

Cancer Research UK – Further information for Senedd Health Committee

What data is currently available on health inequalities in relation to cancer, how the data that is available is being collected and analysed, and where there may be gaps in inequality data.

Health inequalities impact every stage of the cancer pathway, including prevalence of cancer risk factors, screening uptake, stage of disease at diagnosis, and access to treatment, and these all contribute to stark differences in cancer incidence and outcomes. Generally, the strongest data available on cancer inequalities is on socioeconomic deprivation, namely due to smoking.

Understanding the root causes of cancer inequalities, who they impact, and how to eliminate them, is complex and multi-faceted; we need to do more to fully understand cancer inequalities.

Currently, the data available for many population groups on several cancer metrics are outdated, limited, or non-existent. Comprehensive collection of and access to data is critical to effectively developing policy interventions to reduce inequalities targeted at those who need it most.

On screening specifically, we know that screening participation varies hugely by socio-economic group in Wales. For bowel screening, data shows that uptake for those living in the most deprived areas in Wales is 53%, compared to 68% for those in the least deprived areas.ⁱ

The Senedd Cross Party Group on Cancer, chaired by David Rees MS with Cancer Research UK providing the secretariat, is currently conducting an inquiry into cancer and inequalities. The hope is that this work will help uncover the data that exists on inequalities and cancer, with a specific focus on deprivation. The report and recommendations will also highlight the data gaps. On publication, a copy of the report will be shared with the Committee.

We would welcome further inquiry by the Committee into health inequalities and cancer.

Cancer Research UK's views on whether non-GI endoscopy should be included within the National Endoscopy Programme.

Diagnostic testing and play an essential role in diagnosing a range of cancers, for example, colposcopy for cervical cancer, and cystoscopy for bladder cancer. However, given the specific aims of the National Endoscopy Programme, we do not believe that non-GI endoscopy should be included in the Programme.

The NEP was set up to aid with specific issues in GI-endoscopy and to help build capacity to prepare for the introduction of FIT and the optimisation of bowel screening. There is a specific need to focus on workforce and capacity issues within GI endoscopy in Wales, which are separate to any issues related to non-GI endoscopy. This is because it is a different workforce and specialisms in GI and non-GI endoscopy – for example, cystoscopies are conducted by a urologist and colposcopy by a specialist nurse [colposcopist] or gynaecologist. The equipment used and infrastructure needed to perform these types of endoscopies are also different, as well as the innovations (e.g. Cytosponge/TNE) and accreditations (e.g. JAG).

Whilst there are some areas of crossover (for example, all are impacted by shortages in the pathology workforce who analyse biopsy samples), the different specialities and equipment involved mean that conversations about non-GI endoscopy are best had when talking about site specific cancers. Colposcopy capacity and efficiency could be covered within the Committee's inquiry into gynaecological cancers. In addition, for some cancers – including bladder cancer, for example, there are additional diagnostic tests alongside the cystoscopy that are performed including CT scans and MRI scans.

ⁱ Public Health Wales. 2021. Bowel Screening Wales Annual Statistical report 2019-20. Accessed May 2022 via <https://phw.nhs.wales/services-and-teams/screening/bowel-screening/information-resources/programme-reports/bsw-annual-statistical-reports/bsw-annual-statistical-report-2019-2020/>.

Beating Cancer for Everyone

Cancer Research UK Briefing – Cancer Inequalities in Wales, October 2022

Introduction

Health and cancer inequalities are unfair, avoidable, and systematic differences in health across the population, and between different groups within society.¹ They impact every stage of the cancer pathway, including prevalence of cancer risk factors, screening uptake, stage of disease at diagnosis, and access to treatment, and these all contribute to stark differences in cancer incidence and outcomes.

When cancer is diagnosed at an early stage, it is more likely to be treated successfully, increasing chances of survival. Inequalities in stage at diagnosis can therefore worsen inequalities in cancer mortality and survival – and these impact multiple population groups as well as people from more deprived groups for some cancer types². People from ethnic minority communities³ and people with learning disabilities⁴ are all more likely to be diagnosed at a later stage for certain cancer sites. People from more ethnically diverse areas,⁵ people with a learning disability,⁶ and men,⁷ are also less likely to participate in screening programmes, and we know that the cervical screening system creates a number of barriers for trans men and non-binary people's access to appointments.⁸

Research also shows there are significant inequalities in patient experiences of cancer care, with a poorer average rating of care being reported by people from Asian, Black, Mixed and Other backgrounds compared to White respondents (survey categories) in England.⁹ LGBTQIA+ people also have poorer experiences in the healthcare setting than heterosexual groups,¹⁰ with research by Macmillan Cancer Support showing that LGBT+ people face poor communication and felt excluded from decision making in their experience of cancer care.¹¹

It is unacceptable that these factors impact the likelihood of someone being diagnosed with cancer and their cancer outcomes, and this presents one of the greatest and most challenging barriers to improving cancer outcomes in Wales.

Effectively tackling cancer inequalities would have a major positive impact for the Welsh public. CRUK estimates that, in the UK, if all areas had the same cancer incidence rate as the least deprived quintile, this would result in around 22,000 fewer cancer cases a year.¹² It would also have a wider economic benefit. Public Health Wales estimate that improving health equity between the most and least deprived communities could save the health service £322 million a year, particularly through reducing emergency admission and A&E attendance which is higher for the most deprived communities.¹³

Understanding the root causes of cancer inequalities, who they impact, and how to eliminate them, is complex and multi-faceted; we need to do more to fully understand cancer inequalities¹⁴. Currently, the data available for many population groups on several cancer metrics are outdated, limited, or non-existent. Comprehensive collection of and access to data is critical to effectively developing policy and interventions to reduce inequalities targeted at those who need it most.

Wider Context

The Welsh Government have recognised the importance of tackling health inequalities. *COVID-19: Looking Forward* (2021) notes that the pandemic exacerbated existing health inequalities in Wales and recognises the 'importance of ensuring that those in greatest need are central to the future health and social care system' to improve health for all.¹⁵

Health bodies and organisations have also highlighted the importance of tackling health inequalities. Along with 35 organisations, the Welsh NHS Confederation has called on the Welsh Government to take bold action to tackle health inequalities, through working cross-government, investing in prevention, and working in partnership with other organisations and communities.¹⁶

With disparities at every stage of the cancer pathway, tackling cancer inequalities must be a key part of this wider agenda. This will require action to better understand cancer inequalities and their drivers in Wales, as well as targeted activity to address inequalities in the shorter-term based on best practice. This inquiry aims to strengthen the Cross Party Group's understanding of both these areas.

Cancer Inequalities in Wales

Understanding cancer inequalities is complex. Firstly, it is highly dependent on the availability of data which can be broken down by population group, so that we can better understand which groups face poorer outcomes and what may be driving this. Rich, accessible data are also key to assessing where variation between groups is unwarranted and therefore a sign of inequality.

Secondly, some differences between groups may be driven by unavoidable factors such as genetics. It is therefore necessary to distinguish between variation as a result of such factors and variation as a result of inequalities where possible, however this is often not straightforward. Differences between cancer sites – such as some cancers being closely linked to preventable risk factors, and others benefitting from effective, evidence-based screening programmes – mean that different actions may be required to address inequalities for different cancer types.

Intersectionality adds further complexity to understanding cancer inequalities. People's identities, and the circumstances that shape their behaviours and experiences, are multi-faceted. For many people, this means they face numerous, multi-layered barriers to good health, resulting in health inequalities, and these different inequalities intersect, compound, and reshape one another¹⁷. At present, data are often presented to compare groups along one demographic axis – such as gender or ethnicity. Comparing groups is practical and serves to help understand the scale of cancer inequalities. However, it can complicate or obscure the extent and experience of inequality faced by individuals that belong to more than one disadvantaged group.

Currently, there are major gaps in data which limit our ability to comprehensively identify and act on inequalities. The best available data are on socioeconomic variation.¹⁸ These data clearly shows that more deprived groups face greater barriers to good health at every stage of the cancer pathway, creating unacceptable inequalities in cancer incidence and outcomes. We also know that there are major inequalities based on geography in Wales, with people's experience of getting cancer¹⁹ and their cancer outcomes²⁰ differing depending on where they live.

However, there are other types of inequality that will undoubtedly act as a barrier to improving cancer outcomes in Wales for which we currently have less evidence. Surveys and studies from across the UK suggest that cancer inequalities also impact people depending on their ethnic background, disabled people and LGBT people, amongst other groups²¹²²²³. This inquiry provides scope to explore these areas as well as furthering our understanding of how to tackle the better understood inequalities such as those in socio-economic status.

Socioeconomic inequalities

Socio-economic deprivation is a major source of inequalities across the cancer pathway in Wales. Cancer incidence rates are higher for people from more deprived populations. The greatest differences in incidence rates between the most and least deprived areas are generally in smoking-related cancers. In 2018, the number of people in Wales diagnosed with lung cancer in the most

deprived areas more than double the number in the least deprived areas.^{24,25} There is also evidence of major inequalities in cancer mortality and survival^{2, 26,27}. In 2021, the overall cancer mortality rate for the most deprived quintile was almost 55% higher than the least deprived.^{20,28}

The drivers of these inequalities are complex and multi-faceted. Key drivers include the wider determinants of health and variation in cancer risk factors, help seeking behaviour, access to and uptake of health services and health literacy^{29,30,31}.

Around 4 in 10 cancer cases in the UK are caused by preventable risk factors, but these are more prevalent in certain groups compared to others, contributing to significant inequalities in cancer incidence. According to the National Survey for Wales 2019/20, 26% of people in the most deprived quintile currently smoke compared to 11% in the least deprived quintile³², and levels of childhood obesity are higher in the most deprived areas³³.

Another driver of inequalities in cancer outcomes is disparities in cancer screening. Screening participation varies hugely by socio-economic group in Wales. For bowel screening, recent data shows that uptake for those living in the most deprived areas is 53%, compared to 68% for those in the least deprived areas.³⁴

Geographic inequalities

Another major type of cancer inequality in Wales is geography. Currently, where someone lives influences their likelihood of getting cancer, their outcomes and their experience of cancer care. For Cwm Taf Morgannwg health board, the cancer incidence rate is 8% higher than the rest of Wales – incidence rates for some cancer sites are particularly high, with lung cancer rates 20% higher and prostate cancer 15% higher than the rest of the country.¹⁹ Cancer mortality varies substantially between health boards; the highest mortality rate is in Cwm Taf Morgannwg health board, which is 16% higher than the health board with the lowest mortality rate (Hywel Dda).^{20,35,36}

There is also stark variation in cancer performance and waiting times between health boards. The average waiting time for an upper gastrointestinal endoscopy, a key diagnostic test for cancer, is around 114 days in Betsi Cadwaladr University Health Board, almost eleven weeks longer than in the Hywel Dda Health Board (around 38 days).³⁷

Geographical cancer inequalities are often connected with deprivation, and this will in part be true in Wales – we know that (age-adjusted) cancer incidence rates are higher amongst more deprived communities, and the higher deprivation levels in Cwm Taf likely explain, at least in part, why this region has higher cancer incidence.³⁸ But there are other reasons for geographical inequalities too, including rurality and cultural differences. For example, the Welsh Cancer Patient Experience Survey found that people living in rural areas had greater concerns than others about the distance they had to travel to hospital for cancer treatment, with it being too far for those receiving daily treatment.³⁹

About Cancer Research UK

Cancer Research UK is the world's largest independent cancer charity dedicated to saving lives through research. We support research into all aspects of cancer, which is achieved through the work of over 4,000 scientists, doctors and nurses across the world. In 2020/21, Cancer Research UK funded over £4m of research in Wales. Our research in Wales focuses particularly on bowel, breast, urological and prostate cancers, as well as leukaemia. As part of our Cancer Awareness Roadshow, our friendly nurses go into the heart of communities with poorer cancer outcomes, helping people to take positive steps for their health and access support from local services. In 2019/20, the roadshow reached over 1,400 people in Wales.

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