabilities, the elderly and ethnic minority communities.

Opportunities to tackle cancer and health inequalities

- Improve access to health information for all
- Reduce the prevalence of cancer risk factors
- Support informed uptake of cancer screening
- Reduce late-stage diagnosis
- Improve access to optimal treatment
- Advocate for health systems that work for everyone affected by cancer
- Improve the data required to tackle cancer inequalities
- Foster innovation

Opportunities to tackle cancer and health inequalities

Our understanding of the evidence relating to inequalities and our insights from cancer, health and wider policy networks will inform the issues that we focus on. Our work is already wide-ranging, seeking to engage the public and influence policymakers, researchers, health system leaders and health professionals. Our priorities are guided by where we can make the biggest difference, and particularly where our voice as a cancer charity has the most impact. Here we outline our key opportunities to tackle cancer and health inequalities.

- **Improve access to health information for all**

We'll seek to increase the reach of our information in ways that are relevant, inclusive and accessible to all. This will include making sure our digital content is accessible and providing information and targeted activity to reach people who are less able to connect with digital channels.

- **Reduce the prevalence of cancer risk factors**

We'll focus our efforts on the biggest risk factors – tobacco, and overweight and obesity – but will continue to play our part in reducing cancer risk from alcohol, air pollution and UV exposure, and improving people's health through public health interventions.

Support informed uptake of cancer screening

We'll support and advocate for targeted interventions to drive informed uptake of bowel and cervical cancer screening by underrepresented groups. We'll also work with partners in governments and health systems to ensure the equitable introduction of targeted lung screening in all four UK nations. And we'll explore the potential of supporting the implementation of risk-based approaches (such as those using genomic data), making sure that new innovations are equitably introduced.

Reduce late-stage diagnosis

We'll ensure that our work to improve help-seeking and timely presentation of symptoms – whether directly implemented by us or in partnership with others – targets those most in need and is based on rigorous behavioural science. We'll also use our influence to improve access to healthcare by promoting and optimising existing routes and supporting innovative new pathways. And we'll continue to support health systems to implement the most effective approaches for recognising and referring patients, and work with partners to ensure everyone is supported through the diagnostic pathway.

Improve access to optimal treatment

We'll support health systems and policymakers to ensure we have robust data on unwarranted variation and implement recommendations from this and existing clinical audits. We'll also push for equitable access to specialist cancer services. And we'll continue to improve access to clinical trials.

Advocate for health systems that work for everyone affected by cancer

We'll use our influence to improve health systems and address barriers to reducing cancer inequalities. We see variation in workforce with deprivation, for example, deprived areas have fewer GPs and in turn, a higher demand for healthcare [42]. We will advocate for targeted investment to reduce inequalities. Across England, 42 integrated care boards are responsible for developing health plans that meet the needs of their local populations. We will work with them to narrow inequalities between different groups in their local communities, as well as ensuring that new approaches, such as precision prevention, are implemented equitably.

Improve the data required to tackle cancer inequalities

Deepening our understanding of cancer inequalities will enable better targeting and the development of effective strategies. We'll push for better data collection, and for linkage of and access to demographic data across health and care. We'll also seek to gather insights from people impacted by health inequalities to build a clearer picture of the barriers experienced by different groups and inform our action. And we'll explore how we can build confidence in the use of public data to support cancer research among historically underrepresented groups.

Foster innovation

We'll evaluate and encourage the adoption and equitable spread of innovations that address inequalities across the cancer pathway. Working in partnership with a range of stakeholders, we'll make sure that innovation is designed to benefit everyone.

Areas of focus

Deepening understanding of cancer and health inequalities and what works to tackle them

- How we'll maintain our position as a reference point
- How we'll deepen the evidence base for cancer inequalities
- How we'll work with others to improve our understanding of inequalities

Deepening understanding of cancer and health inequalities and what works to tackle them

Our stakeholders look to us for our expertise. As well as our grant-funded research, we've already made significant contributions to the understanding of cancer and health inequalities through evidence synthesis, analysis of existing data and our own primary research. This knowledge informs our policy positions and how we support health professionals to influence health systems and engage with the public. We also share our knowledge widely through our website in reports and blogs, and through peer-reviewed publications. Our work in this area has been influential in highlighting specific inequalities and stimulating action.

However, our current understanding of cancer and health inequalities is still limited and we need to do more to identify effective interventions. Where we have robust data, we have a better understanding of how health inequalities manifest for some groups, but for other groups, and particularly people who fall into multiple data categories, we have a very limited understanding.

Through our cancer and health inequalities strategy, we seek to maintain and develop our position as a reference point for people involved in reducing cancer and health inequalities by generating and disseminating evidence to a wide audience. We also seek to deepen the evidence base for cancer inequalities in ways that will support action and work with others to improve our understanding and increase our impact.

How we'll maintain our position as a reference point

Generate, synthesise and publish evidence

We'll continue to generate and synthesise evidence to inform and support the wider health and cancer ecosystem, including researchers, policymakers and system leaders. Over the next five years, we'll publish reports – including new Cancer in the UK Spotlight reports – and continue to produce blog posts similar to our five-part series on health inequalities [43]. We'll also continue to conduct our Cancer Awareness Measure 'Plus' survey to demonstrate, for example, where awareness of signs and symptoms of cancer varies by socioeconomic status [27]. And we'll continue to generate peer-reviewed articles and publish them in open-access journals. We have already published a report projecting smoking prevalence to 2050, which includes analyses showing varying trajectories by socioeconomic status [22], and a paper on the relationship between ethnicity and stage at cancer diagnosis in England [44], which reveals variations in late-stage cancer diagnosis by ethnic group.

Link determinants of health and cancer outcomes

We'll continue to build evidence on the link between wider determinants of health and cancer incidence where the link to our mission to reduce the impact of cancer on people's lives is clear. We'll also work in partnership with others to support the leading voices on the wider determinants of health. Our report on the association between cancer mortality and socioeconomic status has already been hugely important in making the case for action on inequalities and we aim to build on this with new insights [15].

How we'll deepen the evidence base for cancer inequalities

Improve intersectional analysis of cancer inequalities

Analysis of cancer and health inequalities has predominantly focused on the relationship between cancer outcomes and single demographic indicators, such as age, sex and ethnicity. However, this approach can obscure the nature of inequalities faced by people who belong to more than one disadvantaged group. People's identities, and the circumstances that shape their behaviours and experiences, are multifaceted. Many people face numerous, multi-layered barriers to health information and health services, resulting in significant inequalities.

This intersectionality will be a key focus of our efforts to deepen our understanding of inequalities. In many cases, it's difficult to conduct intersectional analysis on commonly used data sources because of small sample sizes or problems with linking data. Intersectional research requires more interdisciplinary research, evidence synthesis, statistical analysis and embedding patient voices within high-quality, mixed-methods primary research, while maintaining focus on areas where we can have the greatest impact.

Understand the interplay between social and biological cancer risk factors

As a scientific research charity, we have a particular role in understanding biological differences that influence cancer outcomes. Incorporating learnings from the research we fund into the biological mechanisms of inequalities, our developing understanding of cancer genetics, and the wider evidence base, we'll focus on unfair and avoidable differences in outcomes that may arise from the interaction between social and biological factor. For example, where certain groups may have both a genetic predisposition to cancer risk but also suffer from discrimination.

Our developing understanding of cancer genetics helps inform our work on cancer and health inequalities, particularly the development and evaluation of policies aimed at reducing inequalities. When developing a policy with the aim of targeting a particular group, it's important to consider the way identities and biological factors intersect to optimise the policy's impact and avoid the risk of exacerbating inequalities.

Identify what works to reduce inequalities

This interdisciplinary approach will result in richer findings that contribute to our understanding of inequalities and is essential for identifying what works to reduce health inequalities in complex systems. For example, our Test Evidence Transition programme, which seeks to improve outcomes for bowel cancer, takes a mixed-method approach drawn from behavioural and implementation science with a specific focus on cancer inequalities. We'll build on the knowledge generated from this work and a wide range of other research to identify realistic actions that can be taken by policymakers and health systems to ensure a fairer impact on cancer outcomes.

As part of our wider knowledge-generation, we're developing our economic analysis capabilities. In an increasingly resource-constrained environment, these approaches are essential for making compelling cases to decision-makers at national and local levels. Our work on the cost of cancer treatment by stage is an example of research that can support investment decision-making as part of efforts to reduce inequalities [45]. We'll continue to develop this work to understand the cost of cancer to our society.

How we'll work with others to improve our understanding of inequalities

We work collaboratively in all our activities. However, there are some areas where working with others is particularly important for accelerating our impact on cancer inequalities.

Improve the quality and availability of data required to tackle cancer and health inequalities

This is one of our influencing priorities. For some types of analysis, evidence is plentiful – for example, it's relatively easy to assign level of socioeconomic deprivation based on where people live, rather than needing individual-level data. Data completeness has been improving for ethnicity in NHS data for England, but there is more work to be done in other UK nations. However, for other characteristics, such as sexual orientation, there is very little evidence due to a combination of a lack of data collected and the size of some groups being relatively small to allow the identification of true differences.

Better collection of, linkage of and access to demographic data across health and care will enable new intersectional analyses and increase research output to identify inequalities and generate new scientific innovations. We'll collaborate with data custodians and other key stakeholders to drive improvements and use our position to build confidence in the use of public data to support cancer research.

We'll also gather insights from those who experience health inequalities through our qualitative research, patient involvement programme and community engagement activity, and by working in partnership with organisations who represent underserved groups.

Help the cancer ecosystem translate insights and innovation into impact

As the largest charitable funder of cancer research in the UK, we have a particular role in helping researchers collaborate and helping the wider cancer ecosystem to translate insights and innovation into public impact. We'll make sure that the drivers of cancer and health inequalities identified through our activities informs decisions relating to preventing and addressing cancer inequalities through the research we fund.

We'll do this through our existing work, for example, by organising conferences such as our Early Diagnosis Conference, which has a key theme of reducing inequalities [46]. We also run a wide-ranging programme of virtual events on early diagnosis, covering a range of topics related to inequalities [47]. Our findings will inform our research strategy and guide our approach to funding research that addresses cancer inequalities.

Continue to learn from international best practice

International comparative analysis is often compelling for policymakers as it sets the UK in the context of what can be achieved. So we'll continue to host the International Cancer Benchmarking Partnership, which provides rich analysis often at a more granular level, improving our ability to understand not just differences but the drivers of differences too. We'll also collaborate internationally through our Global Cancer Prevention workstream and by working with cancer experts in, for example, the Organisation for Economic Cooperation and Development and the International Agency for Research on Cancer, the cancer agency of the World Health Organization.

Areas of focus

Driving impact through influence

- Influencing for policy change on cancer and health inequalities
- Supporting local health systems and clinicians to reduce inequalities

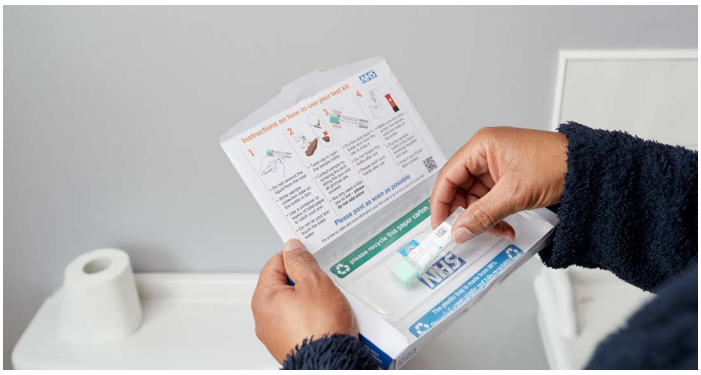
Driving impact through influence

We have a strong track record of influencing policymakers and clinical practice, and engaging the public and patients, to improve cancer outcomes.

Through this strategy, we want to signal a shift to ensure our work to reduce inequalities is coordinated to maximise our impact. We'll take account of the external environment and be opportunistic as required, but a key strength of our work is the breadth and depth across multiple domains, where we can find many opportunities for coordinated campaigns.

▶ For example, for smoking, which is more prevalent in more deprived groups, we've seen significant success in policy-influencing and can continue to lobby governments for more action, while also contributing to the latest evidence and best practice in smoking cessation and continuing to signpost people to stop-smoking services through our nurse-led community engagement activity.

▶ For cancer screening uptake, we will continue to push at a national level for evidence-based expansion of bowel cancer screening by lowering the threshold. Alongside this, we will work directly with targeted communities to address barriers to cancer screening uptake and support health system leaders and health professionals with tailored resources.



Influencing for policy change on cancer and health inequalities

Many of the key levers to address cancer and health inequalities are in the hands of governments across the UK. From laws and regulations that tackle cancer risk factors like smoking and obesity, to the resources made available to local systems dedicated to tackling inequalities, making progress on reducing cancer and health inequalities requires advocating for changes in policy.

However, if they're not specifically targeted to benefiting the communities of highest need, some decisions or measures from governments can actually widen inequalities.

We've seen huge success in reducing smoking across society, including within the most deprived groups, through impactful and bold measures, such as increases in taxation and standardised packaging. However, the difference in smoking rates between socioeconomic groups is still too high and projected to continue increasing unless further targeted action is taken.

Progress can stall, too. For example, world-leading legislation was passed on junk food marketing by the UK Government in 2022 but has not yet been implemented. And in the 2010s, there was a sharp decline in funding for stop-smoking services.

That's why influencing for policy change is a vital part of our strategy to tackle cancer and health inequalities. We endeavour to be the leading voice on cancer, drawing on our unrivalled expertise and credibility, while contextualising that within the impact of wider determinants of health and working in partnership with others to maximise our impact.

For too many communities, access to good health and healthcare is worse than for others due to wider determinants of health, poorer health literacy and less availability of NHS and cancer services where they live. So we work hard to make the case for everyone, no matter their background, to have equitable access to an early and timely cancer diagnosis and the best possible treatment.

We'll continue to advocate for targeted action to reduce inequalities. For example, we welcome NHS England's Core20PLUS5 initiative, which includes early cancer diagnosis as one of its five clinical focus areas and highlights the importance of smoking cessation [48]. Meanwhile, our policy campaigns to introduce lung screening across all four nations will improve lung cancer survival for all. As lung cancer rates are higher in more deprived groups, this is where it will bring greater benefit.

We'll focus our efforts where we can evidence the link between inequalities and cancer outcomes, because that's where our voice can make the biggest difference. And where we need to, we join our voice with others. As of 2024, we fund partnerships to help reduce incidence of cancers caused by smoking, alcohol and obesity.

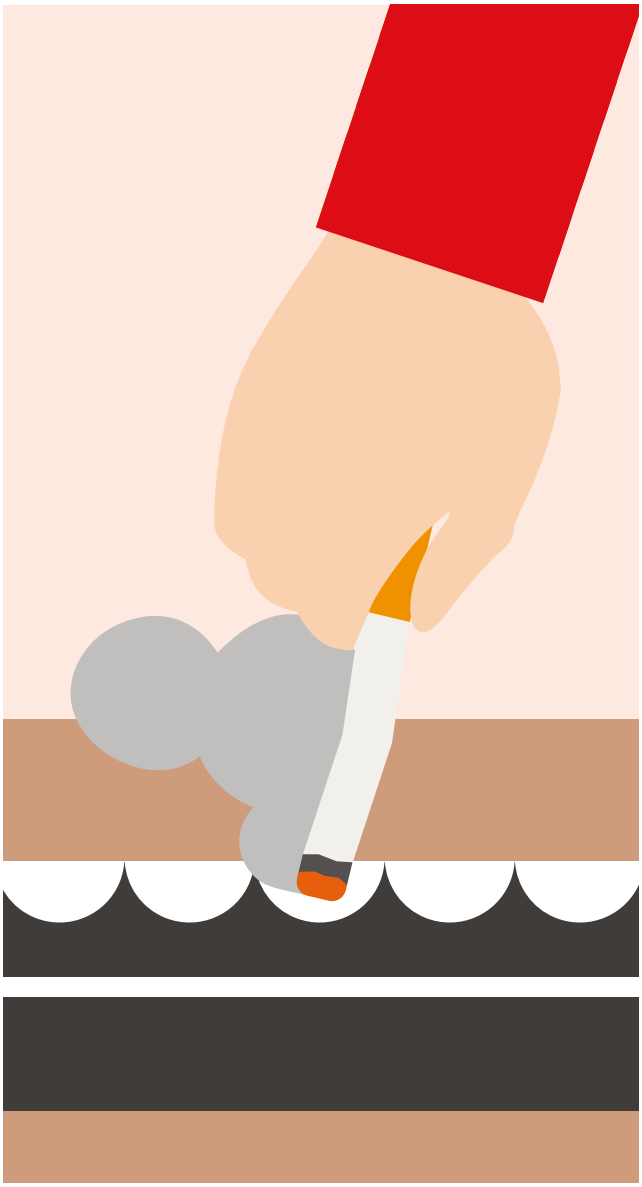
Narrowing inequalities will remain an important factor in selecting our policy priorities: from our initial understanding of an issue, the policy research we commission, the recommendations we make and the stakeholders and audience insight we gather, through to our influential public affairs and campaigns work.

We form our policy priorities and recommendations on the basis of where we can have the most impact, using data, research and insights from people with a range of expertise, including lived experience. And ensuring that all of this work includes an understanding of inequalities and diverse voices. We amplify our work in this area through our participation in and funding of advocacy partnerships that build coalitions of organisations representing a range of issues and professions to focus on particular health risk factors.

Cancer Research UK is recognised and trusted by the vast majority of the UK population: when surveyed, 3 in 4 people agree we are a trusted voice on research [49]. This means we have an extraordinary ability to make the case for evidence-based policy to reduce inequalities through paid and media campaigns, social media presence and media comments.

We regularly engage with ministers, opposition spokespersons, advisers and officials, and members of the UK Parliament, Scottish Parliament, Welsh Senedd and Northern Ireland Assembly through private meetings and public events. And our campaigns, which are supported by more than 250 Campaigns Ambassadors, allow the voice of our supporters to be heard loud and clear by decision-makers. When surveyed, more than 4 in 5 parliamentarians agree that we are effective [50]. This credibility and access to decision-makers has been vital in making progress towards public health legislation on smoking in public places, standard packaging for tobacco and restrictions on marketing food that's high in fat, salt and sugar.

Advocacy in partnership: Action on Smoking and Health



We'll continue to review our approach to funding a number of partnerships that drive our strategic objectives on health risk factors.

Smoking remains the biggest cause of cancer and premature death in the UK [19]. Significantly higher smoking rates among the most deprived groups compared with the least deprived makes smoking the leading driver of health inequalities [2] [20]. People born today in England's most affluent areas are expected to live, on average, up to a decade longer than people in the least affluent [51]. Smoking is the single biggest driver of this inequality [2].

If recent trends continue, England's most deprived areas would become smokefree almost three decades after the least deprived [22]. Realising the smokefree ambition across all socioeconomic groups would be one of the most impactful and equitable actions any government could make.

We have long been a core funder of Action on Smoking and Health (ASH), an organisation dedicated to reducing the burden of disease and premature death caused by tobacco. The work of ASH to reduce health inequalities caused by smoking includes advocating to ensure pregnant women, people with mental health conditions and people who live in social housing have targeted, evidence-based support to help them stop smoking.

Supporting local health systems and clinicians to reduce inequalities

We have a longstanding programme of work supporting primary care. For example, we're a major provider of educational content for clinicians – primarily those working in primary care – focusing on how general practitioners can improve their referrals for suspected cancer.

In 2023, we launched our health systems engagement strategy to provide support to health system leaders across all four nations of the UK. Reducing inequalities is a central theme of this strategy. We aim to translate our knowledge and expertise into tools and products that help local leaders and clinicians develop their own strategies that deliver the best outcomes for cancer and address the 'implementation gap' in the translation of innovation and best practice into patient and public impact.

Inequalities are a priority for local health systems across the UK. For example, the NHS in England has recently set up integrated care boards with one of their four key aims being to 'tackle inequalities in outcomes, experience and access' [52]. While in Scotland, inequalities and population health is one of 10 'Drivers for Recovery' that health boards are required to address [53].

Much of the work to reduce health inequalities needs to happen at the local level. Some of the barriers to early diagnosis of cancer and optimal treatment reflect characteristics of local areas and there are high levels of unwarranted variation in access and outcomes within and between health systems, nations and areas within nations. For example, there are different challenges posed in rural and island areas compared to urban areas, with evidence suggesting that proximity to treatment centres affects the likelihood of receiving optimal cancer treatment.

There are also differences in funding that reflect socioeconomic deprivation. Analysis by The Health Foundation found that general practices serving more deprived populations receive around 7% less funding per need-adjusted registered patient than those serving less deprived populations [54]. With variation in local demographics, local health systems need to adapt their services to be responsive to the specific needs of their communities.

As our health systems engagement strategy progresses, we'll build on deep relationships and co-design approaches to ensure the latest evidence on what works to reduce inequalities is deployed in health systems in all four nations. This will take many forms, including events and briefings for system leaders to transfer our knowledge, but also

facilitating interaction between local systems and expert researchers in inequalities. We'll provide data-based tools and products and explore how we can localise many of our national tools to help people understand their communities better, with a specific lens on being able to understand the experiences of different groups within communities.

We're already piloting a local version of our Cancer Awareness Measure 'Plus' survey in two areas, with an evaluation expected in autumn 2024 [27]. And learnings from our Test Evidence Transition programme will be a key part of our offer to health systems, as it has a central focus on reducing inequalities.

In the short-term, we'll focus on inequalities in cancer screening uptake and we'll develop a local screening uptake tool that will help systems understand how the specific demographic factors in their area affect uptake and identify variation within their systems, so that they can address inequalities locally.

We'll also work with health systems to further develop our programme of local data analysis in ways that help them take action on inequalities. And we'll increase our work to track how changes in health systems policy and oversight are being implemented on the ground, which will encompass impacts on disadvantaged groups – for example, tracking the progress of Scotland's 10-year Cancer Strategy, England's Community Diagnostic Centres or the devolution of specialised commissioning in England. In addition, we'll be working to link to our own public-facing information and engagement activity, such as our Cancer Awareness Roadshow and Talk Cancer training programme, to help amplify their impact and reach the communities that need us the most.

Areas of focus

Engaging and informing the public in ways that are inclusive, relevant and accessible

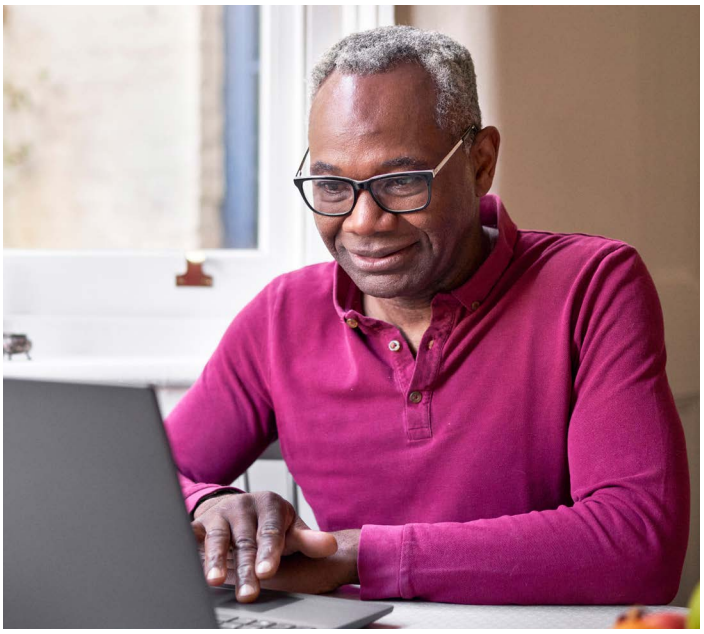
- Digital cancer information
- Printed cancer information
- Nurses helpline
- Cancer Awareness Roadshow
- Talk Cancer
- Cancer Awareness in the Workplace
- Health marketing

Engaging and informing the public in ways that are inclusive, relevant and accessible

We deliver a range of cancer and health information for people affected by cancer and the wider public.

Through our patient information, we answer people's questions about cancer and help them better understand their situation. And through our health information and targeted community engagement activity, we raise awareness and help people to take positive action to reduce their risk of cancer or seek help if they have any health concerns.

We use a variety of channels, including digital, paper and face to face, to provide people with trusted and clear information in a way that is most relevant and helpful for them. Our online and printed information is consistently awarded the Patient Information Forum TICK, the UK's independently assessed quality mark for trusted health information, which includes meeting the health inequality needs of our audiences. We'll continue to seek and maintain this accreditation as we create content and use our channels to reach as many people as possible, especially people who have less access to information and services.

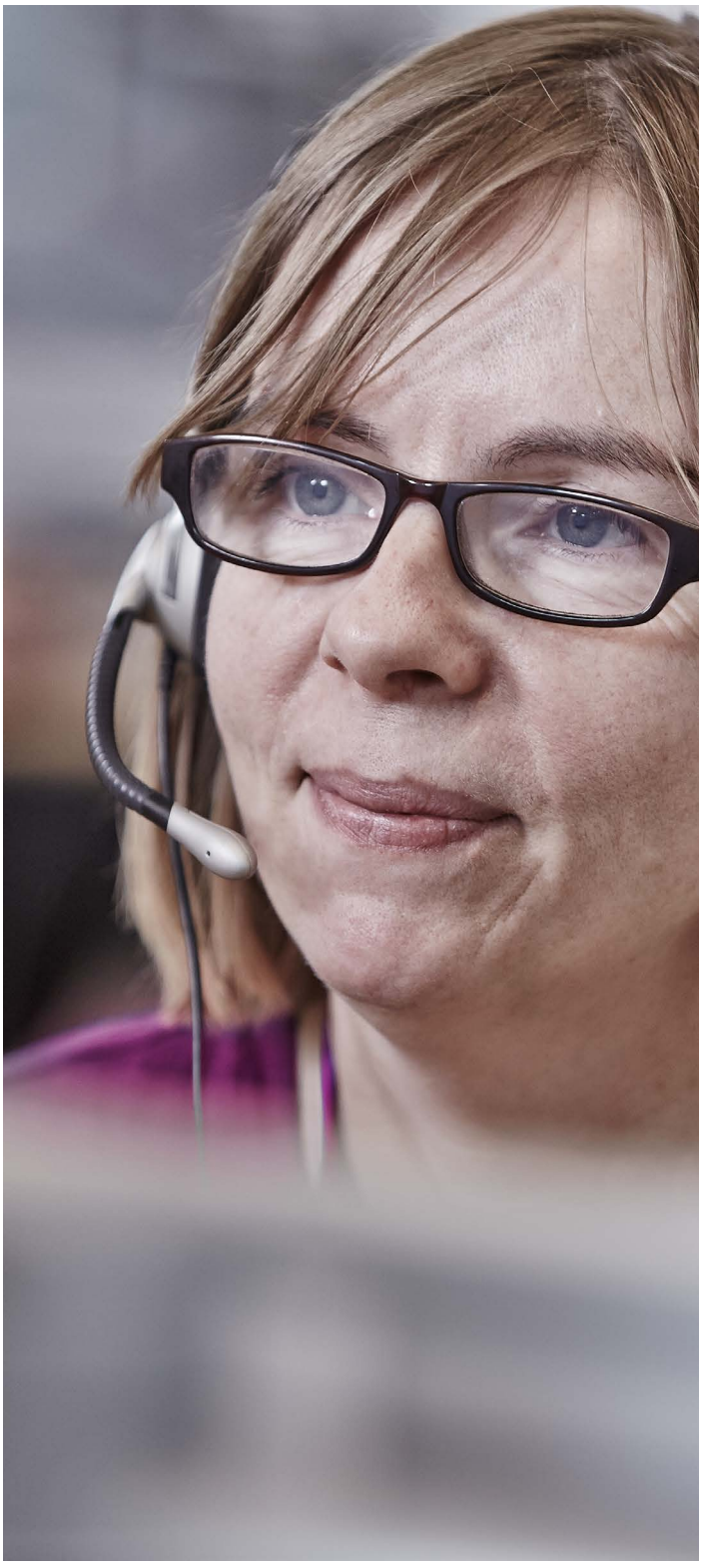


Digital cancer information

We're a leading UK charitable provider of digital cancer information. Our About Cancer website contains around 4,000 pages of externally accredited, evidence-based and accessible content for 95% of cancers [55]. We also provide information on more than 2,800 cancer trials written in accessible language. And our online forum, Cancer Chat, is fully moderated and provides a safe space for people affected by cancer to give and get support from others [56]. In 2023-24, our About Cancer pages and Cancer Chat forum had over 59 million views from more than 24 million active users [57]. We provide information in a range of formats, including written content, diagrams, infographics, video and animation. We share our video content on YouTube, where it receives verification for credibility, and bite-sized content via social media. And we continue to optimise our webpages for low literacy audiences, using plain English suitable for a reading age of 9 to 11 years old. We'll regularly review our cancer and health content to identify gaps and opportunities to make it even more inclusive, relevant and accessible. And we'll run pilots to determine recommendations for targeting demographic groups within our existing resource.

Printed cancer information

Digital exclusion remains a key issue for people accessing health information in the UK, with 8.5 million people lacking the most basic digital skills [58]. By May 2022, more than a third of UK adults had already reported that the rising cost of living was impacting their ability to go online. So for many people, offline resources are the only option, while others may prefer information they can hold. So it's vital that we're able to offer a range of accessible and inclusive ways for them to engage with our information.
We distribute more than a million printed publications each year, including information on the prevention and early diagnosis of cancer and our cancer treatment record book, which is used in secondary care to help people monitor the side effects of their treatment [59]. All our public-facing leaflets are available in print as well as downloadable PDFs that can be viewed digitally or printed economically in healthcare settings or at home. Just over half of our publications are distributed via GP surgeries and health centres, while others are used in our settings, such as our shops, Cancer Awareness Roadshow and Race for Life events.



Nurses helpline

Our nurse helpline provides information to anyone affected by cancer [60]. Our team of nurses respond to around 12,000 enquiries each year. And for people whose first language is not English, we can offer an interpretation service in over 240 languages through Language Line.

Cancer Awareness Roadshow

Our programme of community-based cancer awareness activity targets areas of greatest need. Launched in 2006 in partnership with the Marie Keating Foundation, our Cancer Awareness Roadshow takes specially trained nurses into communities with the poorest cancer outcomes, reaching 50,000 people each year. They talk to people about reducing their cancer risk, knowing what's normal for their body and going to the doctor with any concerns, and signpost them to local services.

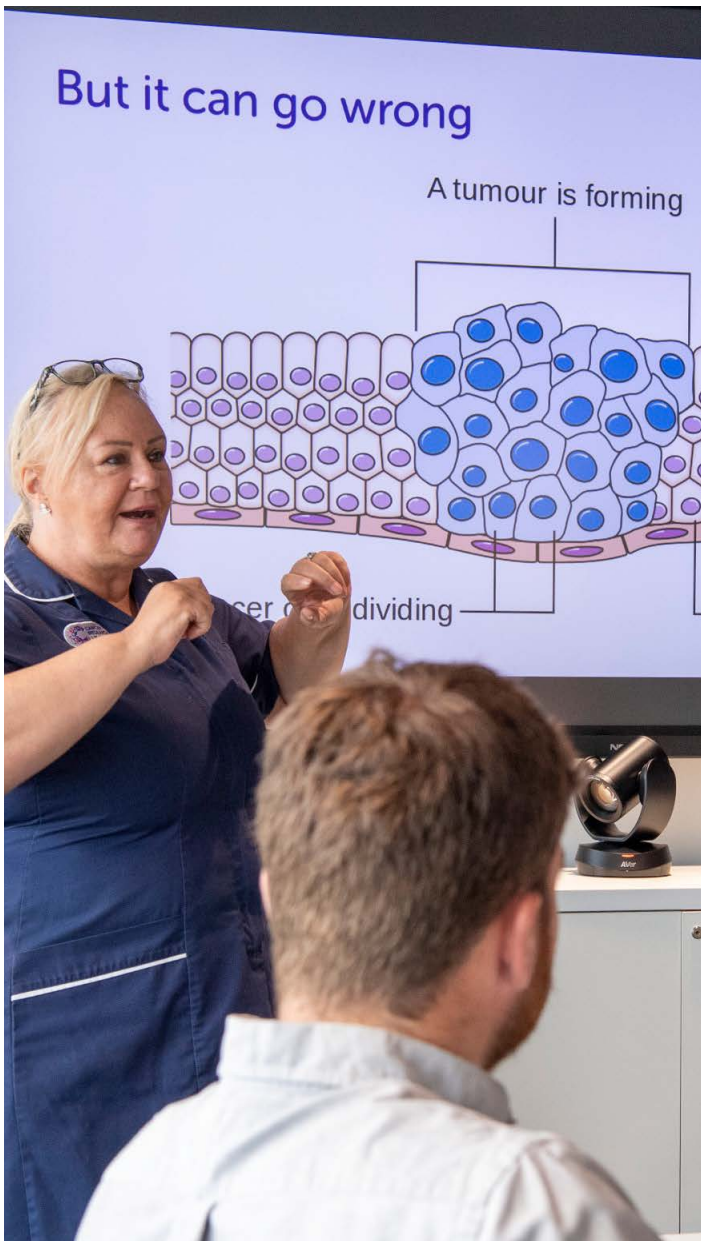
Through this work, our nurses signpost thousands of people every year to their GP, to screening opportunities and to services such as support with weight management and stopping smoking.

Talk Cancer

Our UK-wide Talk Cancer programme includes face-to-face and online workshops delivered by nurse trainers, who help equip people who work and volunteer in community roles with the knowledge, confidence and skills they need to open up conversations about health and cancer [61]. This includes healthcare professionals, public health staff, charity workers, faith leaders and local champions.

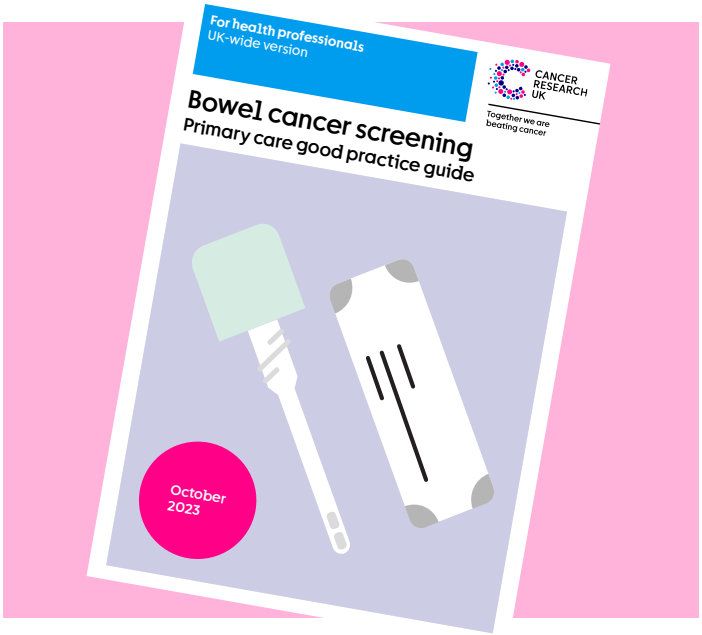
Cancer Awareness in the Workplace

Our UK-wide Cancer Awareness in the Workplace programme delivers a range of activities to raise awareness and support positive health changes among workforces across the UK. We work with our corporate partners and other companies, focusing on reaching underserved groups [62].



Health marketing

The majority of our health marketing activity for the public aims to reach populations with higher deprivation. We are insight-driven in choosing which campaigns to run and where, using data such as the number of people starting cancer treatment, referrals and behavioural insight to steer our marketing activity. For example, we ran an early diagnosis campaign in Northern Ireland in partnership with the Public Health Agency and the Northern Ireland Cancer Programme, which aimed to encourage people most at risk of cancer to go to their GP if they experience any potential signs and symptoms of the disease. The campaign was targeted at people aged 50+ and from a lower social grade (C2DE), as the risk of cancer increases with age and there is evidence of socioeconomic variation in cancer incidence and outcomes. Members of the target audience supported the development of our campaign assets and messaging. And the campaign was complemented by nurse-led activity in the community to help engage people who couldn't be reached as easily via mass media.



▶ **We'll work with underserved groups when reviewing our content and the mix of channels we use.** And we'll gather insights through our patient involvement and community engagement activity to identify gaps and opportunities for improvement, making sure our information continues to be inclusive, relevant and accessible.

Working in partnership to reach underserved groups

We'll continue to work alongside other community groups and organisations to engage people who we might not otherwise reach. For example, we've been working with SAFEENA to reach Muslim communities across the UK with health information and draw on their insights of cultural barriers and faith-based sensitivities to inform our work:

- Our Cancer Awareness Roadshow nurse in the northwest of England has worked with local SAFEENA community champions to deliver joint cancer awareness activity in mosques and other Muslim centres, and talks for Muslim women.
- We've delivered Talk Cancer training for the SAFEENA champions and leaders of mosques and community centres.
- SAFEENA has contributed to some of our key projects, including the revalidation of our Cancer Awareness Measure 'Plus' survey and on the imagery we use in our health communications to ensure we're being as representative and inclusive as possible.

As part of our publications strategy, we've gathered insights from people with learning difficulties and worked with this audience to inform the development of easy-read leaflets.

We've also worked with local partners and interpreters to develop and deliver Talk Cancer workshops in other languages, including Urdu, Punjabi, Dari, Pashto and British Sign Language [63].

Enablers

- Patient and public involvement
- Partnerships

Enablers

Ensuring the voices of people affected by cancer is at the heart of our work and is embedded in our organisational strategy. We consult, collaborate and partner with them, drawing on their unique lived experience and knowledge to help increase the relevance, quality and impact of our work.

Patient and public involvement

We're working to increase the diversity of our involvement network to make sure it's representative of the wider population by reaching out to communities that historically have been less engaged with our work. We'll also reach out to more organisations who represent key groups of people who are impacted by cancer and health inequalities to gather insights on the barriers they face and inform our efforts to tackle inequalities.

Examples of where we've used patient and public involvement to help reduce cancer and health inequalities include:

- establishing an Inclusion in Involvement Steering Group to set the agenda for equality, diversity and inclusion and tackling cancer and health inequalities
- consulting on Cancer Research UK projects with groups of people whose cancer experiences are shared, for example carers, children and young people, and people who are currently receiving treatment, in their post-cancer journey or are bereaved by cancer
- creating a dedicated advocacy workstream as part of a new project within Cancer Grand Challenges, a global research initiative we co-fund that identifies the toughest challenges in cancer research
- consulting with cancer patients to understand the impact of the cost-of-living crisis on people affected by cancer as part of our manifesto for cancer research and care

Partnerships

We can't tackle cancer and health inequalities alone. Delivering this strategy requires working in partnership with others. We'll build on our strong foundation of existing partnerships and relationships to proactively collaborate with others to accelerate our work and progress in reducing cancer and health inequalities in the following ways:

- Social and commercial factors drive determinants of health and cancer in turn. We will work in partnership to advocate for change on a range of issues where we offer impact and expertise, and our voice is strengthened by joining with people or organisations beyond the health sector. For example, we already advocate for change on the preventable risk factors for cancer, such as smoking or obesity. We won't seek to focus our resources on areas outside our expertise, such as on the wider social determinants of health, but only areas that can be directly and robustly linked to cancer outcomes.
- We'll build on our partnerships with health systems and governments to address issues in health service delivery, such as the sustainable future of primary care or diagnostics investment.
- We'll continue to work with others to deepen our understanding of inequalities through better quality and availability of data, widening our evidence base and gaining insights by working with organisations that represent underserved groups and groups who experience inequalities.
- We'll develop new partnerships with groups and organisations that reflect the diversity of the UK population. Together, we'll create appropriate and empowering health information to help tackle taboos and barriers and shift attitudes and behaviour within communities.

Tesco 'Let's Talk' pharmacy service

We have a strong track record of corporate partnerships that support our work financially but also provide innovative opportunities for expanding our reach and accessibility. For example, our health charity partnership with Tesco.

Launched in 2018 together with the British Heart Foundation and Diabetes UK, the partnership delivers specialist training to Tesco pharmacists and pharmacy staff to help them provide better information and support to anyone at risk of developing or living with cancer, heart and circulatory disease and type 2 diabetes.

Across the country, Tesco pharmacies see half a million customers every week and their customer segmentation and data shows they are a target audience for our information.

Tesco is also the only UK supermarket with a pharmacy chain and their pharmacies can be more accessible than community pharmacies as they have longer opening hours, including evenings and weekends.

▶ **We developed the Let's Talk e-learning and information programme for Tesco pharmacy teams with an ambition for this to be a long-term and impactful service.**

It also provides us with a unique opportunity to pilot and evaluate pharmacy campaigns, reaching millions more customers through Tesco Clubcard and other communication channels, and providing valuable insight for our social and behavioural research team.

Concluding statement

Concluding statement

Our first cancer and health inequalities strategy is our commitment to play our critical part in addressing the considerable challenges we face. We know what we need to do.

By deepening our understanding, driving impact through influence and making sure we're engaging with people in ways that are inclusive, relevant and accessible, we will make improvements.

Beating cancer means beating it for everyone. And we won't stop in our pursuit of a world where everybody lives longer, better lives, free from the fear of cancer.

References

References Links in **bold**

1. NHS England. **What are healthcare inequalities?** Accessed 2024
2. Marmot M. **Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010.** 2010
3. Cancer Research UK. **Our long-term organisational strategy.** 2022
4. Cancer Research UK. **Our research strategy**. 2022
5. Calculated by the Cancer Intelligence team at Cancer Research UK. Based on the percentage change of annual average European age-standardised mortality rate for all cancers combined (ICD-10 C00-C97), from 326.3 per 100,000 people in 1971– 1973 to 259.3 per 100,000 people in 2018+2019+2021. 2004
6. Quaresma M, Coleman MP, Rachet B. **40-year trends in an index of survival for all cancers combined and survival adjusted for age and sex for each cancer in England and Wales, 1971–2011: a population-based study.** The Lancet, 2015
7. NHS England. **The NHS Cancer Plan.** 2000
8. The Auditor General and the Accounts Commission. **Health inequalities in Scotland.** 2012
9. Welsh Assembly Government. **Fairer Health Outcomes For All: Proposals for indicators of health inequity.** 2013
10. Department of Health, Social Services and Public Safety (Northern Ireland). **Making Life Better.** 2014
11. Public Health Scotland. **Cancer survival statistics.** 2023
12. Public Health Wales. **Cancer survival in Wales.** 2023
13. Queens University Belfast. **Cancer incidence and survival statistics for Northern Ireland: 1993-2021.** 2024
14. NHS Digital. **Cancer survival in England 2016–2020, followed up to 2021.** 2023
15. Cancer Research UK. **Incidence of common cancers by deprivation.** Accessed 2024
16. Jackson SS et al. **Sex disparities in the incidence of 21 cancer types: Quantification of the contribution of risk factors.** Cancer, 2022
17. Delon C et al. **Differences in cancer incidence by broad ethnic group in England, 2013–2017.** Br J Cancer, 2022
18. Cancer Research UK. **Cancer incidence for common cancers.** Accessed 2024
19. Brown K et al. **The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015.** Br J Cancer, 2018
20. Office for National Statistics. **Adult smoking habits in the UK: 2022.** 2023
21. Public Health England. **Health matters: smoking and mental health.** 2020
22. Cancer Research UK. **Smoking prevalence projections for England based on data to 2021.** 2023
23. Cancer Research UK. **When could overweight and obesity overtake smoking as the biggest cause of cancer in the UK?** 2018
24. Simmonds M et al. **Predicting adult obesity from childhood obesity: a systematic review and meta-analysis.** Obesity Reviews, 2015
25. NHS Digital. **National Child Measurement Programme, England, 2022/2023 School Year.** 2023
26. Barclay M et al. **Socio-demographic variation in stage at diagnosis of breast, bladder, colon, endometrial, lung, melanoma, prostate, rectal, renal and ovarian cancer in England and its population impact.** Br J Cancer, 2021

27. Whitelock V. **Cancer Research UK's September 2023 Cancer Awareness Measure 'Plus' (CAM+).** Data collected by YouGov PLC and analyses conducted by Cancer Research UK. 2023

28. Marcu A et al. **Educational differences in responses to breast cancer symptoms: A qualitative comparative study.** Br J Health Psychology, 2017

29. Ajayi O. **A perspective on health inequalities in BAME communities and how to improve access to primary care.** Future Healthcare Journal, 2021

30. Lifford K et al. **Satisfaction with remote consultations in primary care during COVID-19: a population survey.** Br J Gen Pract. 2024

31. Nuffield Trust. **QualityWatch: Younger people and people of minority ethnicities have more visits to a GP before a cancer diagnosis.** Press release, 2024

32. Young B, Robb KA. **Understanding patient factors to increase uptake of cancer screening: a review.** Future Oncol, 2021

33. BMC Medicine. **One size does not fit all: working towards increasing participation of minority groups in cancer screening programmes.** BMC Med, 2023

34. Osborn DP et al. **Access to cancer screening in people with learning disabilities in the UK: cohort study in the health improvement network, a primary care research database.** PLoS ONE, 2012

35. Kerrison RS et al. **Inequalities in cancer screening participation between adults with and without severe mental illness: results from a cross-sectional analysis of primary care data on English Screening Programmes.** Br J Cancer, 2023

36. Morris S et al. **Socioeconomic variation in uptake of colonoscopy following a positive faecal occult blood test result: a retrospective analysis of the NHS Bowel Cancer Screening Programme.** Br J Cancer, 2012

37. Douglas E et al. **Colposcopy attendance and deprivation: A retrospective analysis of 27,193 women in the NHS Cervical Screening Programme.** Br J Cancer, 2015

38. Green LI et al. **Attendance at early recall and colposcopy in routine cervical screening with human papillomavirus testing.** Int J Cancer, 2021

39. Calculated by the Cancer Intelligence team at Cancer Research UK. Based on **bowel cancer screening uptake 2021/22: aged 60 to 74 years** Fingertips, **deprivation score by GP practice (IMD 2019)** Fingertips, **number of patients registered at a GP Practice April 2021** NHS England and **estimated cancer detection rate based on Moss et al. (2016).** A generalised linear mixed-effects model was applied to the number of people screened in the least deprived quintile, using proportion of people aged 70-74 as a fixed predictor. Clinical commissioning group (as were) was used as a random predictor to account for differences across clinical commissioning groups. Differences in age and distribution were accounted for. 2023.

40. McPhail S et al. **Use of radiotherapy in patients with oesophageal, stomach, colon, rectal, liver, pancreatic, lung, and ovarian cancer: an International Cancer Benchmarking Partnership (ICBP) population-based study.** The Lancet Oncology, 2024

41. Given B, Given CW. **Older adults and cancer treatment.** Cancer, 2008

42. Nussbaum C et al. **Inequalities in the distribution of the general practice workforce in England: a practice-level longitudinal analysis.** BJGP Open, 2021

43. Cancer Research UK. **Cancer News Health inequalities series.** 2022–2023

44. Fry A et al. **Relationship between ethnicity and stage at diagnosis in England: a national analysis of six cancer sites.** BMJ Open, 2023

45. Wills L et al. **Estimating surgery, radiotherapy and systemic anti-cancer therapy treatment costs for cancer patients by stage at diagnosis.** Eur J Health Econ, 2023

46. Cancer Research UK. **Early diagnosis conferences.** Accessed 2024

47. Cancer Research UK. **CRUK Early Diagnosis Research – Virtual Events.** Accessed 2024

48. NHS England. **Core20PLUS5 (adults) – an approach to reducing healthcare inequalities.** Accessed 2024.

49. **Public First polling for Campaign for Science and Engineering May 2022.** Accessed via CaSE Messengers 2024

50. nfpResearch, March–April polling. 2024

51. Office for National Statistics. **Health state life expectancies by national deprivation deciles, England: 2018 to 2020.** 2022

52. NHS England. **What are integrated care systems?** Accessed 2024

53. NHS Scotland. **NHS Scotland delivery planning guidance 2024/25.** 2023

54. Fisher R et al. **Level or not? Comparing general practice in areas of high and low socioeconomic deprivation in England.** The Health Foundation, 2020

55. Cancer Research UK. **About Cancer.** Accessed 2024

56. Cancer Research UK. **Cancer Chat.** Accessed 2024

57. Cancer Research UK. **Find a clinical trial.** Accessed 2024

58. Good Things Foundation. **Our Digital Nation.** 2024

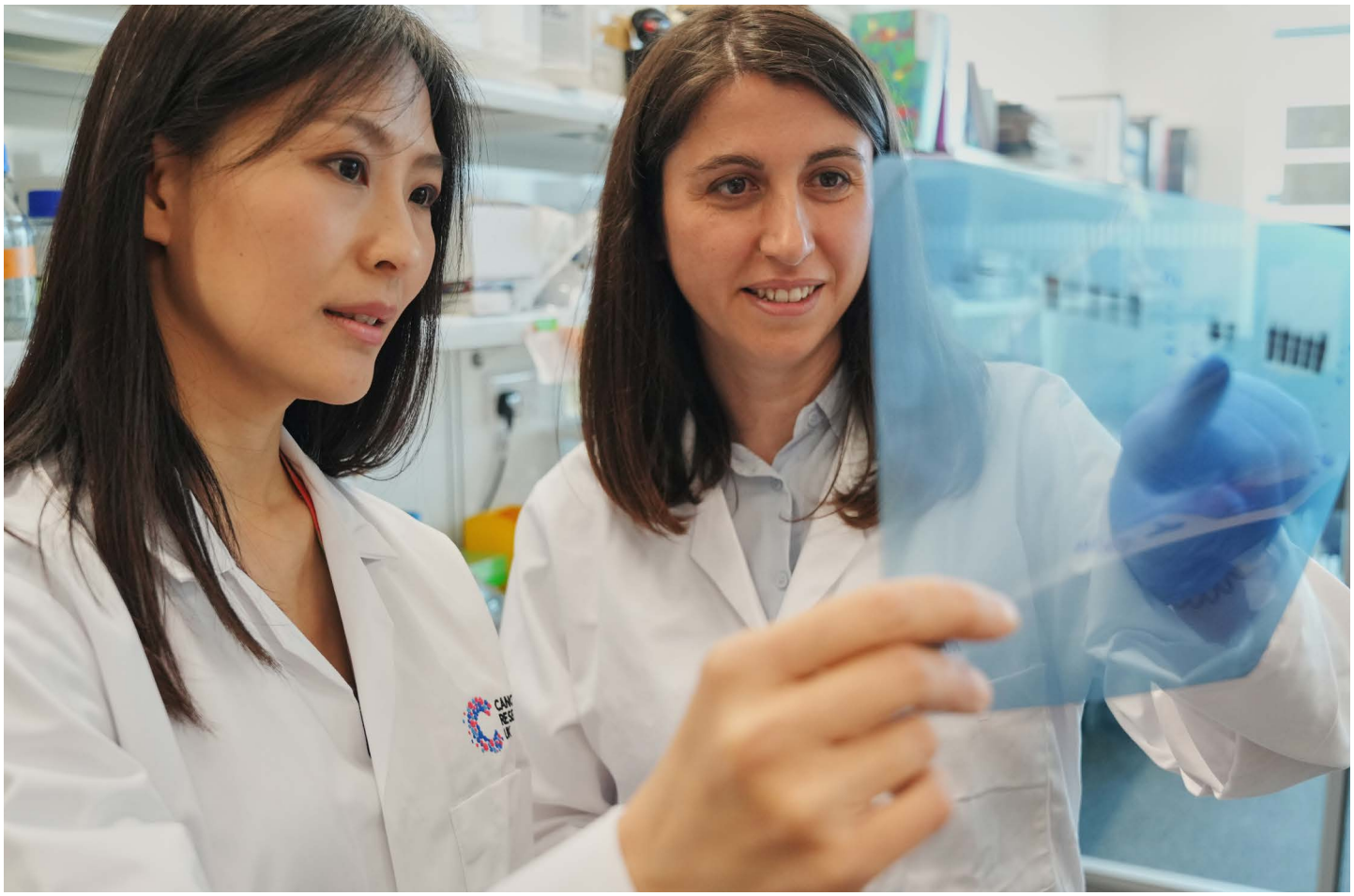
59. Cancer Research UK. **Patient Services.** Accessed 2024

60. Cancer Research UK. **Ask our nurses a question.** Accessed 2024

61. Cancer Research UK. **Cancer awareness training programme.** Accessed 2024

62. Cancer Research UK. **Cancer Awareness in the Workplace.** Accessed 2024

63. Cancer Research UK. **Interpreted cancer awareness workshops: talking about cancer with South-Asian communities.** Cancer News. 2022



CANCER RESEARCH UK

Together we are beating cancer

Produced by Cancer Research UK, November 2024.
Reg charity numbers 1089464, SC041666, 1103 & 247 © Cancer Research UK 2024