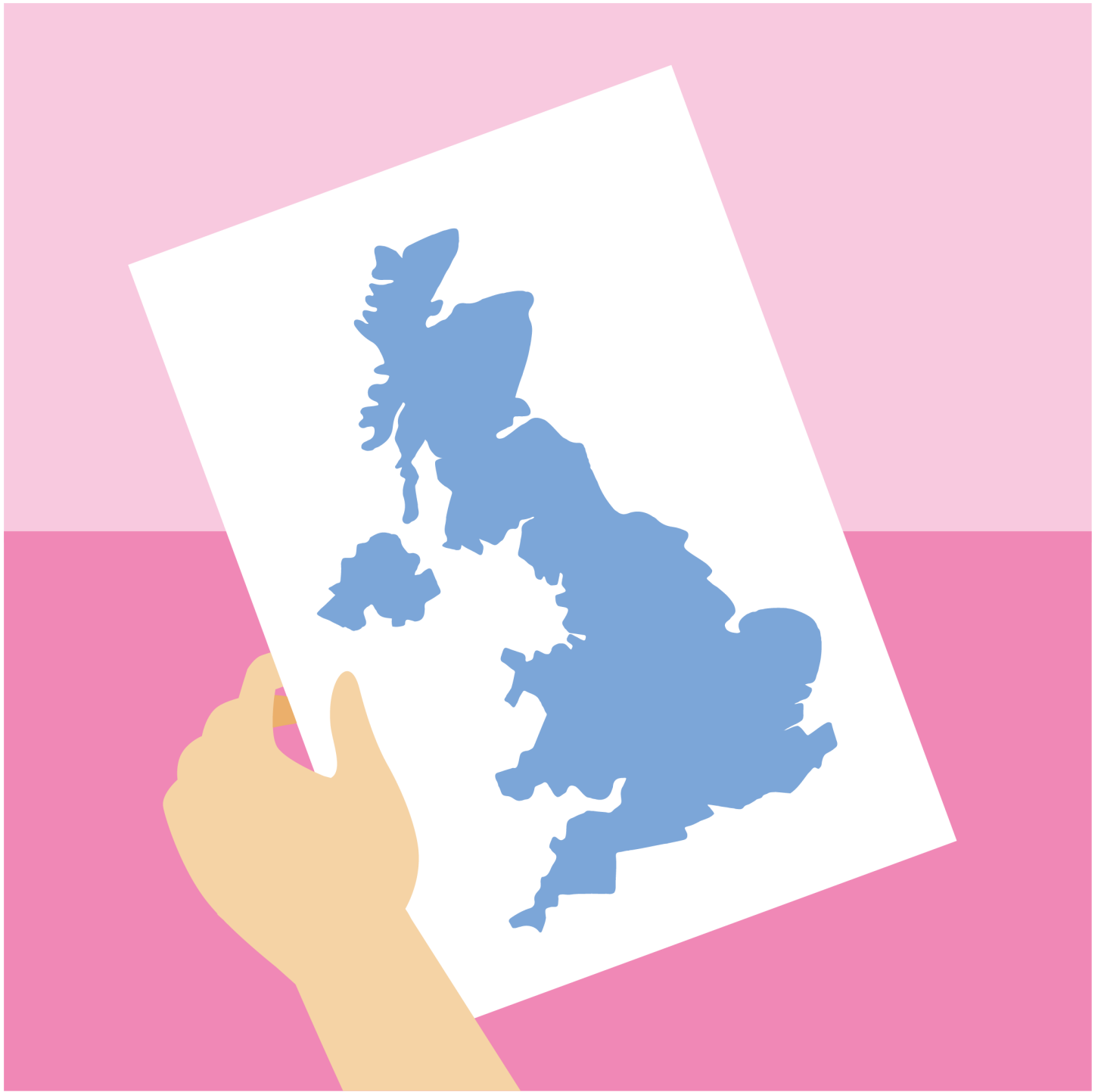




Cancer in the UK

Age 2026



CANCER
RESEARCH
UK

Together we are
beating cancer

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Reference

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About Cancer Research UK

We're the world's leading cancer charity, dedicated to saving and improving lives with our research, influence and information. Over the past 50 years, our pioneering work has helped double cancer survival in the UK. And today it's continuing to save lives, here and around the world.

Our vision is a world where everybody lives longer, better lives, free from the fear of cancer. And step by step, day by day, our researchers are making this vision a reality thanks to our dedicated community of supporters, partners, donors, fundraisers, volunteers and staff.

Together we are beating cancer.



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Foreword



Naser Turabi
Director of Health
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Increasing age is the biggest predictor of cancer risk. 9 in 10 (90%) cancer cases occur in people over 50, with more than half (53%) of all cases in people over 70, underlining the profound influence of age on cancer incidence and outcomes.

As the population grows and ages, more people will be diagnosed with cancer, particularly older adults. Health services across the UK will need to meet rising demand and adapt to more complex care needs, including dealing with comorbidities that can affect tolerance or suitability of different treatment options. In practice, this means thinking about the cancer workforce, the range of treatments health services offer, addressing barriers to potential treatment options and considering the wider package of support that is required to be suitable to the needs of an older population.

At the same time, we must redouble efforts to address the impact of cancer on children and young people. Cancer is the leading cause of death by disease for children and young people over the age of one in the UK. Research into children's and young people's cancers, including the development of less toxic, more effective treatments is critical to improving outcomes and enabling a high quality of life beyond cancer.

Understanding how cancer outcomes differ by age across the UK is essential if we are to target action effectively and improve cancer outcomes for everyone. National cancer strategies in Scotland, Northern Ireland and England, and cancer policy in Wales, all recognise the distinct needs of people with cancer at different ages – from dedicated investment in children and young people's treatments, to tailoring services for older people with cancer. But there is still much to do. Governments and health systems must continue to act on the evidence to ensure that everyone affected by cancer, regardless of age, has the best possible outcomes.

A handwritten signature in black ink, appearing to read 'Naser Turabi'.

Glossary of terms

Incidence

- **Incidence:** The total number of new cancer cases diagnosed in the population in a specified time frame, usually within one year.
- **Age-specific incidence rate:** A measure of cancer cases per 100,000 people in the population in the specific age group in a given timeframe (usually a year). This is generally used to compare the rate of cancer between age groups, accounting for the different size of the population in each age group.
- **Age-standardised incidence rate:** A measure of cancer cases per 100,000 people in a given timeframe (usually a year), weighted for each age group to a standard population so that comparisons over time are not affected by the changing size of the population over time.

Survival

- **Survival:** The percentage of people who are expected to survive their cancer after a specific amount of time (usually 1-year, 5-years or 10-years) after a cancer diagnosis. This takes into account the chance of dying from other causes of death, therefore is not the chance of being alive after this time, but the chance of not dying from their cancer within the timeframe.

Mortality

- **Mortality:** The total number of deaths from cancer in the population in a specified timeframe, usually within one year.
- **Age-specific mortality rate:** A measure of cancer deaths per 100,000 people in the population in the specific age group in a given timeframe (usually a year). This is generally used to compare the rate of cancer mortality between age groups accounting for the different size of the population within each age group.
- **Age-standardised mortality rate:** A measure of cancer deaths per 100,000 people in a given timeframe (usually a year), weighted for each age group to a standard population so that comparisons over time are not affected by the changing size of the population over time.

Prevention

- **Overweight & obesity prevalence:** The proportion of the population that is estimated to have overweight (a Body Mass Index [BMI] between 25.0–29.9) or obesity (BMI greater than 30).
- **Smoking prevalence:** The proportion of the population that is estimated to smoke cigarettes on a daily or occasional basis.

Screening

- **Screening coverage:** The percentage of eligible people who are up to date with their screening (have participated within the last screening round).
- **Screening uptake:** The percentage of people invited for screening who were screened within 6 months of the invitation.

Early diagnosis

- **Emergency Presentation:** Patients who had an emergency hospital admission (for example, through A&E, emergency GP referral or other emergency admission) in the 28 days prior to their cancer diagnosis.
- **Stage at diagnosis:** Staging is a way of describing the size of a cancer and how far it has grown. Most types of cancer are categorised using the TNM system and have four stages, numbered from 1 to 4; stages 1 and 2 are considered 'early', where the cancer is small and hasn't spread into the surrounding tissues; stages 3 and 4 are considered 'late', where the cancer may have started to spread into surrounding tissues and lymph nodes.

Cancer services and treatment

- **62-day standard:** The Cancer Waiting Times referral-to-treatment-standard, measuring the proportion of patients who started their first treatment for cancer within 62 days of their urgent referral. Each UK nation has a different target for the proportion of people starting cancer treatment following a referral (England: 85%; Northern Ireland and Scotland: 95%).
- **Faster Diagnosis Standard:** A Cancer Waiting Times standard in England, which measures the proportion of people who have their cancer diagnosed or ruled out within 28 days from an urgent referral. Currently, the target is for 80% of people to meet this standard.

Introduction

This report is the latest instalment in our Cancer in the UK series. It provides an overview of how the experience and impact of cancer varies with age. We explore how cancer prevention, incidence, diagnosis and treatment differ by age across the UK, and how these patterns shape cancer outcomes.

Age is a core demographic factor that plays an influential role in determining the needs of a population. Not all variation by age is indicative of inequality – many differences along the cancer pathway are expected, driven by biological, physiological and developmental factors that influence how cancer develops and how people respond to treatment at different stages of life. However, some disparities indicate unequal access to care or differences in how services are delivered and warrant further investigation and action.

This report draws on the most up-to-date UK-wide insights and data or, where this is not available, data from individual UK nations [1].

Not all UK nations report on all metrics included in this report, and in some instances, results aren't directly comparable between nations. We've used the age breakdowns as they are reported within each metric; this may result in some differences in the age groups used across metrics and nations. This report provides a high-level overview of the trends by age and illustrative examples are used. Further detail on trends by age can be explored for specific nations and sites on the [**Cancer Research UK website**](#) or in the sources referenced throughout the report.

As the UK population grows and ages, understanding variation by age is increasingly important for designing services that are both effective and equitable. This report aims to support a more nuanced view of how age shapes how cancer outcomes and experiences across the UK. It also sets out key action areas for governments and health systems to support future service planning, research and policy development.



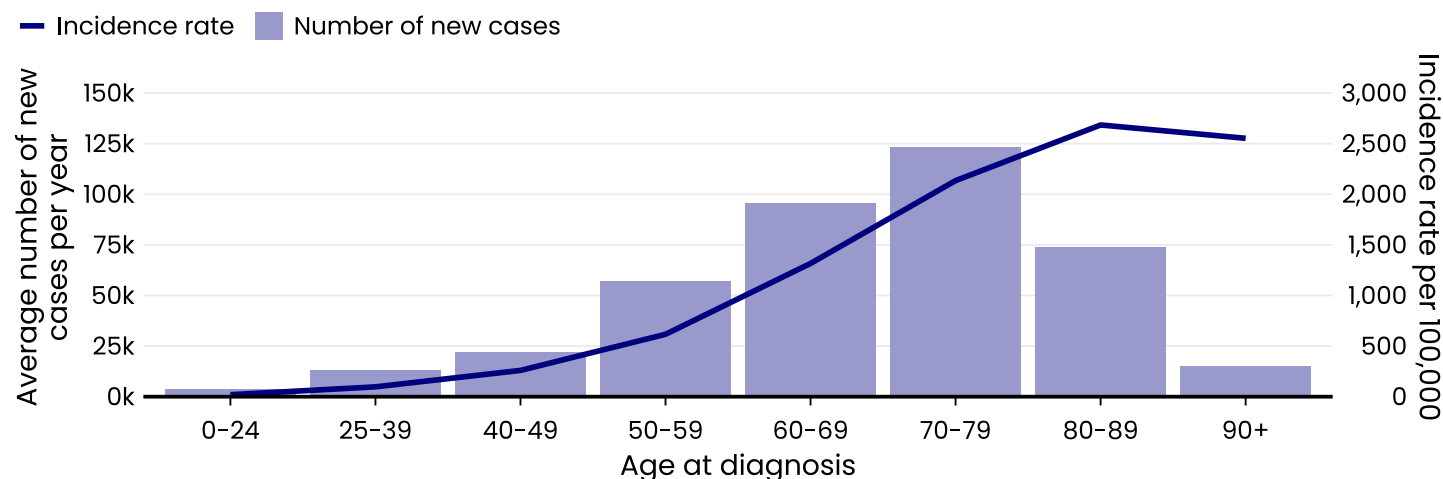
Most cancer cases occur in older adults

There are more than 403,000 new cancer cases every year in the UK [2–5]. More than half (53%) of all new diagnoses are in people aged 70 and over and almost 4 in 10 (38%) are in people aged 50 to 69. The remaining 10% occur in people under 50 years, with the

majority (90% of these) in people aged 25 to 49. As people get older, their risk of being diagnosed with cancer increases. This is largely due to biological ageing, cellular damage over time and longer exposure to risk factors.

New cancer cases by age and age-specific incidence rates

UK, 2019, 2021, 2022



Sources: NHS England, Public Health Scotland, Public Health Wales, Northern Ireland Cancer Registry

The largest increase in the absolute number of cancer cases since the early 1990s has been in older people [6], largely due to an ageing population as a result of improved life expectancy and increasing population density in older ages, which is expected to continue for decades [7]. However, the pattern differs when looking at the relative increases in incidence rates (new cancer cases per 100,000 people in the population). Since the early 1990s, cancer incidence rates in the UK have risen for all age groups. The largest increases have been in people aged 25 to 39 (32% increase) while the smallest increases have been in people aged 80 to 89 (10%) and 90 and over (9%); rates in other age groups have increased by around 13%–19%. Incidence rates are projected to

increase in all age groups between 2025–2027 and 2038–2040 [8].

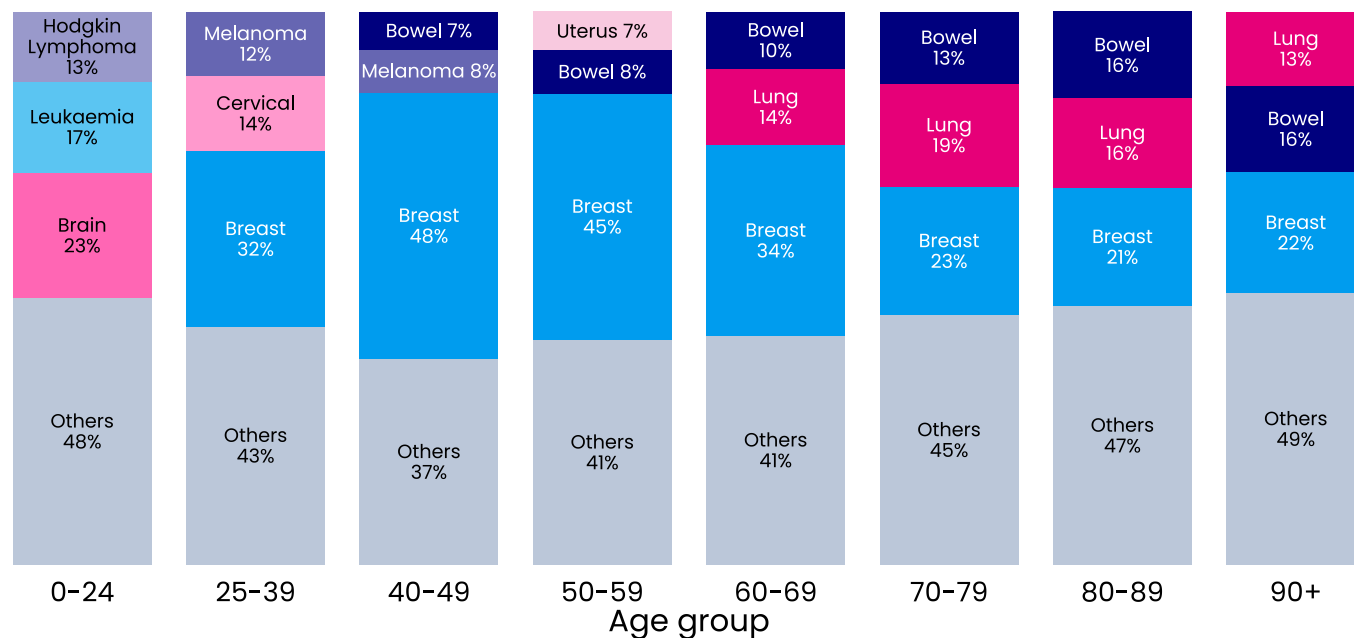
The most common cancers vary by age and sex, influenced by genetic and modifiable risk factors and screening programmes. In people aged 0 to 24, the most common cancers are brain tumours, leukaemia and Hodgkin lymphoma. In people aged over 60, the most common cancers are consistently breast (in women), prostate (in men), bowel and lung.

The changing case mix of cancer types is important to understand because of differences in how easy cancers are to diagnose and their outcomes. These trends also affect stage at diagnosis and cancer mortality.

Further breakdowns for incidence by age and for individual cancer sites can be found on the [Cancer Research UK website](#).

Most common cancers in females by age

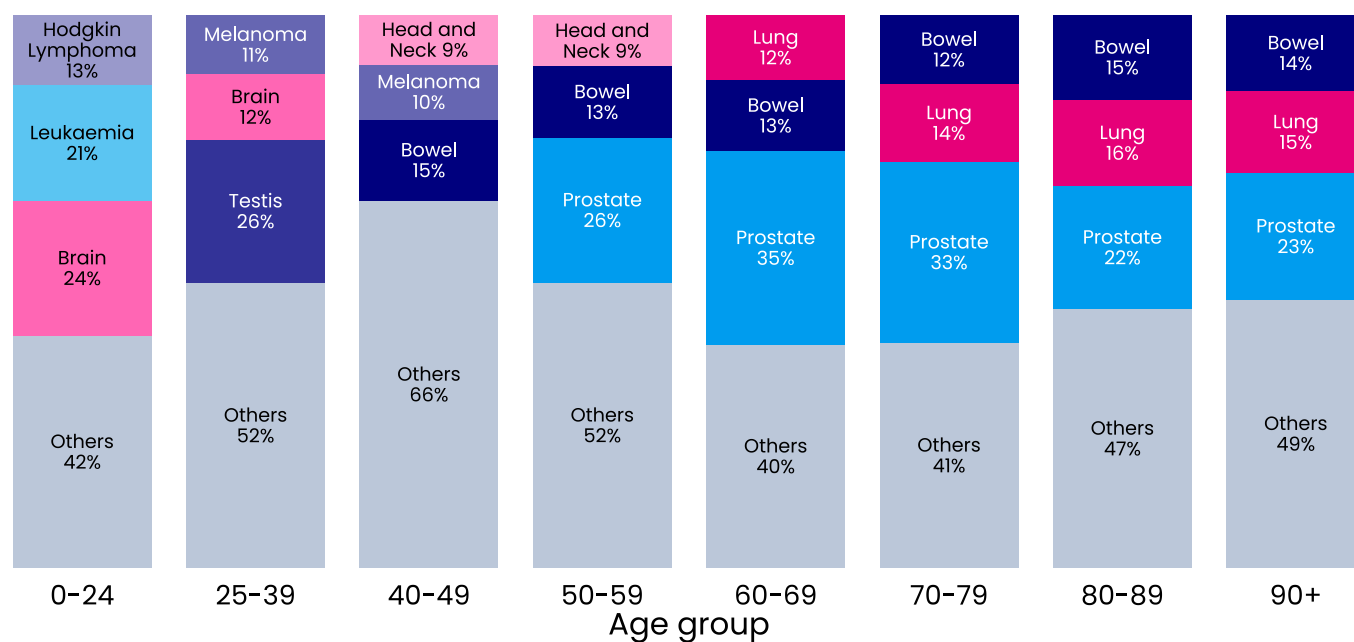
UK, 2019, 2021, 2022



Sources: NHS England, Public Health Scotland, Public Health Wales, Northern Ireland Cancer Registry

Most common cancers in males by age

UK, 2019, 2021, 2022



Sources: NHS England, Public Health Scotland, Public Health Wales, Northern Ireland Cancer Registry

Further breakdowns for incidence by age and for individual cancer sites can be found on the [Cancer Research UK website](#).

Older people have worse cancer survival

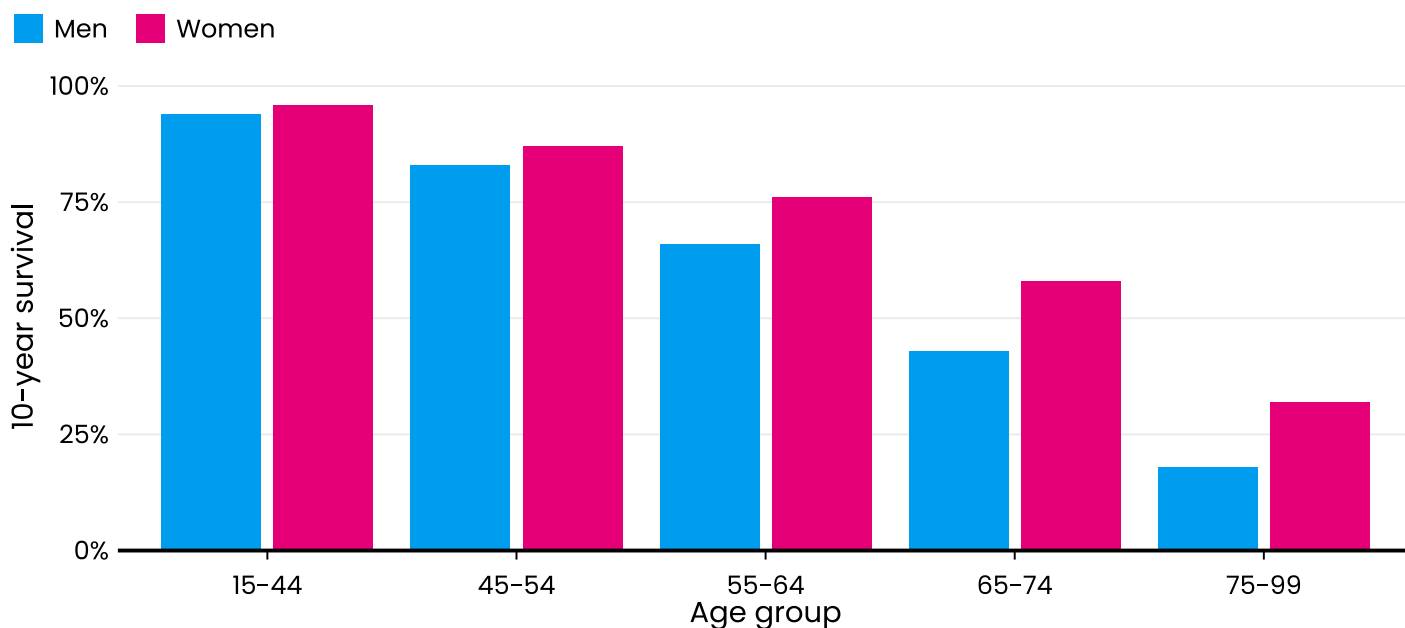
The likelihood of a person surviving their cancer is lower in older adults across all common cancer sites. In the UK, 10-year cancer survival is lowest in those aged 75 to 99 and highest in people aged 15 to 44 [9]. While survival for some cancers, such as lung, pancreas, oesophagus and stomach, is poor across all age groups, the impact of age is particularly pronounced for certain sites. Cancer sites with the biggest absolute gap

in survival – where older adults have much lower survival than younger adults – are Hodgkin lymphoma, myeloma and brain for men and ovary, cervix and Hodgkin lymphoma for women.

Cancer survival differences across all older age groups are often due to later-stage diagnoses and the impact of frailty and comorbidities, which make treatment and recovery more challenging in older adults.

10-year survival for Hodgkin lymphoma by age

UK, 2018



Source: London School of Hygiene and Tropical Medicine

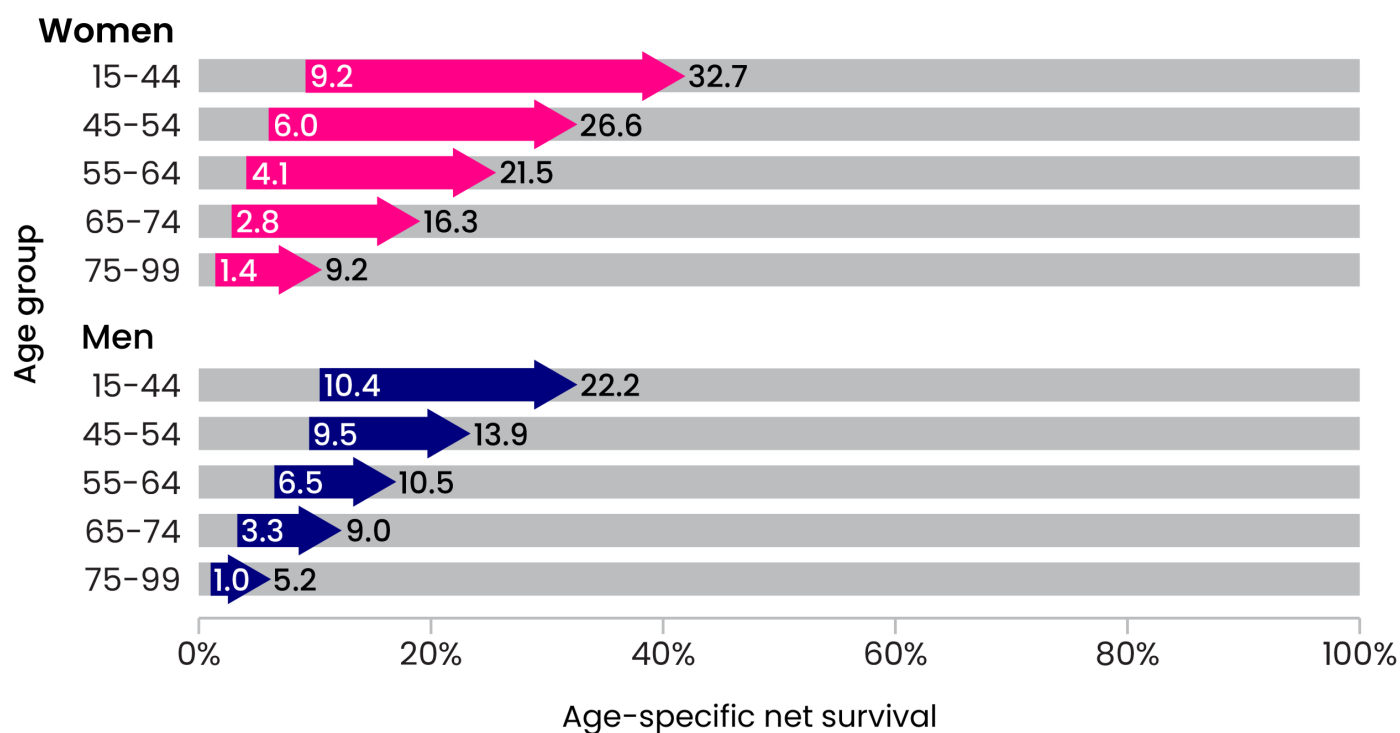
There is also variation in the improvements seen in cancer survival over the last 50 years. Improvements in 10-year cancer survival have been greatest among younger adults, while those aged 75 and over have experienced the slowest progress over time [9]. This pattern is consistent across many cancer sites, with absolute survival gains decreasing with age. Similar trends are found internationally, where improvements in 5-year cancer survival between 1995 and 2014 were greater for

people diagnosed under age 75 than for those aged 75 and over [10]. This reflects the types of cancers diagnosed at different ages.

5-year cancer survival in children, teenagers and young adults (ages 0 to 24) has improved over time, from 78% for those diagnosed in 1997–2001 to 86% for those diagnosed in 2012–2016 [11]. However, survival for some cancer sites, including brain, bone and soft tissue sarcomas, still remains low, highlighting the need for research and better treatments.

10-year net survival changes for lung cancer by age

UK, 1971–1972 to 2018



Source: London School of Hygiene and Tropical Medicine

Cancer mortality rates are strongly related to age

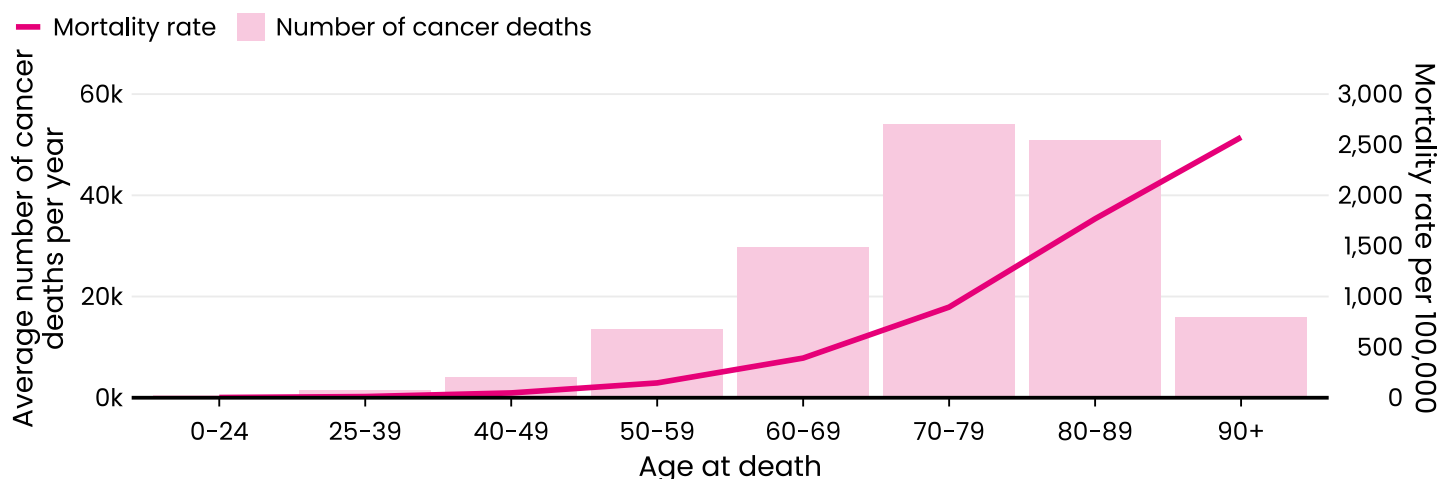
Cancer mortality rates (the number of people who have died from cancer for every 100,000 people in the population) increase with age and are highest among people aged 90 and over. Overall age-standardised mortality rates are at their lowest recorded level, and have been falling since the 1990s, reflecting improvements in cancer prevention, diagnosis and treatment. The reduction in cancer mortality rates has been seen across all age groups except those aged 90 and over [8].

Despite the fall in cancer mortality rates, the UK's ageing and growing population has meant that the number of cancer deaths has increased, to around 170,000 cancer deaths each year in the UK [12]. Around 7 in 10 (71%) of cancer deaths are in people aged 70 and over, with a further 25% in people aged 50 to 69.

The high rates of cancer deaths in people aged over 70 is predominantly driven by the increased risk of developing cancer and therefore the higher numbers of cancer cases in these age groups.

Cancer deaths and age-specific mortality rates by age

UK, 2022–2024



Sources: ONS, Public Health Scotland, Northern Ireland Cancer Registry

Cancer is the leading cause of death in the UK, accounting for more than a quarter (26%) of all deaths [13] and leading to a loss of around 2.4 million years of life each year [14]. While the number of children and young people who die from cancer is relatively small, they have a particularly high impact in terms of years of life lost to cancer [15].

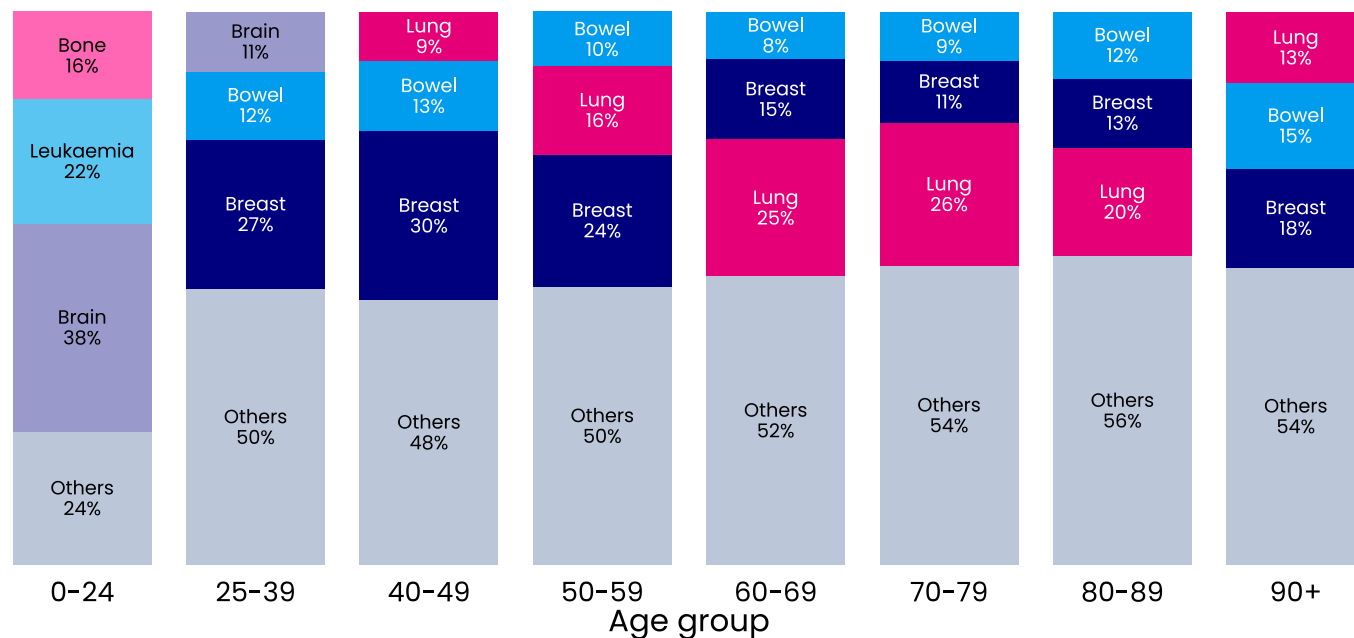
The cancer sites causing the most deaths vary

by age (due to differences in incidence and survival) and sex. The most common cancer deaths in people aged 0 to 24 are brain, leukaemia and bone cancers. In females aged 40 and over, the most common cancer deaths are breast, lung and bowel; in males, the most common cancer deaths vary until age 70, where prostate, lung and bowel are the most common.

Further breakdowns for mortality by age and for individual cancer sites can be found on the [Cancer Research UK website](#).

Most common causes of cancer death in females by age

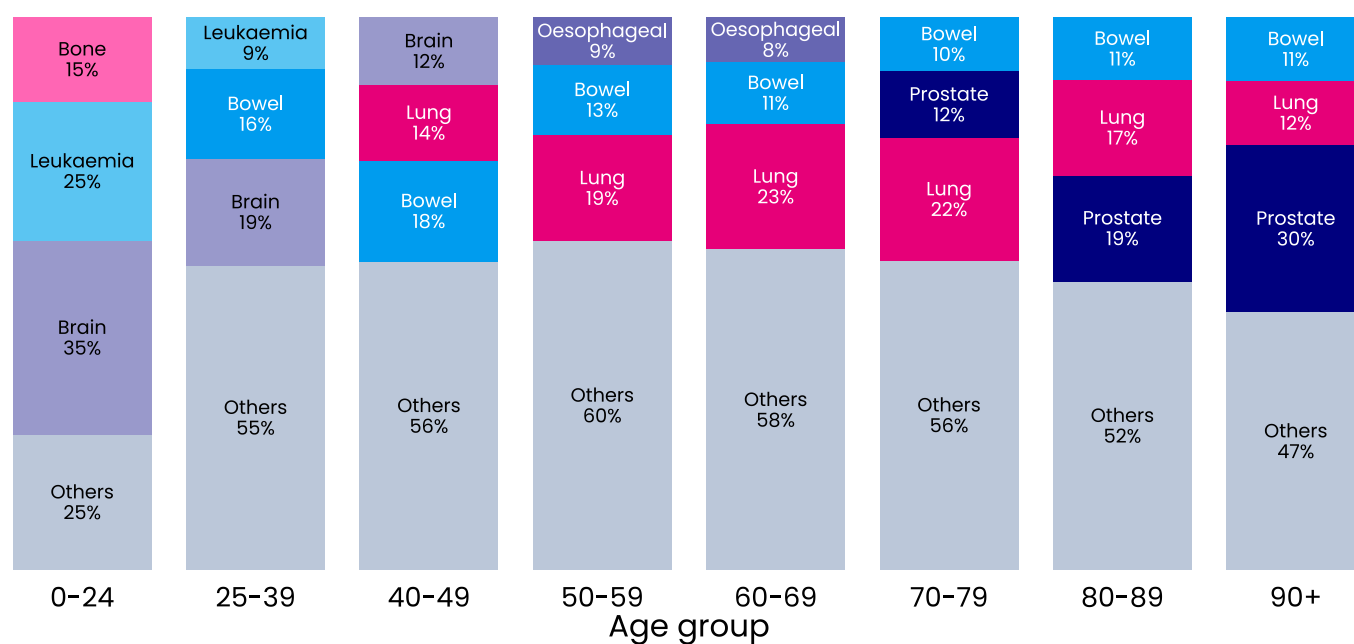
UK, 2022–2024



Sources: ONS, Public Health Scotland, Northern Ireland Cancer Registry

Most common causes of cancer death in males by age

UK, 2022–2024



Sources: ONS, Public Health Scotland, Northern Ireland Cancer Registry

Further breakdowns for mortality by age and for individual cancer sites can be found on the [Cancer Research UK website](#).

Smoking prevalence has decreased across all age groups

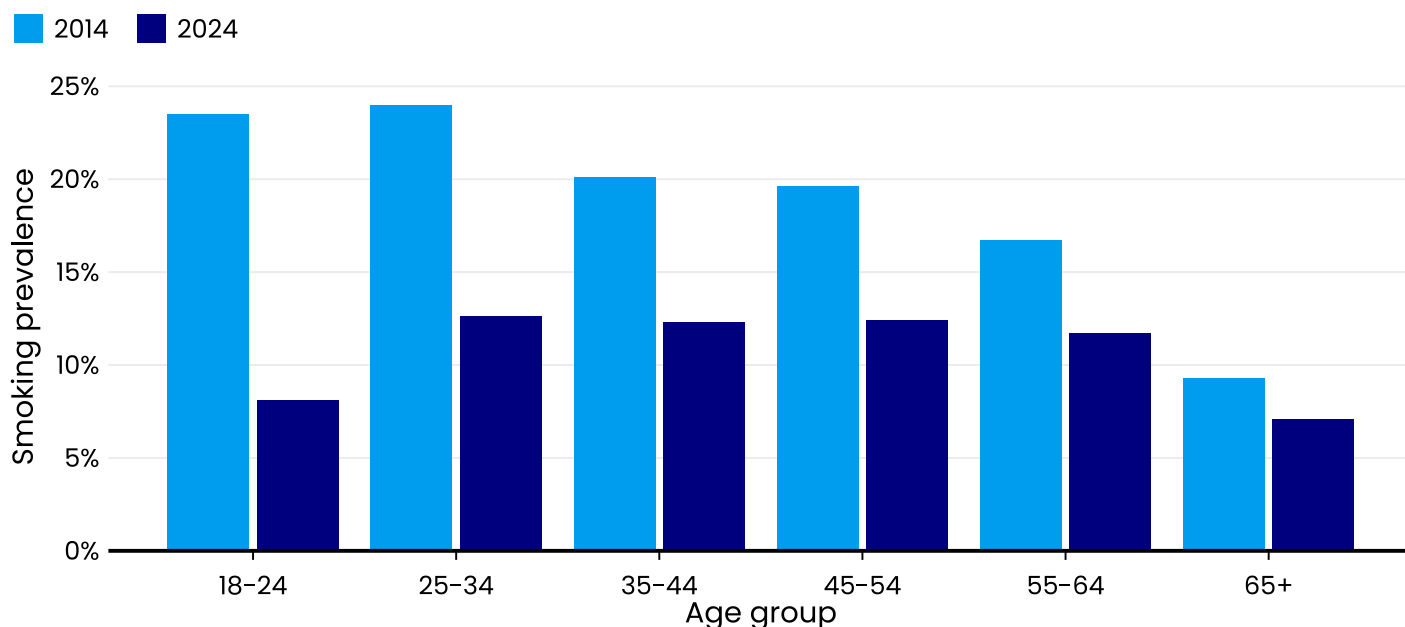
Smoking is the biggest preventable cause of cancer in the UK and is responsible for around 57,700 cancer cases every year [16]. Smoking prevalence in all age groups in the UK has been decreasing with tobacco control policy action [17,18]. However, the reduction in smoking prevalence has been much smaller in older people. This reflects the lower prevalence seen historically, alongside this age group mainly representing people who have been smoking over a much longer time-period.

Current smoking rates are lowest among older adults (aged 65 and older) in the UK, but rates

of ex-smoking are highest in this age group. This is partly because many people quit as they get older, often due to health concerns (current ill-health or concern about future ill-health) or cost [19]. In addition, some long-term smokers may not reach older age due to smoking-related illnesses [20,21]. The effect of reducing smoking rates on cancer incidence takes decades to appear, and people who formerly smoked still have elevated cancer risk compared with never-smokers for decades after stopping [20,21].

Smoking prevalence by age

UK, 2014 and 2024



Source: Office for National Statistics

Adult overweight and obesity prevalence is high across all age groups

Overweight and obesity is a risk factor for at least 13 different cancer types [22]. Almost 7 in 10 (66%) adults are estimated to have overweight or obesity in the UK [23].

Prevalence increases with age, peaking around middle age – 55 to 64 in Scotland and Northern Ireland, 45 to 64 in Wales and slightly later in England (65 to 74) – before declining slightly in the oldest age group [24–27]. This pattern reflects factors including metabolism changes with age, lifetime accumulation of excess bodyweight and the challenge of sustained weight loss and ill-health in older age causing weight loss [28–30].

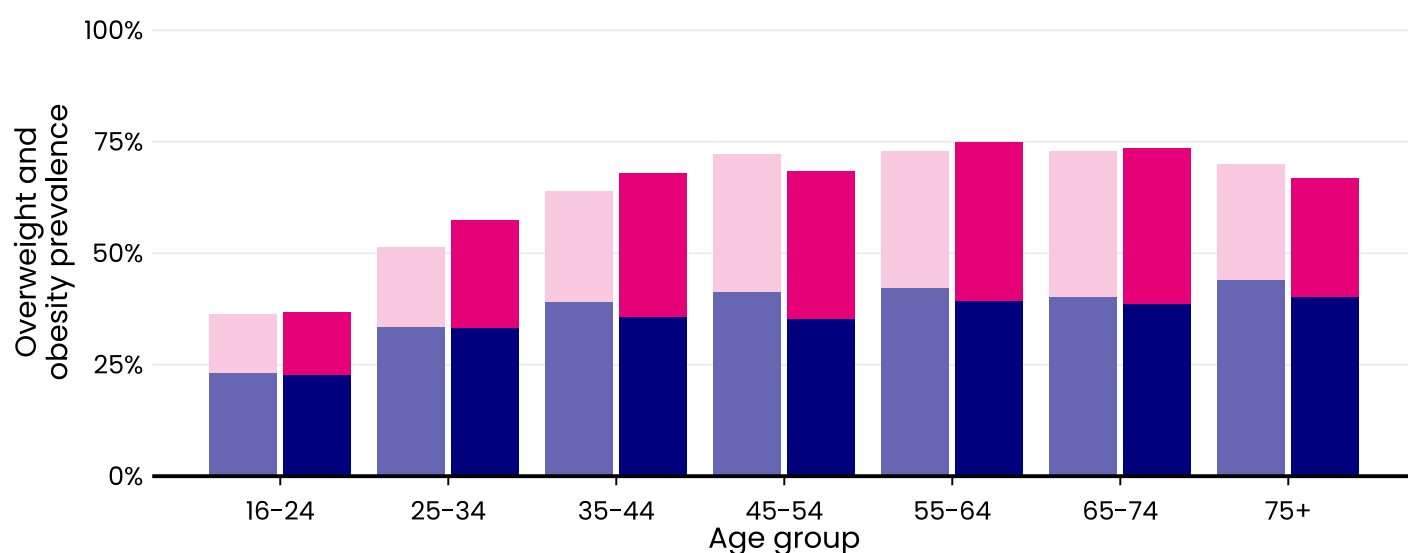
The estimated proportion of adults who have obesity (BMI 30+) in the UK has risen from around a quarter (26%) in 2014 to almost a third (30%) in 2024 [23]. This rise in overweight and obesity is expected to lead to future increases in cancer incidence.

Children who have overweight or obesity are more likely to have overweight or obesity in adulthood [31]. Having overweight and obesity in adulthood has an increased risk of developing cancer. Today, around a quarter (24%) children aged 4 to 5 years in the UK have overweight or obesity [32].

Overweight and obesity by age

England, 2012 and 2022

Obesity – 2012 Obesity – 2022 Overweight – 2012 Overweight – 2022



Source: Health Survey for England

Screening participation generally increases with age but there are barriers to participation

Screening participation generally increases with age, though patterns vary by programme. Across UK nations, cervical screening coverage rises with increasing age, peaking in people aged 50 to 54, but reduces in people aged 55 to 59 and 60 to 64 [33–36]. The lowest coverage is seen in the youngest eligible age groups (25 to 29 and 30 to 34) and the oldest eligible age group (60 to 64). As HPV vaccination substantially reduces the risk of cervical cancer, the screening programme is likely to require fewer screening invitations as vaccinated cohorts reach screening age.

Bowel screening uptake increases with age, rising from around 60% in the youngest eligible age groups to 74% in people aged 70 to 74 in both England and Scotland [37,38]. Breast screening uptake in England shows only small variation by age, ranging from 68% to 72% across the age-eligible population [39].

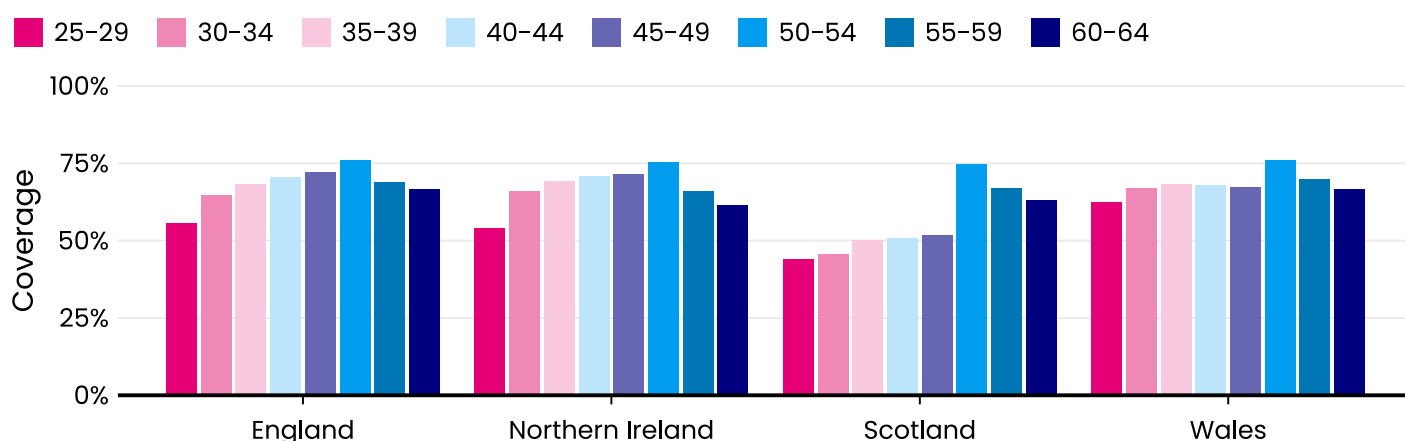
Across all three screening programmes, younger age groups are more likely to identify barriers to participation [40]. For cervical screening, the youngest eligible adults (25 to 29 years) are more likely to report more barriers to participation. People aged 30 to 49 are most likely to report difficulty getting an appointment compared to other age groups.

For bowel screening, the youngest eligible adults (50 to 54 years) are more likely to report barriers to participation. Messiness is consistently cited across age groups, though less often with increasing age.

For breast screening, women aged 50 to 54 express more concern than people aged 55 and older about pain, worry that they would find being at the appointment physically uncomfortable or difficult, and concern over potential findings.

Cervical screening coverage by nation and age

England (2023/24), Northern Ireland (2024/25), Scotland (2024/25) & Wales (2022/23)



Note: The most recent cervical screening coverage figures in Scotland are likely to be an underestimate because of recent changes to the cervical screening interval.

Sources: NHS England, HSC Public Health Agency, Public Health Scotland, Public Health Wales

People over the age of 75 are less likely to be diagnosed at an early stage for some cancer sites

People with cancer diagnosed at an early stage (stage 1 or 2) have better survival than people diagnosed at a later stage (stage 3 or 4) as the cancer has not spread to other organs and patients are more likely to be able to receive curative treatment [41–43]. Around 51%–55% of cancers in Scotland, Northern Ireland and England are diagnosed early [41,44,45], but this varies by cancer site and age group.

Examining differences within individual cancer sites helps to better understand age-related differences. In England, ovarian, thyroid and cervical cancers show the largest gaps between younger and older adults in proportion of people diagnosed early. For example, 69% of ovarian cancer cases are diagnosed early in people aged 20 to 49

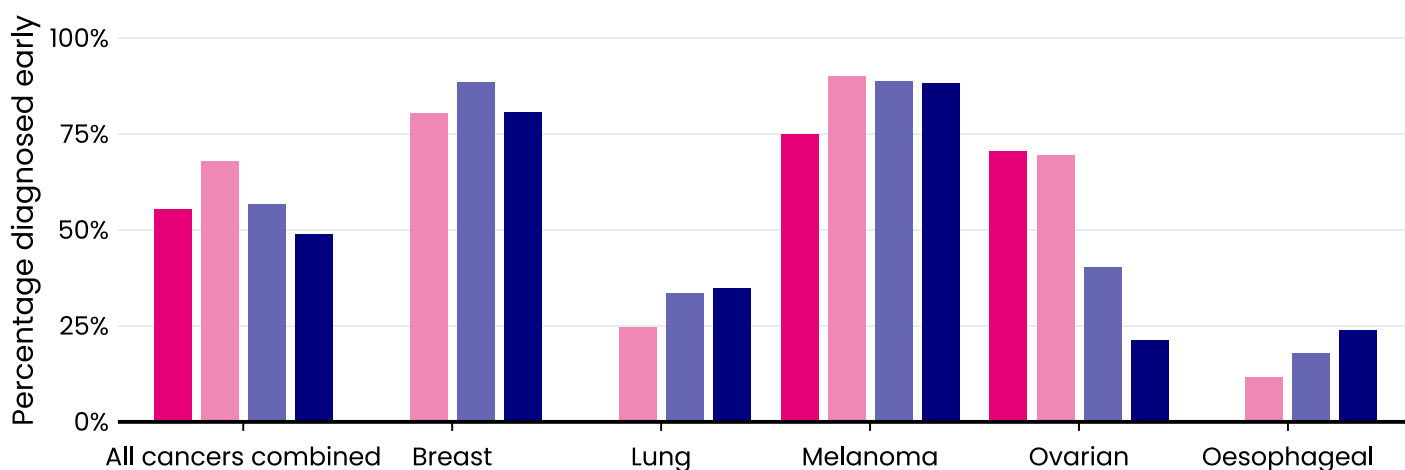
years compared with only 21% in people aged 75 and over – a 48-percentage point difference.

But for some cancer sites, including bladder, colon, lung and rectum, a lower proportion of young adults (aged 20 to 49) are diagnosed early compared to older adults (aged 50 to 74 and aged 75 and over). This trend may be due to several factors. This could include lower suspicion of these cancers in younger people, different sub-types of cancers in younger ages with different symptom presentations (or lack of), younger and older people being outside the screening eligibility age, giving less opportunity for earlier detection. There is also indication that sociodemographic factors, such as sex and deprivation, play a role in shaping the observed patterns [46].

Percentage of cancers diagnosed at stages 1 or 2 by age

England, 2022

0–19 20–49 50–74 75+



Note: Percentage of patients aged 0–19 years with breast, lung and oesophageal cancers diagnosed early not available due to low patient numbers.

Source: NHS England

People in the oldest age groups are more likely to be diagnosed via emergency routes

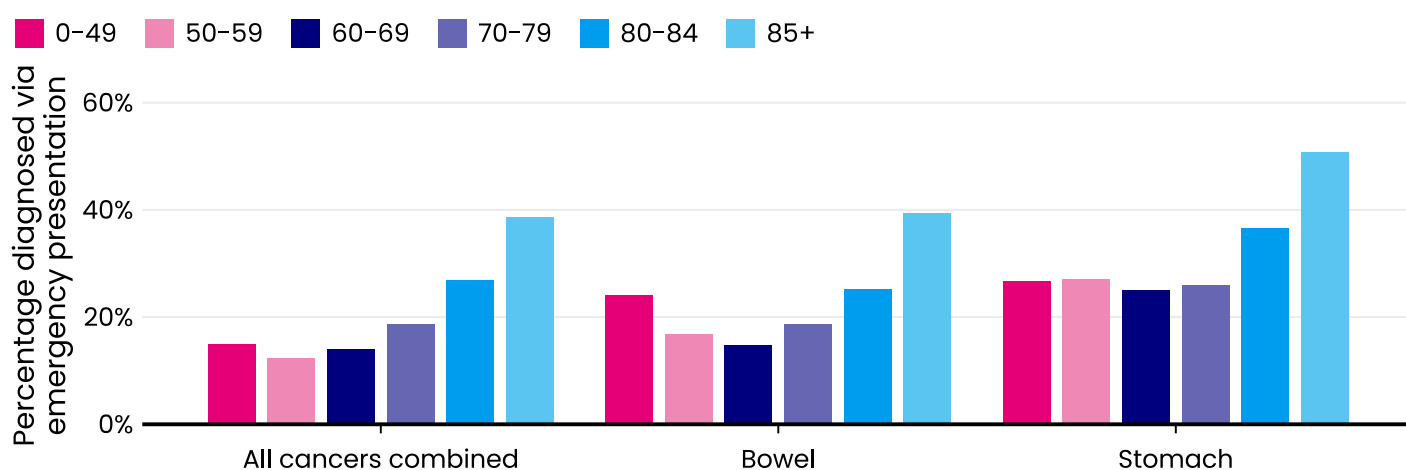
Patients diagnosed via emergency routes are more likely to have later-stage disease, fewer treatment options and poorer outcomes and experiences of cancer care [47–51]. The proportion of adult cancer cases with emergency presentations generally increases with age, partly reflecting differences in cancer types across age groups.

Emergency presentation data are only available for England and Northern Ireland. In England, the proportion diagnosed via emergency presentation is more than twice as high in people aged 80 and over compared to people under 50 [49]. A similar trend is seen in Northern Ireland and across most cancer sites in both countries [50].

The higher likelihood of emergency presentation in older age groups remains after adjusting for other socio-demographic characteristics [52]. For some cancers, including colon and stomach, the likelihood of emergency diagnosis also increases among people aged 25 to 34. This may be because symptoms can be less clear or develop more quickly, and some cancers in younger people grow faster, leaving less opportunity for diagnosis before an emergency occurs. Cancer may also be considered less likely in younger people, meaning symptoms are overlooked or attributed to other conditions [52–54].

Percentage of cancer cases diagnosed via emergency presentation by age

England, 2019



Source: NHS England

The survival gap between younger and older patients is much more pronounced for emergency presentations compared to managed routes (e.g., screening or GP referrals) [49]. For example, when diagnosed via urgent suspected cancer referral, 5-year bowel cancer survival in England is 68% for

people aged 15 to 54 compared to 61% for people aged 75 and over. But for people diagnosed with bowel cancer via emergency presentation, 5-year survival is 50% for people aged 15 to 54 and 18% for people aged 75 and over.

There are differing levels of symptom recognition and help-seeking behaviours across age groups

In the UK, people aged 50 and over who experience a potential cancer symptom are more likely to contact their GP within six months (64%) compared to people aged 30 to 49 (58%) and 18 to 29 (48%) [40]. However, people aged 18 to 29 are more likely to go back to their GP after still experiencing any potential cancer symptom. In addition, younger people are more likely to contact their GP practice more than once to try and make an appointment for any health concern (18 to 29 years (52%); 30 to 49 years (51%)), than those aged 50 and over (42%). Of those who were unable to make a GP appointment following any health concern, younger people (aged 18 to 29) more commonly state that they couldn't get an appointment 'at a convenient date or time' (13%), compared to 5% of people aged 50 and over.

Barriers to help-seeking also vary by age. People aged 18 to 29 years report, on average, a slightly higher average number of barriers (8.56) to discussing any symptom or health concern with a healthcare professional, compared to those aged 30 to 49 years (8.14), or aged 50 and over (6.98) [40].

People aged 18 to 29 years are more likely to state that they don't feel confident talking about symptoms (33%). However overall, they were less likely to report that it was difficult to get an appointment generally (42%), or with a particular health care professional (39%). In addition, people aged over 50 are more likely to report barriers of thinking their symptom is an existing illness (42%) and not wanting a remote appointment (41%).



Faster Diagnosis Standard performance is poor across all age groups

The Faster Diagnosis Standard (FDS) in England sets the expectation that people referred for suspected cancer should be told if they have cancer or not within 28 days of their referral. When the standard was introduced, the NHS had a target of meeting this standard for 75% of people – this target rose to 80% at the end of March 2026. There are clear differences by age in performance against the target between people diagnosed with cancer and those where cancer is ruled out [55].

For referrals where cancer is ruled out, FDS performance steadily declines with age; younger groups have a higher proportion of

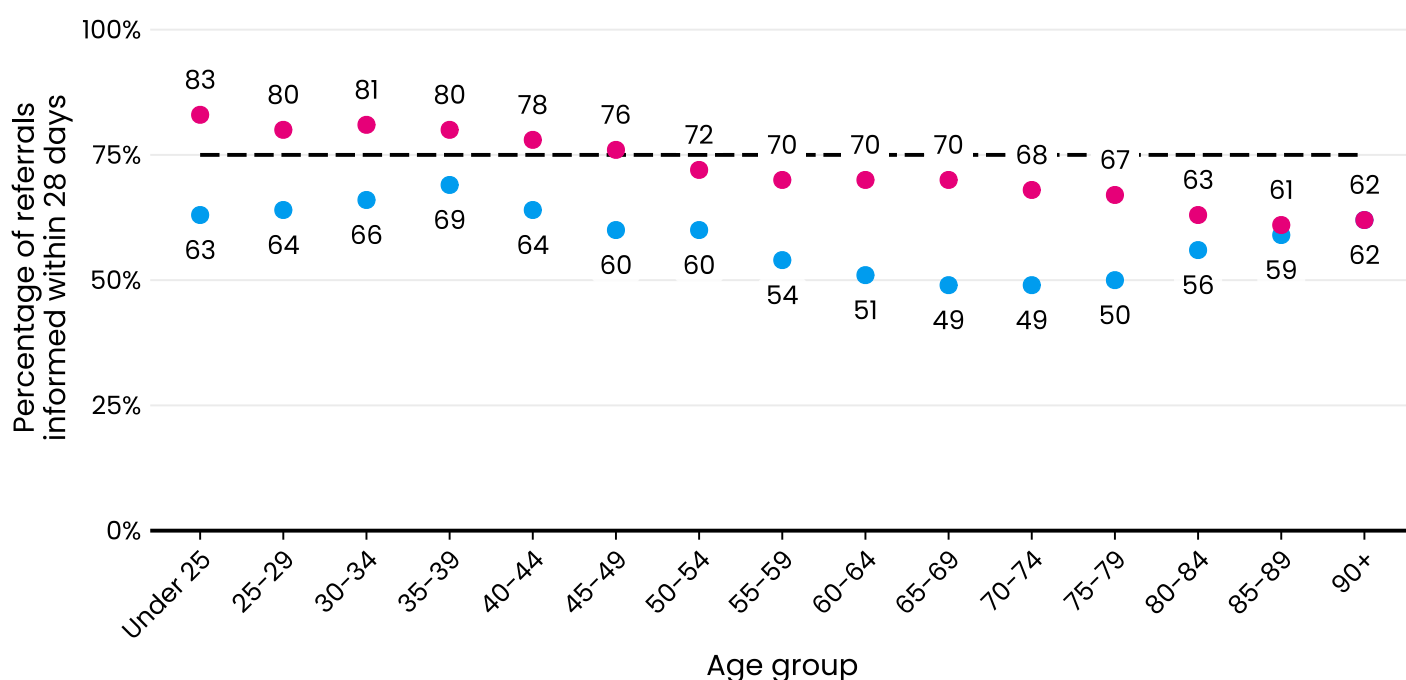
cancer ruled out within 28 days compared to older age groups. This could be, in part, due to the types of cancer diagnosed in different age groups or the presence of comorbidities in older groups, creating more complex diagnostic pathways [56,57].

In contrast, FDS performance for people diagnosed with cancer drops between the ages of 65 to 84, falling from around 60% to around 50% before improving again for people aged above 85. However, the FDS target was not met for any age group when looking only at people diagnosed with cancer.

Average FDS performance by referral outcome and age

England, October 2021 to June 2024

● Diagnosed referral outcome ● Ruled out referral outcome — Target



Note: As the chart data relates to 2021 to 2024, the FDS target is shown as 75%. This target was increased to 80% in March 2026.

Sources: Cancer Research UK, NHS England

Treatment delays are increasing across all age groups

Across UK nations, one key target for cancer pathways is that patients should start their first treatment for cancer within 62 days of a suspected cancer referral. This target has not been met since 2012 in Scotland, and has never been met in Northern Ireland since being introduced in 2008 [58,59]. Wales is also yet to meet its target for the Suspected Cancer Pathway, which was implemented in June 2019 [60]. In England, the 62-day target hasn't been met since December 2015, and in 2025, around 1 in 10 (9%) patients waited more than 104 days to begin their cancer treatment, a group known as long-waiters [61].

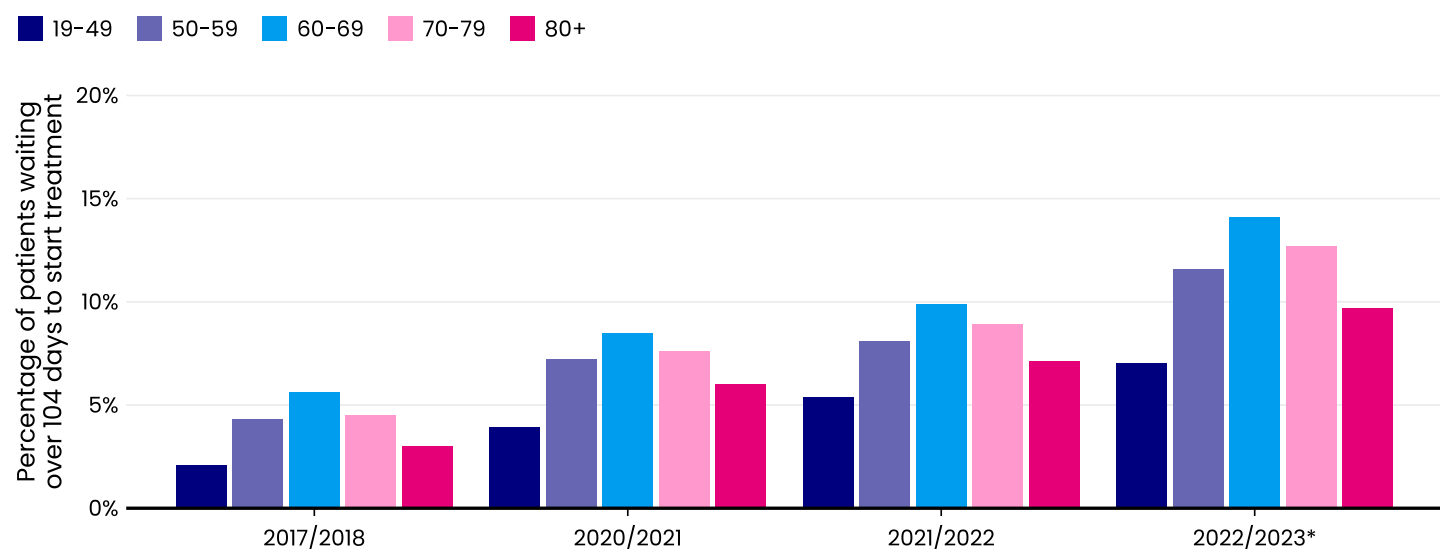
Between 2017/18 and 2022/23, all age groups have seen an increase in the proportion of long-waiters [62]. The 60 to 69 age group consistently has the highest percentage of long-waiters, whereas the 19 to 49 age group has the lowest. Differences in the cancer types

diagnosed will contribute to differences by age, as some cancer types are harder to diagnose and treat. However, the gap between age groups has widened over time, with the sharpest increase in long-waiters occurring among patients aged 60 to 69, compared to a more gradual increase among younger patients aged 19 to 49.

For many cancer sites, including bladder, cervical, colon, lung, melanoma skin, ovarian, rectal and uterine cancers, the likelihood of waiting more than 104 days to start treatment increases with age. Some cancers, such as kidney, liver, oesophageal and prostate, show a different pattern, where younger patients (19 to 49) and the oldest patients (80 and over) are less likely to experience long waits than people aged 50 to 69. Only pancreatic cancer shows a decrease in the likelihood of being a long-waiter with increasing age.

Percentage of patients waiting more than 104 days to start cancer treatment following an urgent suspected cancer referral by age

England, 2017–2023



*Q1 and Q2

Sources: Cancer Research UK, NHS England

The likelihood of receiving cancer treatment decreases with age

People with cancer may be offered, and receive, different treatment options at different ages depending on factors such as cancer site, stage at diagnosis, fitness, comorbidities and patient choice. However, we still see unwarranted variation in the treatment that people receive.

The proportion of patients receiving surgery, systemic anti-cancer therapy (SACT) or radiotherapy as part of their initial treatment decreases with each decade of age [63]. This trend is partly because some older people may not be fit enough for intensive cancer treatments, they may have comorbidities or higher frailty or decide they don't want to put themselves through treatment.

While older patients are more likely to be frail

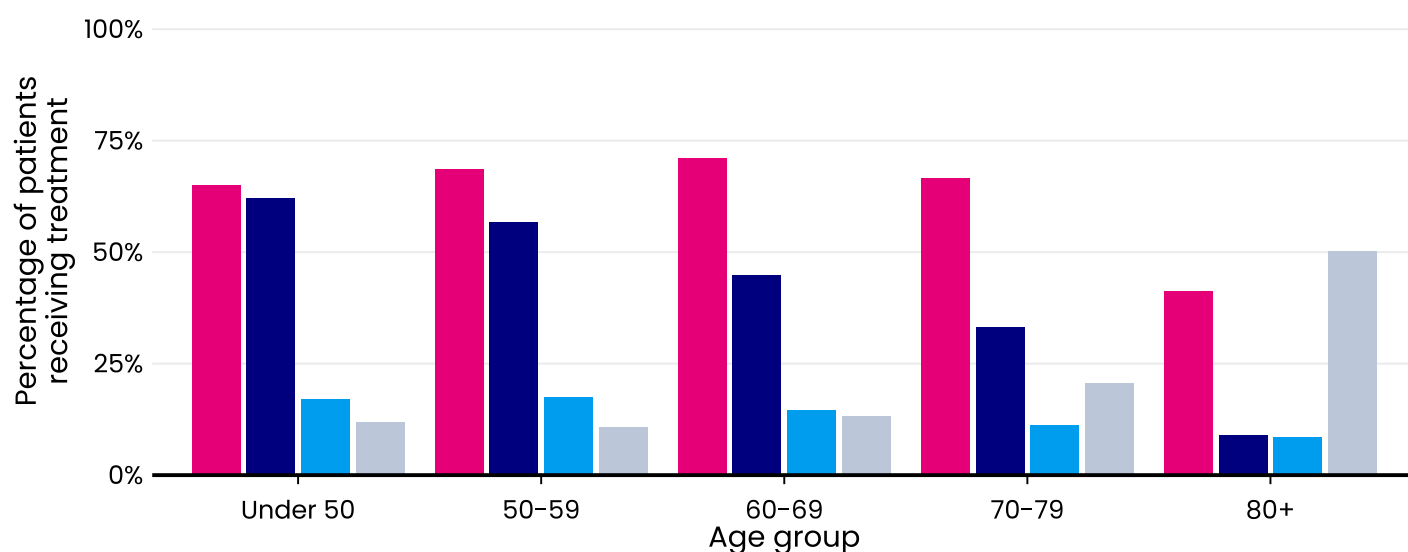
or have comorbidities, some variation in treatment by age may be unwarranted and lead to inequalities in care and outcomes. Older people are often excluded from clinical trials due to age cut-offs, which could result in treatments that are less effective for this age group [64], or doctors may base treatment decisions on a patient's chronological age, rather than considering their biological age [65].

International comparisons have also shown that older people in the UK are less likely to receive chemotherapy or radiotherapy than in other comparable countries [66,67]. This disparity contributes to lower survival, particularly for advanced cancers and older age groups.

Percentage of bowel cancer patients treated with surgery, SACT or radiotherapy by age

England, 2022

■ Surgery ■ SACT ■ Radiotherapy ■ Other care



Source: NHS England

Patients of all ages feel positive about the care they receive

Across cancer patient experience surveys in all UK nations, there is little variation in overall experience of care between age groups [47,68–70]. Older patients generally rated their care slightly higher than younger patients. The average score of a patient's overall experience

with the NHS on a scale of 0 (very poor) to 10 (very good) ranged from around 8.0–8.8 for younger adults to around 8.8–9.3 for people aged 65 and over across England, Wales and Northern Ireland. Scotland reported over 94% positive ratings in all age groups.



Together we are beating cancer

The strongest predictor of cancer risk is increasing age. As the UK population is ageing, the number of people diagnosed with cancer is expected to rise. This, in turn, increases demand for cancer services when capacity is already stretched and key cancer targets have been missed for over a decade throughout the UK. Cancer services must be equipped to meet rising demand, ensuring there's enough capacity to provide every patient with timely diagnosis and treatment.

It's important to recognise that much of the variation identified in this report is not a sign of inequalities on its own. The differences for older people are, in part, due to the additional complexities that come with ageing that impact cancer diagnosis and treatment. This includes having multiple health conditions, cellular damage and longer exposure to cancer risk factors. But age-related variation does offer important insight on the differential impact of cancer. And where evidence suggested that this variation is unwarranted and is contributing to cancer inequalities, this insight must be used to shape the strategies and interventions to improve cancer outcomes for everyone.

Cancer risk factors continue to contribute to cancer incidence across age-groups. Addressing these must be a priority focus of policy action. Smoking is still the leading cause of cancer and is one of the biggest causes of death in the UK. It's vital that we act to help prevent the next generation from suffering a lifetime of potential addiction, ill health and premature death. The Tobacco and Vapes Act will help to achieve a smokefree generation, but it will need to be effectively implemented and enforced. For the 5.3 million adults in the UK who currently smoke [71,72], it's essential that the Government supports them by committing to sustained and sufficient funding for evidence-based cessation interventions,

including Stop Smoking Services, mass media quitting campaigns, swap to stop initiatives and financial incentives for pregnant women.

Overweight and obesity prevalence has been increasing over the past decade across all age groups [24,73–75]. Governments must effectively implement existing commitments to tackle obesity and identify further regulatory measures that will help people maintain healthier habits. This should come alongside ensuring sustainable funding and service capacity for weight management services, including ensuring that weight loss drugs are provided to those who need it alongside wrap around support.

Reducing the proportion of cancers diagnosed at a later stage is key to improving cancer outcomes for all age groups, but the barriers to accessing healthcare vary significantly for people of different ages. A one-size-fits-all approach isn't suitable. It is important to ensure everyone eligible can make an informed choice to partake in screening if they want to, and that people can access appropriate diagnostic services in a timely manner and start treatment as soon as possible, regardless of age.

Health systems across the UK must deliver regular public awareness and help-seeking interventions to improve health knowledge, enable access to primary care and encourage positive behaviours like screening uptake. This should be targeted to the known barriers experienced by different populations, including across different age groups.

It's important to ensure that health systems are equipped with the resources they need to provide care quickly when it is needed– and that tools such as cancer referral guidelines are up to date and reflect the best evidence available.

The treatment patients receive can also be influenced by age. For example, younger adults are more likely to have surgery to remove tumours than older adults [63]. This may be in part because they are less likely to suffer from frailty or comorbidities that can affect their fitness to receive surgery. We need more comprehensive data collection, audit and research to understand where variation in treatment is unwarranted and to support providers to implement best practice, including undertaking appropriate assessments to ensure patients have access to optimal treatment.

While there are many factors that can add additional layers of complexity to treatment planning for older patients, this is not to say that treating cancer in younger people is easier – cancer remains a leading cause of

death for children and young people across the UK [76–78]. We need more dedicated research into what causes cancer in younger people, and into kinder, better treatments that work for young patients – especially as most children and young people whose treatment is successful then experience serious, long-term side effects.

With cancer cases predicted to rise, our health system must be equipped to adapt to meet these changing demands so that everyone can access the highest quality care when needed. This includes delivering the increasingly complex care required by an older population and ensuring there are clear strategies for reducing cancer incidence and driving earlier diagnosis of early-onset cancers.



Data saves lives

Much of the evidence in this report uses data provided by patients and collected by the health service as part of their care and support. The data is collated, maintained and quality assured by different organisations across the UK, including the four cancer registries. By analysing and interpreting data from across the cancer pathway, we can identify where improvements can be made for patients. This report uses the latest data available as of 31 March 2026.

The routine collection of data on demographics, diagnosis, treatment and outcomes for every patient is invaluable in improving cancer outcomes for everyone. Although this report focuses on age, there are many other patient characteristics where evidence of variation or inequalities isn't available, as there isn't appropriate data collection. This limits our ability to understand where improvements need to be made for people affected by cancer in different communities.

Patient confidentiality is critical, but aggregated data with identifiable information removed needs to be regularly reported so differences and inequalities can be understood and addressed. Effective safeguards are essential to maintain the confidentiality and anonymity of patient data, alongside transparent processes that enable timely analysis and research while building patient and public trust.

Many challenges exist in access to and the availability of data for analysis and research. The data collected across the UK for cancer patients is world-leading, but the process for accessing data differs between all four nations, often lacks transparency and can take years from application to receiving data. This means our ability to conduct data-driven research is compromised. In addition, not all UK nations collect and report consistently on key metrics across the cancer pathway and where data is collected, it isn't always comparable. There are gaps in this overview report where data isn't available for every UK nation.

Accessing data across the whole of the UK is vital to further our understanding of where improvements can be made for patients. A UK-wide approach would streamline access to data for the research and healthcare community, improve consistency and completeness of key cancer datasets and support more efficient data flows and data linkage, without compromising data security. Working across the four UK nations brings valuable insights, and Cancer Research UK continues to work with other charities and organisations, as well as the data custodians in each country, to collaborate on improving access to data.

Beating cancer must mean beating it for everyone.

Our other Cancer in the UK publications

- [Cancer in the UK: Overview 2026](#)
- [Cancer in the UK: Overview 2025](#)
- [Cancer in the UK: Socioeconomic deprivation, 2025](#)
- [Cancer in the UK: Overview 2024](#)
- [Cancer in the UK: Deprivation and cancer inequalities in Scotland, 2022](#)

Explore our full range of reports and publications on the [**Cancer Research UK website**](#), including interactive data dashboards. For example, further detail on trends by age for specific nations and sites can be found on the [**Cancer Cases, Deaths and Survival Data Hub**](#).

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