



Foreword:

**Addressing health
inequities to close
the care gap**

As individuals and organisations in countries around the globe join forces for World Cancer Day, the central theme of the campaign, ‘Close the Care Gap,’ is more relevant than ever.

This campaign theme is not just a slogan; it’s a commitment to action. Cancer touches lives indiscriminately, but the level of care that people receive is far from equitable. Over three years, the campaign has focused on raising awareness, encouraging tangible change, making sure that quality health services are accessible to all, irrespective of their personal circumstances.

This vision of a fairer and more equitable world when it comes to health is what we aim to address in this report. Our goal is to bring to light the contrasts in cancer journeys experienced in different geographies and how can we improve access to cancer care and health for all. It’s about putting people and their diverse experiences at the centre of our discussion and our actions.

Nations around the world are actively working to bridge the gaps in their countries. But there is still much work that can and needs to be done to ensure that everyone, everywhere has access to the care they need and deserve.

This World Cancer Day Equity Report offers heartfelt testimonies, experiences, perspectives and expert insights from current and former UICC Board Members into the issue of equity in cancer care. It’s about understanding, addressing, and ultimately overcoming the disparities that exist in cancer treatment and access worldwide.

A common thread in the report is the fact that cost-efficient, accessible measures to improve awareness of cancer risk factors, and early detection of disease with accessible quality treatment, could help prevent up to 50% of all cancers.

Another essential, though sadly often overlooked, component of effective response to cancer is the pivotal role of a fully funded and trained healthcare workforce. This report emphasises the critical need to support, expand and empower healthcare workers and caregivers – from frontline nurses and primary care physicians to radiologists, surgeons and supportive care staff.

In writing this foreword, we don’t just reflect on the challenges; we also offer a vision for the future. A future where healthcare equity is the norm, not the exception. Our collective mission is clear: we must work together to ensure that everyone, regardless of where they come from, has equitable access to cancer care.

In this last year of the ‘Close the Care Gap’ campaign, we are calling on world leaders to act. We are doing so with a global call to action, offering nine recommendations listed in this report, which can be adapted to local contexts to reduce disparities in cancer care.

This report is a tool for change, intended to inform and inspire policymakers, advocates and the broader healthcare community to work towards more inclusive health services. Equitable cancer care should not be a privilege, but a universal standard.

Dr Cary Adams,
CEO Union for International
Cancer Control





Executive Summary: Global inequities in health and cancer care



The World Cancer Day Equity Report is a collection of testimonials by past and present UICC Board Members to illustrate the global cancer care gap through a local lens, relate how countries are responding and suggest further measures to close the care gap by 2030.

While each testimonial is unique and is particularly relevant to a specific country or region, the commonalities weave together a shared narrative of health inequities based on who someone is – their gender, race, ethnicity, socioeconomic background – where they live and how much money they have.

In the Western Pacific, there are widening gaps of cancer care in rural Australia where screening rates are significantly lower. In China, differing diagnosis and treatment standards between hospitals contribute to disparities, while Japan faces an increase in cervical cancer incidence after suspending active promotion of the HPV vaccine.

In South-East Asia, the cost of cancer treatment is simply out of reach for most people in India, especially those lacking health insurance. In Malaysia, community-level programmes for screening and early detection of the ‘screenable’ cancers (notably breast, cervical and colorectal) are slowly being reactivated post-pandemic.

In Europe, people with low socioeconomic status in Sweden face a notably higher risk of dying from cancer compared to those who belong to more privileged groups, while in Portugal three out of the 10 most common cancer causes are associated with tobacco consumption. In the UK, the largest known cancer inequity exists between areas of higher and lower disadvantage, with more than 30,000 additional cancer cases a year associated with socioeconomic deprivation.

In the Eastern Mediterranean, social and political instability have exacerbated existing challenges, leading to delays in treatments, shortages of cancer medicine, and soaring prices in Lebanon. In Jordan underprivileged populations, especially refugees, contend with poor access to cancer diagnosis and treatment.

In Africa, limited resources dedicated to the health workforce and cancer care as well as cultural, geographical and other considerations negatively impact access to screening, early diagnosis and treatment. Testimonies in this report reveal how patients in Kenya, Nigeria and South Africa are often diagnosed with cancers at advanced stages, undermining treatment options, survival and quality of life.

In the Americas, those who live in the North and Northeast regions in Brazil are more likely to die from cancer types associated with poverty, such as lung cancer fuelled by increased smoking rates; and in Mexico, for people with no social security, there is currently no policy or programme to provide access to affordable healthcare.

These testimonials paint a vivid picture of the range of social, economic, and environmental factors – the wider determinants of health – that shape a person’s access to cancer care. They are the major root cause of health inequity.

In the final year of the ‘Close the Care Gap’ campaign, UICC together with the cancer community, calls on leaders to eliminate health inequities by addressing their root causes, ensuring that everyone has access to quality health services when, where and how they need them.

Recommendations for greater equity in cancer control

UICC recognises the diverse cancer burdens faced by different nations, each with their unique context of challenges and resources available to tackle them.

The following recommendations are crafted to serve as a universal blueprint, adaptable to the specific needs and capacities of individual countries.

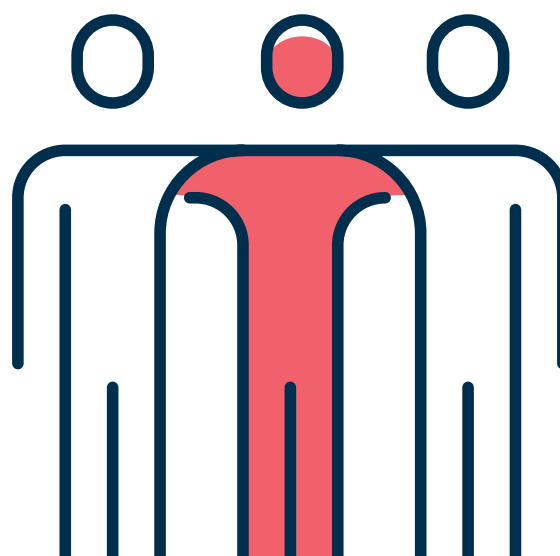
UICC urges governments to implement the following key actions to improve equity in health and cancer care, make it easier for all populations to enjoy affordable and accessible cancer services, reduce disparities in cancer incidence and mortality and in quality of life, and close the gap in cancer care.

- 1. Foster patient-centred care that acknowledges and addresses the unique needs and experiences across patient populations, including older adults.** Train healthcare providers on cultural competency and how to provide patient-centred care. Encourage patient engagement in decision-making around their care.
- 2. Increase funding for cancer research to understand the country's cancer burden, the main disparities in cancer outcomes and the barriers that prevent certain populations from accessing care even when it is available.** Prioritise funding for research that aims to understand and address cancer disparities in different populations.

Encourage collaboration between researchers, healthcare providers, and community organisations to ensure that research is relevant and addresses the needs of underserved populations.

- 3. Establish a population-based cancer registry,** to facilitate research and understand incidence, stage at diagnosis, mortality and survival and other indicators of cancers in the population; track trends over time and identify specific at-risk groups; guide policy decisions and allocate healthcare resources effectively; and evaluate the effectiveness of control strategies.
- 4. Design and implement an effective national control cancer strategy,** the actions to take for the prevention, diagnosis, treatment, palliation, survivorship care, data collection and monitoring of cancer, founded on an evidence-based assessment of the country's cancer burden and which addresses financial hardship and the barriers faced by underserved populations in accessing care. Use this national cancer control plan to guide the inclusion of cancer in a national Universal Health Care (UHC) package.

5. Incorporate comprehensive cancer services into national health benefit packages to achieve universal health coverage, including a comprehensive package of quality cancer services: prevention, screening, diagnosis, treatment (medicines, radiotherapy, surgery), supportive and palliative care and survivorship services in basic health insurance benefits packages. UHC cannot be achieved if cancer, as the **second leading cause of death** globally, is not covered by national health benefits packages.
6. Enhance health literacy and education around cancer. Develop culturally appropriate educational materials and programmes that are accessible to all populations. Provide training to healthcare providers and community leaders on how to communicate effectively with patients. Ensure that reliable information on cancer risk factors and how to reduce exposure to them, as well as on the need to participate in routine screening of common cancers, is made widely available and accessible.
7. Address the commercial determinants of health by heavily regulating the production, sales and marketing of carcinogenic products such as tobacco, alcohol, and ultra-processed foods and beverages. Measures include in particular:
 - a. Increase taxation
 - b. Enforce marketing limitations
 - c. Improve labelling: Impose product warning and information labels.
 - d. Run extensive public education campaigns to improve knowledge of risk factors and further counter misleading advertising, market promotion and policy interference.
8. Implement programmes for the routine screening of common cancers (breast, cervical, colorectal and prostate) and vaccination against HPV and hepatitis B, and ensure that access to these early detection programmes is available and affordable. Integrate cancer screening/early diagnosis interventions into existing primary healthcare programmes. Develop partnerships between community organisations and healthcare providers to bring screening programmes to areas with high rates of cancer incidence and mortality. Coordinate with other outreach programmes, such as HIV, and integrate health services. Implement telemedicine services and mobile screening units to help reach populations in remote or rural areas.
9. Address systemic social determinants of health that impede an individual's ability to access cancer care, tackling prejudices and assumptions based on diverse social markers (including education, poverty, geographical location and prejudices and assumptions based on race and ethnicity, gender norms, sexual orientation, age and disability), by working with communities for more effective and people-centred programmes.





Portugal
Sweden
United Kingdom

Europe





Portugal

The factors in Portugal's cancer care gap

The Constitution of the Portuguese Republic recognises equity in healthcare access as a fundamental principle for all citizens, regardless of their economic status. The importance of equitable and adequate access to healthcare is unequivocally mirrored in one of four strategic axes of the country's National Health Plan in place since 2020.

'Access' is a multidimensional concept involving both predisposing factors and enabling factors. The predisposing factors include variables that influence the likelihood of individuals to seek care, such as beliefs and attitudes towards health. Enabling factors include personal, family or community resources which may either facilitate or hinder the use of healthcare services.

Therefore, the effective use of healthcare services depends on several interrelated dimensions, such as adequate demand and quality of services, availability, proximity and direct and indirect costs.

Factoring cancer into healthcare

In Portugal, **cancer represents** the second highest cause of death and is the leading cause of potential lost years of life. The most **frequently identified cancer** locations are colon and rectum, breast, prostate, lung and stomach.

The incidence of cancer is increasing, mainly as a consequence of an aging population, but also due to modifiable determinants – namely greater exposure to oncogenes, both environmental, such as tobacco, alcohol and pollution; and viral, such as the Human Papilloma Virus (HPV) or hepatitis.

In fact, among the 10 most common **causes of cancer**, three are strongly associated with tobacco consumption and are responsible for one in six diagnoses of lung, bladder or pancreatic cancer. And despite having population-based screening programmes, one in every three new diagnoses each year are breast cancer and cancer of the colon and rectum.

Predisposing factors

We must address the predisposing factors, specifically the beliefs and attitudes towards health and cancer, as they are core to the success of prevention and the adherence to measures aimed at improving living conditions and healthier lifestyles in the population.

The design of efficient public policies that influence and promote actions for cancer mitigation depends on the understanding of its modifiable determinants, such as tobacco and alcohol consumption, which is why health education and empowerment are essential.

We should aim not only to inform but, above all, to empower individuals to know how to look for, access and use health information and resources.

Enabling factors

The regulation and limitation of exposure to oncogenic agents, whether biological through vaccination or therapy, or environmental through social or occupational exposure control policies, are enabling factors.

On one hand, Portugal has efficient policies to prevent exposure to biological oncogenic agents with a robust National Vaccination Program. The vaccine against the Hepatitis B virus has **achieved 98% coverage** in successive cohorts of children since 1995; and, since 2012, the country has **covered 91%** of the female child population with the HPV vaccine against cervical cancer.

On the other hand, current policies to prevent exposure to environmental oncogenes do not promote equal legal or regulatory treatment of carcinogens – even when they possess the same level of risk. Smoking prevention control policies have been successful in reducing significant increase in consumption, which is currently lower than the European average.

Yet, when we compare tobacco control policies with those for substances like alcohol, there are inconsistencies. The fiscal and regulatory strategies related to consumption, advertising and marketing remain less restrictive than those adopted for tobacco.

Addressing inequities in health and cancer

Portugal has three national population-based cancer screening programmes: breast cancer, cervical cancer, and colon and rectal cancer, and its implementation has varied depending on cancer type and region.

In 2017, the Ministry of Health updated the screening guidelines to homogenise the criteria followed by several health regions and increase screening rates. Screening attendance seems to have improved over time, with the highest attendance for breast cancer, followed by cervical cancer and lower attendance for colon and rectal cancer.

In the last decades due to investment in research, diagnosis and therapy, there has been continued improvement in the prognosis of cancer patients. Understanding the role of genetics and genomics, and new management technologies, data has allowed for the development of more effective and progressively more individualised therapeutic strategies.

This has resulted in an increase in the probability of cure and survival time in situations of more advanced-staged cancer.

Improving access and closing the cancer care gap

For more than 40 years, the National Health Service has aimed to provide the population with complete and high-quality healthcare, independent of their social or economic status.

For Portugal to continue this evolution, improving the quality of care for everyone – including those at risk, patients and survivors, and support for caregivers and family members – and move towards closing the cancer care gap by 2030, there are three main factors to consider:

1. Policies

Promoting multisectoral policies is necessary to encourage the evolution towards a society where the modifiable determinants of cancer become smaller and smaller, thereby reducing cancer incidence.

2. Resources

The increase in the incidence of cancer, the limitation of resources and the need to factor in other health requirements outside of cancer, imposes the need for a transparent evaluation of the existing health resources at local, regional and national level, to provide, in an equitable way, access to the best treatment options for cancer patients.

3. Diversity

To continue quantifying and reducing inequalities, it is essential to consider the population shift and ensure that the health system is accessible and inclusive of refugees and migrants, transgender people, individuals who are not fluent in Portuguese, and those residing in rural territories or experiencing greater socioeconomic disadvantage.

Through cancer prevention policies and advocacy, increased cancer screening, and equitable distribution of resources for cancer treatment and care throughout the country, Portugal can continue to evolve to provide all citizens, regardless of background, with equitable access to quality health and cancer care.



About the author

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Cristiana Fonseca is the Head of Health Education and Capacity Building Department of the Portuguese League Against Cancer, Northern Branch, and a UICC Board Member since 2018.





Sweden

The disparities between income, education and health

Sweden is a country with traditions of good healthcare; all Swedish residents are covered for health services, regardless of their nationality.

While the national Government is responsible for regulation and supervision, the 21 Swedish regions have responsibility for financing, purchasing, and providing health services.

Over the past decade, survival for several different types of cancer has increased in Sweden and is now **amongst the highest** in the EU, reflecting the success of earlier diagnosis and efficacy of treatments.

However, challenges persist in providing equal access to care depending on where people live in Sweden, their economic status, and their level of education.

Disparities and divided responsibilities

Sweden today, is not a country in which access to healthcare is equitable.

For people affected by cancer, the division of responsibilities between 21 autonomous regions is not always an advantage.

The disparities experienced can be seen across the cancer pathway, from participation in screening programmes to survival rates.

At a national level, responsibility is needed to ensure that every citizen, regardless of their place of residence, can be guaranteed equitable care.

Participation in screening

The Segregated screening report published by the Swedish Cancer Society in 2021 highlighted the clear socioeconomic differences in screening participation in Sweden.

Women in areas with higher incomes and higher education participate in cervical and breast cancer screening programmes to a greater extent than women in areas with lower incomes and lower education.

The same gap exists for screening participation for colorectal cancer – the higher the education and income, the higher the participation in screening programmes.

There are also obvious disparities in terms of implementation of new and improved screening programmes between regions in terms of the length of time to implement, and how successfully they are implemented.

Mortality from cancer

Cancer mortality is significantly higher among people who have an education below secondary school level. Among men with only primary school education, the mortality is greatest.

For people with low socioeconomic status, the risk of dying from cancer is notably higher compared to those who belong to more privileged groups – and this is largely influenced by three factors: individual decision making; attitudes of healthcare professionals; and healthcare governance.

People with higher education generally have more time with healthcare professionals to ask questions when seeking care than those with only primary school education who are more likely to refrain from care-seeking in the first place.

Socioeconomic status can also influence the degree to which a cancer patient is likely to follow through on treatment and drug recommendations – ultimately impacting on the cancer outcome.

Evidence shows that inequities within the healthcare system – from diagnosis to treatment and rehabilitation – can arise by the actions, or rather inaction, from healthcare professionals due to preconceived notions about different groups.

The likelihood of receiving a correct cancer diagnosis at an early stage varies between groups. People with lower education are less likely to have access to recommended diagnostics, and after diagnosis, studies show that different demographic and socioeconomic groups are offered different treatments.

In Sweden, how healthcare professionals act in different situations depends to a large extent on the guidelines and structures that organise healthcare.

The country's decentralised model with independent regions is, in many ways, a driving force for local ideas, solutions and traditions.

However, these are not always based solely on science and evidence, but also on other varying considerations, such as local policy, labour market issues, or personal status.

The independence of the regions makes it more challenging to implement common guidelines and approaches that could help to counteract the barriers faced by people from less privileged groups.

Addressing the inequities in Sweden's healthcare system

The Swedish National Board of Health and Welfare has national guidelines in place to support the allocation of resources and provide standards of quality health and social services.

These guidelines are evaluated every few years, and in cases where inequities persist, the Government instructs local authorities or the Regional Cancer Centres to produce proposals on how they could be resolved, and these are then implemented in the regions.

Civil society organisations, similar to our organisation – the Swedish Cancer Society (Cancerfonden) – play an integral role in research, advocacy and accountability, ensuring that the Government and decision makers continue to address existing and emerging inequities to improve cancer care across all regions.

As Sweden's largest charity, we are working to defeat cancer so fewer people in Sweden will be affected by cancer, and those who are have a greater chance of survival.

We strive to support patients, friends, and relatives, by informing them about cancer, treatments, and research, offering information and support via our cancer support services.

We also work to spread knowledge about prevention, and the fact that **30% of all cancers** can be prevented through healthy lifestyle choices.

Closing the cancer care gap by 2030

Closing the cancer care gap by 2030, especially for people with lower education and socioeconomic status, will take concerted action by all actors across the cancer care pathway.

1. Sweden must establish national measurable goals for how the socioeconomic and geographical differences in cancer care are to be reduced.
2. There needs to be national responsibility for levelling out regional differences in cancer care, with regions making positive progress sharing learnings and successes to help other regions improve.

1. Finally, national support and funding are needed to implement lessons learned and proven methods to improve health in the groups where it is lowest.

To close the care gap in Sweden, we must focus our attention to where inequity persists to guarantee every citizen equal access to quality healthcare – no matter where they live, what level of education they have, nor what their socioeconomic status is.



About the author

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Ulrika Årehed Kågström is the President-elect of UICC, past Board Treasurer from 2020 to 2022, and a member of the Board since 2018. She is the Secretary-General of the Swedish Cancer Society, Sweden's largest charity funding more than 500 research projects each year.





United Kingdom

Tackling inequities across the UK cancer pathway

The UK has one of the leading health systems in the world, with a founding principle of providing care for all regardless of ability to pay. It is a high-income country with a history of strong cancer planning, a strong civil society, and a well-established cancer research base.

And yet, very significant inequities exist across every part of the cancer pathway. We have a strong moral imperative to better understand these inequities, their root causes, and to take urgent short-term and long-term action to address them.

Cancer inequity in the UK

Awareness of health inequities was significantly enhanced by **the Marmot Review** in 2010, which laid bare the scale of the issue in England and made a series of recommendations.

However, a follow-up **review in 2020** found that limited progress had been made since; life expectancy has stalled, and the gaps in life expectancy between the most and least underprivileged areas had widened.

Further, the COVID-19 pandemic has worsened existing inequities, and introduced further pressure across the broader UK health system.

The picture for cancer inequalities reflects that of wider health inequity in the UK. Cancer disparities are apparent across the pathway, from risk and early diagnosis, through to treatment – affecting both cancer incidence and survival.

There is evidence of inequity across multiple characteristics, including, but not limited to, ethnicity, disability, age, and gender.

The largest known cancer inequity exists between areas of higher and lower disadvantage, with more than 30,000 additional cancer cases a year associated with **socioeconomic deprivation**.

In the UK, many of the causes of health inequities lie not in the health system itself, but in the broader environment.

A range of social, economic, and environmental factors – the wider determinants of health – shape an individual's health, access to care, and exposure to a number of risk factors.

In particular, wider determinants make it harder for some groups to live a healthy life, and with around four out of 10 cancer cases preventable in the UK through modifying risk factors, this directly impacts on cancer incidence.

For example, people in routine and manual occupations in England are around 2.5 times more likely to smoke than people in managerial and professional occupations.

There are nearly twice as many cancer cases caused by smoking in the poorest areas in England compared to the wealthiest.

In 2019, 35% of people living in the most disadvantaged areas were obese, and this is estimated to increase to 46% by 2040.

In comparison, 22% of people living in the least disadvantaged areas **were obese** in 2019, and this is estimated to increase to 25%.

The wider **determinants of health** are the major root cause of cancer inequity – and they take effect long before the point of diagnosis.

Inequities across the cancer pathway

From prevention measures to access to screening, treatment and care, inequities exist at every stage of the cancer pathway in the UK.

People from disadvantaged areas are more likely to be diagnosed at a later stage for some cancer sites when cancer is less likely to be treated successfully.

This is likely due to a number of factors, including **lower recognition** of possible cancer symptoms, and practical and emotional barriers to seeking help.

In Great Britain, there is inequity in uptake of lifesaving cancer screening programmes for breast, bowel and cervical cancers, with people in lower income areas less likely to access them.

They also report worse experiences of cancer care and inequities in treatment options.

This is exacerbated by underrepresentation in clinical trials, including for older people, people of colour, and minority ethnic groups.

This not only risks their access to new treatments, but it also affects data collection on the efficacy of these treatments in certain groups.

Finally, and often as a result of inequities experienced earlier in the cancer pathway, there are also disparities in cancer survival in the UK.

For example, for bowel cancer, there is a deprivation **gap in survival** of almost 9 percentage points in Wales.

We will not beat cancer unless we beat it for everyone – we have a moral imperative to proactively close the gaps in cancer outcomes.

Closing the cancer care gap

Closing the gap requires far-reaching change and concerted action at all levels, including how we conduct and prioritise research, public health activities, screening, and care provision.

This requires intervention and prioritisation from the Government, civil society organisations, and private sector bodies. For example, smoking cessation services are a highly effective and cost-effective intervention, however, funding cuts to public health have limited the reach of these services.

At an organisational level, Cancer Research UK has put tackling inequity at the heart of its vision for the future and works on multiple fronts to build the evidence base needed to raise awareness, advocate for change, and to tackle issues directly.

For many years, we have built the evidence base and campaigned for improved tobacco control – addressing one of the most important underlying causes of cancer inequity.

Similarly, we have campaigned for measures to reduce childhood obesity, which we know disproportionately impacts lower socioeconomic groups.

In targeted disadvantaged areas, we carry out roadshows to help build awareness of ways to reduce risk factors and improve rates of early diagnosis, reaching 50,000 people directly each year.

Access to information for people with cancer, and their support network, is also of vital importance. Our cancer information webpages, which receive more than 20 million unique page views a year, are written in plain English for a reading age of between 9 to 11 years old.

These campaigns are backed by research and strive to include historically underrepresented groups so we can understand the inequities experienced across the cancer pathway and what impact the interventions have in practice.



Actions to tackle cancer care inequities

A broad range of interventions, delivered collaboratively across sectors, will be required to tackle cancer inequities in the UK. Three priorities with the potential to achieve the biggest impact are:

1. Cross-governmental commitment to reducing health inequity. The underlying causes of cancer inequities are closely tied with those of broader health inequity and stretch well beyond the health system. We need a cross-governmental strategy that includes short and long-term commitments and change across all governmental departments.
2. Committed action to reduce inequities in smoking prevalence. A target of 5% or less smoking prevalence across all socioeconomic groups by 2040 is challenging, but achievable. This would have a significant long-term impact on the inequitable burden of lung and other smoking-related cancers.
3. Reduction in barriers to accessing care, including barriers to early diagnosis and participation in screening programmes. Targeted activity is needed to encourage and enable help-seeking and screening participation in underrepresented groups that are less likely to be diagnosed at an early stage, when cancer is more likely to be treated successfully.

To underpin this, and broader progress, health services must continue to improve the collection of consistent data about cancer prevention, cancer patients, and those engaging with cancer services.

This includes the comprehensive collection of demographic information so we can better understand the nature and scale of cancer inequities.

Only then can we tackle the myriad of complex and interconnected factors that drive the inequities we see in the UK today and progress closing the cancer care gap for all.



About the author

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Nick Grant is the Executive Director of Strategy and Philanthropy at Cancer Research UK and a past UICC Board Member, serving from 2016 to 2022.