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It Can Be Done — Beating Inequalities in Cancer Care

ACTION REPORT

Inequalities Network

The Inequalities Network is one of the European Cancer Organisation's Focused Topic Networks, established as part of our Strategy for 2020-2023. The Inequalities Network was launched in July 2020.

More information is available on our website.

If you would like to find out more about the Inequalities Network, please contact us at: info@europeancancer.org

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Acknowledgements

This report was produced by the European Cancer Organisation's Inequalities Network, based on the Community 365 Roundtable Meeting on Inequalities on 14 October 2020 and in line the European Cancer Organisation's policy decision-making process. The Network comprises of representatives drawn from the European Cancer Organisation's Member Societies, Patient Advisory Committee members, Community 365[a] and other invited stakeholders.

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[a] Community 365 is group of charity, philanthropy and industry contributors to the Focused Topic Networks of the European Cancer Organisation. Community 365 provide ideas, guidance, practical support and resources for our work in convening stakeholders and building consensus in the European cancer community. Community 365 contributors do not have a decision-making role in our policy work. Rather, policies of the European Cancer Organisation, such as those represented in this document, are agreed by our Board after consultation with our Member Societies and Patient Advisory Committee, via our Policy Pathway process. More information here: www.europeancancer.org/community-365

Introduction

Matti Aapro, President of the European Cancer Organisation & EU Cancer Mission Assembly Member

Inequalities are sadly a feature of cancer care, not just in Europe but all around the world. They reflect all aspects of life, in which a patient’s age, sex, gender, level of education, socioeconomic status, disabilities and, crucially, location can have a major impact on the quality of cancer care they receive.

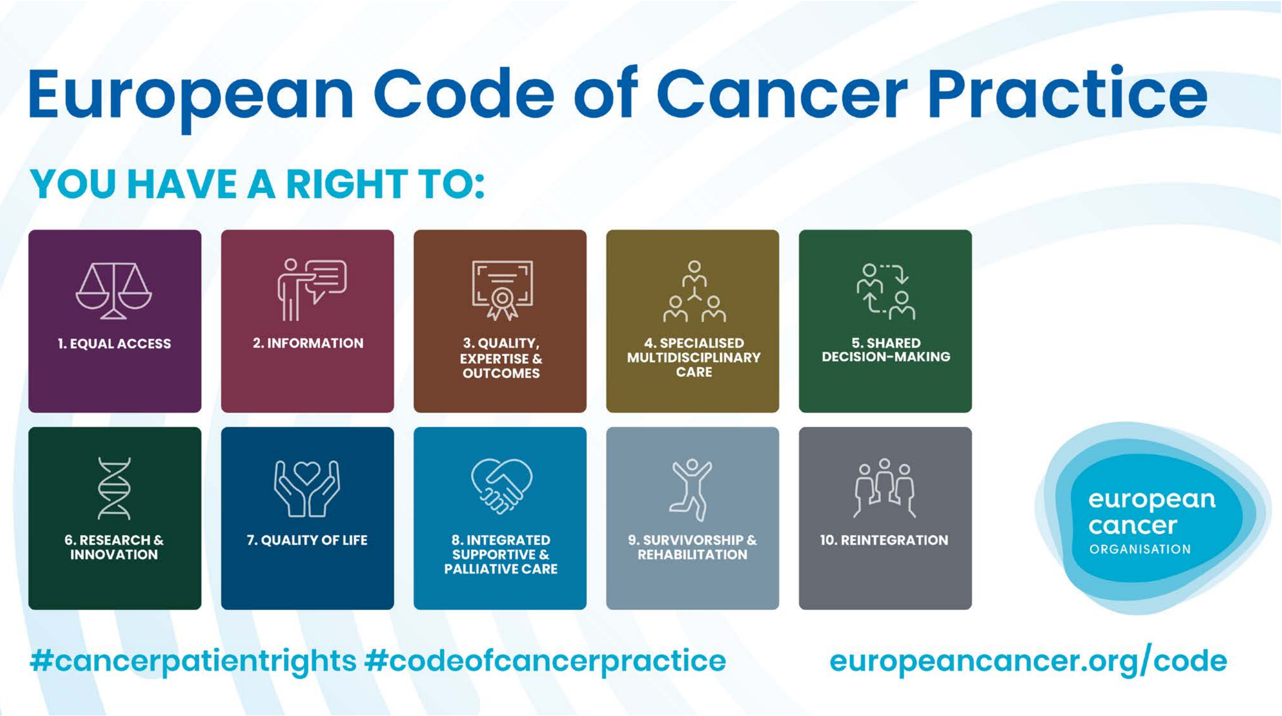
The European Code of Cancer Practice enshrines a series of ten overarching rights for patients, and in particular signposts what patients should expect from their health system, in order for them to achieve the best possible outcomes.

However, it is a reality of cancer care in Europe today that many patients cannot enjoy those rights, and it is only through coordinated action and policy developments at local, national and regional levels that the aim of equal access to high-quality cancer care for all will be realised.

Bringing the Community Together to Tackle Inequalities

The Community 365 Roundtable on Inequalities was our first Community 365 Roundtable, since this initiative was launched in January 2020. These meetings bring together charity, philanthropy and industry contributors to the Focused Topic Networks of the European Cancer Organisation, with the aim of providing ideas, guidance, practical support and resources for building consensus in the European cancer community.

The topic of Inequalities was chosen for the first Roundtable not least because of the importance placed on the subject by the EU



Health Commissioner, Stella Kyriakides, in previous meetings with our Member Societies and Patient Advisory Committee, as well as in the forthcoming Europe's Beating Cancer Plan.

The Inequalities Network, led by Co-Chairs Dr Nicolò Matteo Luca Battisti, SIOG President-Elect, and Professor Hendrik Van Poppel, EAU Adjunct Secretary General, aims to shine a spotlight on the cancer inequalities, so that readily available policy mechanisms can be enacted to bridge gaps and raise standards and outcomes in cancer care across all of Europe, for all groups in society. In so doing, the Network builds on the existing work of Network participants, and liaises closely with the EU institutions and others in providing advice and recommendations.

With collaboration on the programme of Sanofi and Pfizer representatives, this Roundtable, held on 14 October 2020, brought together policy-makers, politicians, oncology experts and patient advocates to discuss important areas of inequality in cancer care in the weeks before the launch of Europe's Beating Cancer Plan in December in two dedicated, in-depth sessions:

- Treating Ageing Patients with Cancer
- The East–West Divide

These highlighted the wide-ranging issues faced by the ageing patient with cancer and those in less advantaged areas of Europe.

Underpinning both topics is the absolute need for the development, in collaboration with regional experts, of a comprehensive, data-driven and fully implemented national cancer control plan (NCCP). These must build on a thorough understanding of the local cancer care landscape to tackle inequalities all along the cancer pathway, from screening and prevention through diagnosis and treatment to survivorship and palliative care, underpinned by clinical research and innovation.

Treating the Ageing Patient with Dignity

For the ageing cancer patient, addressing inequalities in cancer care means first and foremost that they must no longer be treated based on their age but rather on who they are as a person. This must take into account their health status, associated comorbidities and socioeconomic situation. In other words, they must be treated with dignity.

This must stretch beyond their immediate cancer care and be reflected in the way research is conducted for cancer therapies. Older patients have been systemically excluded from clinical trials, where the focus has been on younger patients with a good performance status. The result is that there is a dearth of evidence on the efficacy and safety of medications in older individuals with multiple comorbidities, as well as on optimum radiotherapy schedules or even the expected outcomes of surgical interventions.

To better tailor management, oncologists must work closely with geriatricians to develop age-appropriate care plans. In line with Right 4 of the European Code of Cancer Practice, multidisciplinary and multi-professional care is fundamental to the provision of best quality cancer care to any cancer patient. For older patients, potentially with multiple conditions, this includes such elements as pharmacist assistance in the management of polypharmacy. The concept of multi-professional care must also be expanded to include general practitioners, so that care is no longer denied to patients simply based on their age and that they receive appropriate follow-up once outside the hospital.

The example of France has shown how the specific inclusion of older patients in the NCCP can lead to the identification of key priorities and the establishment of networks of geriatric oncology centres, as well as national guidelines and specialist training.

National Cancer Control Plans Reflecting Local Contexts

The East–West divide has come under the spotlight recently, with key figures at the European Union (EU) recognising the need to address the often stark inequalities that exist between and within countries, which are associated with large disparities in cancer survival.

Increased funding for healthcare, while an important factor in ensuring equitable care, is not the only answer, however. Access to reliable data and robust evaluation are both critical factors in identifying priorities and developing cancer policies that reflect the local context.

In recent years, countries such as Slovenia have made huge strides in improving cancer care through the development of a modern NCCP in collaboration with experts from across the region. These plans must focus not only on access to innovation but also on comprehensive cancer reporting through population-based cancer registries, health education and health promotion, improvements in cancer screening, early detection and treatment, and survivorship issues.

Another crucial aspect is participation in clinical trials and research, as it has been shown time and again that clinical research is a key determinant of improvements in cancer care, all of which underscores the need for stakeholder collaboration across sectors and borders in the region.

We have seen that, through determined effort and coordinated policy initiatives, inequalities can be reduced and progress can be made. The opportunity is there and it is up to us to seize it. We must work together to drive change: The time for action is NOW.

Action Points for Tackling Inequalities in Cancer Care

The Ageing Patient

- Treatment should no longer be chosen based on a patient's chronological age but on a comprehensive understanding of their health status and circumstances

- Surgical, radiation and medical oncologists must routinely use geriatric assessment tools and work in conjunction with geriatricians to develop joint care plans

- Older patients must be included in clinical trials to broaden the evidence base and allow treatment optimisation

- General practitioners and other healthcare professionals must be included in ongoing follow-up to ensure better understanding of the individual's circumstances and better access to personalised care

- Older patients must be specifically named in national cancer plans to develop national guidelines and establish specialised treatment centres

The East–West Divide

- An evidence-based approach to decision-making and policy development via a national cancer control plan is essential to achieving affordable, equitable cancer control

- Cancer control must be driven by robust cancer monitoring and reporting and comprehensive cancer intelligence to allow a detailed understanding of the local cancer landscape

- Multidisciplinary care and standardised treatment pathways must be developed to ensure quality care along the patient pathway and the optimal use of resources

- A learning environment must be developed to highlight key challenges and inequalities and measure progress and benchmark best practice.

Treating the Person Not the Number: Improving Care for Older Cancer Patients

The Treating Ageing Patients with Cancer session was chaired Matti Aapro, President of the European Cancer Organisation & EU Cancer Mission Assembly Member, and co-chaired by Hampton Shaddock, Head, Global Public Affairs, Oncology at Sanofi.

Counting the Cost of Cancer Care

Peter Lindgren, Managing Director of The Swedish Institute for Health Economics, opened the session by highlighting that cancer is an age-associated disease, and the ageing people population has led to a 50% increase in cancer incidence and a 20% increase in cancer mortality since the mid-1990s.[1]

This has had enormous consequences for healthcare systems, with a 86% per capita increase in direct cancer costs over the same period.[2] This is in part due to demographic shifts but also to innovations in management and therapies that have improved survivorship.

While cost of newer oral cancer therapies has been partially offset by a move towards more outpatient care, the transition in some instances to a more chronic condition has led to consequences both for healthcare services and the wider care economy.

Older Patients Often Treated Blindly

The importance of this is underlined by the fact that one third of cancer patients are older, said Professor Etienne Brain, Co-Chair Corporate Relations Committee for SIOG and Department of Clinical Research & Medical Oncology, Institut Curie. This means that all adults oncologists are geriatric oncologists, they just do not know it yet.

Older cancer patients nevertheless often find themselves in the position of either being victims of therapeutic nihilism, in which they do not receive any treatment, or blind therapeutic enthusiasm, in which they are given futile or non-beneficial treatments.

Kathy Oliver, Vice-Chair of the European Cancer Organisation's Patient Advisory Committee, reminded the audience that the issues of cancer care in older patients were underlined by the COVID-19 pandemic.

There were instances of patients being excluded from decision making and denied the opportunity for consent, and she warned that older patients can end up being seen as a double burden.

Conflicting Priorities Between Young and Old

Professor Brain said part of the problem is a gap between the way society views older patients and their needs, a key aspect of which is frailty. There is typically a focus on the tumour extent and biology, as well as patient preferences and treatment acceptability, but less consideration of patients' general health status and treatment toxicity.

Comparing the management of younger and older cancer patients highlights several apparently conflicting sets of priorities, he said, such as the quantity versus the quality of life, treatment response versus cognition and functional status, and the molecular status of the disease versus the global status of the patient.

He said that geriatric assessments can nevertheless result in modifications of the initial treatment plan in approximately two fifth of cases, and the use of less intensive treatments in around two thirds. [3] Moreover, they lead to greater emphasis on the functional and nutritional status of the patient.

Professor Brain said that, to allow closer cooperation between oncologists and geriatricians, clinicians and policymakers need to be disruptive in the organisation of care and inclusive in their language, as well as train younger generations in geriatric oncology.

Change at All Levels

This need for broad changes was endorsed by Dr Enrique Soto, from the Older Adults Task Force of the American Society of Clinical Oncology. He said the issue cannot be solved simply by changing how doctors treat patients but by tackling the ageism that exists at all levels of society.

It needs to be easier for cancer patients to achieve age-appropriate care, and the largely administrative barriers that physicians encounter in caring for older adults need to be lifted. He said that cancer healthcare professionals are already convinced of the need to perform geriatric-aware assessments but they do not have the tools available.

One initiative could be to develop a simple geriatric assessment replicable across care settings that allows for patients to be identified and treatments to be modified, all in a research-mindful manner.

Building Systems that Meet Patient Needs

In the final presentation, Dr Cary Adams, Chief Executive Officer of the Union for International Cancer Control, said that the longevity revolution means that policies specific to older patients need to be developed that will improve health promotion and prevention, alongside building health systems responsive to their unique needs (Figure 1).

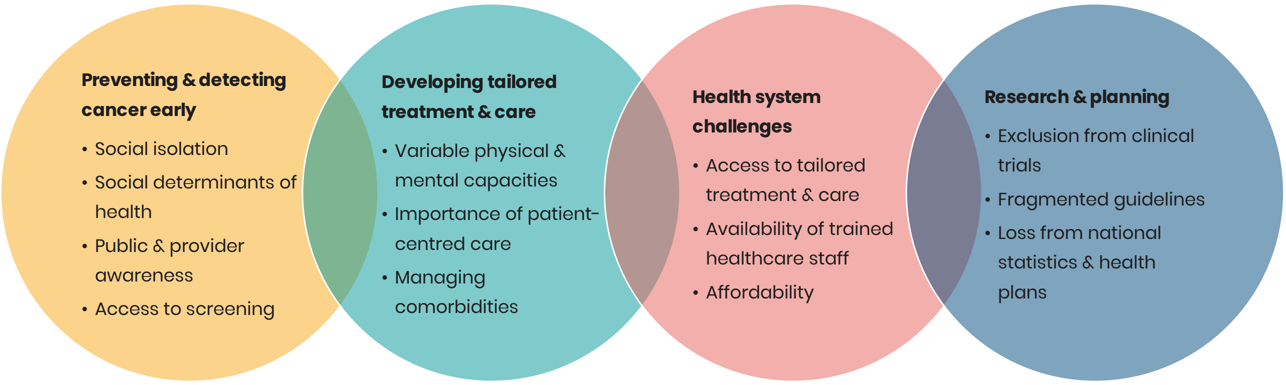
This will require research and planning, and coordinated policy responses on a national, regional and even global level, all backed by coordinated investment.

He emphasised that every country should have a robust, comprehensive, fully funded and implemented NCCP that reflects the challenges and needs of older patients. A good example is France, where older patients were specifically included in their cancer plan. Through coordinated investment, and the development of priority actions and networks, there are now 28 geriatric oncology units across the country.

Dr Adams believes that money should be diverted to non-communicable diseases on a European Union level, and that the common needs of the ageing population across the region is an opportunity for joint advocacy across diseases. This means connecting different ranges of action at a national level across prevention, diagnosis and treatment, survivorship and research (Figure 2). While this can be challenging, the aim must be to ensure that the older cancer patient is included in all initiatives, and at all levels.

Figure 1. Recognising unique needs

Older adults have a series of unique needs which interact and introduces additional complexity in managing cancer across every health system.



Preventing & detecting cancer early

- Social isolation
- Social determinants of health
- Public & provider awareness
- Access to screening

Developing tailored treatment & care

- Variable physical & mental capacities
- Importance of patient-centred care
- Managing comorbidities

Health system challenges

- Access to tailored treatment & care
- Availability of trained healthcare staff
- Affordability

Research & planning

- Exclusion from clinical trials
- Fragmented guidelines
- Loss from national statistics & health plans

Figure 2. Connecting different levels of action

National planning	Prevention	Diagnosis and treatment	Research
2017 Cancer Resolution	EU Beating Cancer Plan	EU Beating Cancer Plan	EU Cancer Mission
UN Political Declaration on UHC	2017 Cancer Resolution	2017 Cancer Resolution	WHO Global Strategy and Action Plan on Ageing and Health
WHO Global Strategy and Action Plan on Ageing and Health	High-level Political Declarations on NCDs	2014 Palliative Care Resolution	
ICCP Technical Assistance	WHO FCTC, Global Strategy to reduce the harmful use of alcohol etc.	UN Political Declaration on UHC	
		COVID-19 Response	

Meeting the Unique Challenges of Ageing Cancer Patients

The Treating Ageing Patients with Cancer session was co-chaired by Hampton Shaddock, Head, Global Public Affairs, Oncology at Sanofi.

"The convergence of ageing and cancer creates a tidal wave that will place significant burden not only on individuals, but on their families, communities, societies, economies and healthcare systems worldwide. Unfortunately, most societies around the world are not equipped to address the societal and economic implications associated with this rise."

"This is exactly why Sanofi launched the When Cancer Grows Old initiative on World Cancer Day 2020 to help address the unique challenges faced by ageing cancer patients and their caregivers, including an often complex patient journey. We are hopeful that Europe's Beating Cancer Plan can be implemented at national-level in a way that is inclusive and responsive of the unique needs of ageing patients with cancer, so that the WHO's Decade for Health Ageing can be a reality for all."

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Improving Outcomes with Data-Driven Care: Tackling the East–West Divide

The East–West Divide session was chaired Matti Aapro, President of the European Cancer Organisation & EU Cancer Mission Assembly Member and co-chaired with Linda Gibbs, Oncology Lead for Central/Eastern Europe, Pfizer.

Pan-European Cooperation

At the start of the session, John Ryan, Director for Public Health, DG SANTE, European Commission, said that the EU is aware of the health inequalities that exist across Europe, which are revealed in the dramatic differences in life expectancy not only between but also within member states.

He emphasised the importance of ensuring that the introduction of improvements in cancer care does not increase the gap between the countries but rather bring those at the bottom closer to those at the top. This will require the mobilisation of support at the EU level, where equal access to care is a key issue.

With Europe's Beating Cancer Plan, he said, there is an opportunity to include specific provisions to tackle inequalities, not just in terms of grants and funding but also policies for legislative changes to improve cancer screening and uptake, encourage best practice and improve access to innovation.

Maria Carvalho, MEP, Portugal, agreed that tackling the East-West divide is about narrowing the gap between regions and countries. More than that, it is related to issues of cooperation and coordination between various stakeholders and between countries.

While there is a drive to increase cancer care budgets, the proposed Horizon Europe programme should focus not only on money but also on cooperation across all areas of care, including twinning between countries in different regions of Europe.

This, she said, should be underpinned by more clinical research, which has been shown to be clearly linked to improvements in healthcare outcomes.

Benchmarking Optimal Care with the Cancer Dashboard

Professor Mark Lawler, European Cancer Organisation Board Member, and Associate Pro-Vice Chancellor and Professor of Digital Health, Queen's University Belfast, said that, despite the current challenges due to the COVID-19 pandemic, there have been chinks of light in recent years. Health has been established as an EU priority, and cancer has become a clear area of focus through Europe's Beating Cancer Plan and the EU Cancer Mission.

Lawler emphasised that it is absolutely critical that the opportunities offered by the political momentum around cancer in Europe are grasped, but equally important that these opportunities be used wisely. He also underlined that the European Code of Cancer Practice and its implementation offers an unrivalled opportunity to address the cancer inequalities that many European face every day.

The diverging incidence and mortality rates for cancer across Europe are multifactorial in nature. Healthcare expenditure is a challenge, and it is notable that total healthcare spending across Central and Eastern European (CEE) countries is below the EU average. While some countries in the region are outspending their peers, this is not reflected in improved outcomes, highlighting that it is not necessarily what you spend but how you spend it.

Lawler stressed the absolute primacy of appropriately resourced, data-enabled NCCPs. Data and cancer intelligence must be deployed to ensure that local and regional contexts are captured, and that funding is appropriately allocated. Data can also highlight health inequalities, and empower clinical research to be focused in the right areas. Nevertheless, some CEE countries still do not have an implemented, appropriately resourced NCCP.

The Central and Eastern European Cancer Action Group, which involves a range of stakeholders from the region, was established over three years ago to review the cancer landscape in CEE countries, collect cancer intelligence and develop tools to help improve care. Four recommendations were made: invest in research education and training; standardise patient pathways, enhance capacity; and patient advocacy.

Crucial to this aspiration is the development of a cancer learning environment that highlights key challenges and inequalities, and allows progress to be measured and best practice to be benchmarked. To achieve this, a CTRL Cancer Country Dashboard was developed, offering an easy-to-use tool for visualising the current status of cancer care and research. The tool, which covers 16 CEE countries, also allows monitoring and benchmarking of progress on key components within each NCCP.

Meeting the challenges of implementing a cancer plan

Véronique Trillet-Lenoir MEP, Lead Rapporteur for the Special Committee on Europe's Beating Cancer Plan, introduced the next section of the session, which focused on three recently developed NCCPs from CEE countries: Slovenia, Poland and Croatia.

She emphasised that there is much to learn from the experience of others, and successful initiatives must be built upon in a collaborative way so that in-country knowledge and best-practice can be exchanged.

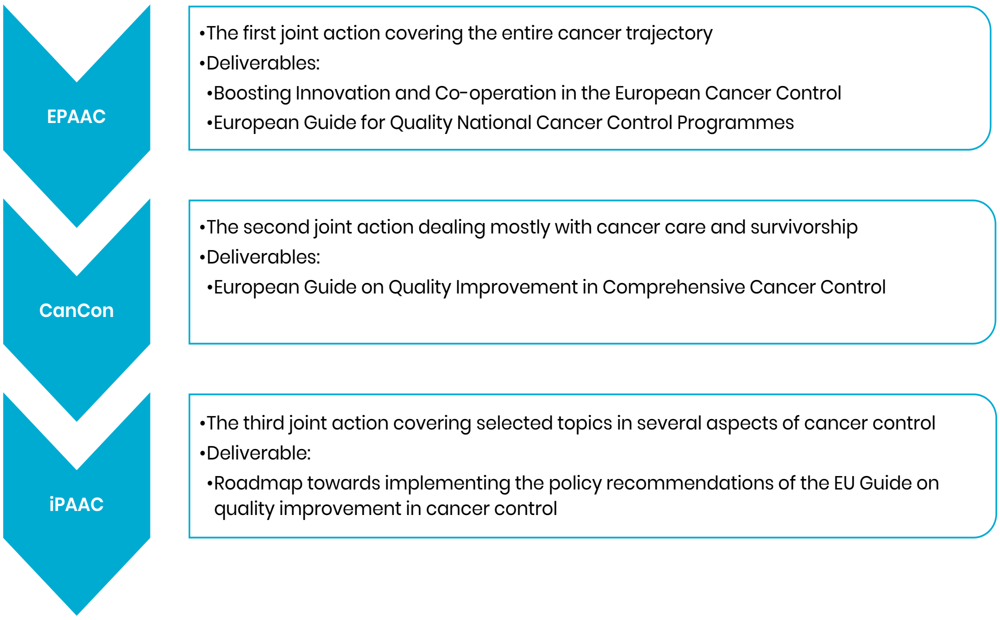
Mapping services and international collaboration

Professor Tit Albreht, Head of the Centre for Health Care, National Institute of Public Health, Slovenia, said that their cancer registry, one of the oldest in the world, has allowed for the very precise monitoring of cancer data and, through the introduction of screening programmes, they have been able to significantly lower cancer incidence and mortality.

Slovenia has also produced two NCCPs, the first tailored to mapping cancer services and ensuring access to high quality care, the second focused on survivorship. Within these NCCPs, they have improved multidisciplinary care, allocated funds, concentrated on infrequent cancers and developed a joint guideline with GPs on pain management, despite many challenges along the way.

The country has a clear commitment to cancer care and has been closely involved in cancer policy at a European level, through initiatives such as the European Partnership for Action Against Cancer. This led to the development of a roadmap for implementing the recommendations of the European Guide on Quality Improvement in Comprehensive Cancer Control, and involvement in the Innovative Partnership for Action Against Cancer (Figure 3).

Figure 3. Slovenia's Involvement in the European Cancer Policy



- The first joint action covering the entire cancer trajectory
- Deliverables:
  - Boosting Innovation and Co-operation in the European Cancer Control
  - European Guide for Quality National Cancer Control Programmes

- The second joint action dealing mostly with cancer care and survivorship
- Deliverables:
  - European Guide on Quality Improvement in Comprehensive Cancer Control

- The third joint action covering selected topics in several aspects of cancer control
- Deliverable:
  - Roadmap towards implementing the policy recommendations of the EU Guide on quality improvement in cancer control

Tackling inequalities at all levels of care

Professor Piotr Rutkowski, Professor, Surgical Oncology, Maria Sklodowska-Curie National Research Institute of Oncology, said that it is estimated that 50% of cancer deaths in Poland are preventable, and the incidence of the disease is set to rise by 28% in the next decade.

In response, the Polish NCCP was launched in February 2020, with a focus on health education and promotion, early detection, diagnosis and treatment, access to high quality care and clinical research.

Setting targets for breast, cervical, colorectal and lung cancer, as well as melanoma, they developed five areas that needed to be resourced: medical staff, education and prevention, secondary prevention, science and innovation, and a cancer care system (Figure 4).

Within those areas, there are a range of actions and measures to improve the coordination of cancer care, the development of standards and guidelines, support for patients during and after therapy, the establishment of cancer units and a new national oncology portal, and the digitalisation of the national cancer registry.

Data-driven targets and clear frameworks

Professor Eduard Vrdoljak, Head, Center for Oncology and Professor, Faculty of Medicine, University of Split, said that Croatia was in desperate need for an NCCP, as the mortality rate among male cancer patients, for example, was twice as high as that in Denmark.

A group of stakeholders assessed the magnitude of the problem, set measurable objectives, evaluated evidence-based strategies for cancer control and prevention, and identified their priorities for initial activities.

Working with foreign experts, they developed, over three years, an NCCP that covered the entire spectrum of cancer care, from prevention to palliation and beyond, into education and research, based around three initial priorities (Figure 5).

The NCCP set data-driven targets around smoking, alcohol consumption and obesity measures for primary prevention, early detection for key cancers, and a framework for increased participation in cancer research that incorporated legislation, infrastructure and promotion to healthcare professionals and the public.

This can lead to huge gains in quality adjusted life years at an average cost far below the World Health Organization recommended GDP per capita threshold for cost effective care.

Figure 4. National Cancer Plan – Scheme

Scope 1

Investing in medical staff – Improvement of the staff's situation and quality of education in oncology

Scope 2

Investing in education, primary prevention and lifestyle – Decreasing cancer incidence through a reduction of risk in cancer primary prevention

Scope 3

IInvesting in patient, secondary prevention – Improvement of the secondary prevention effectiveness

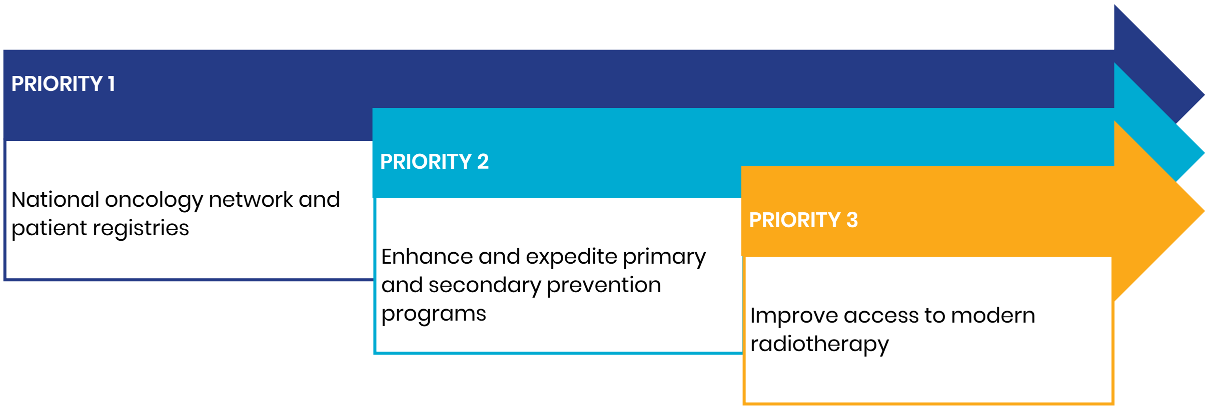
Scope 4

Investing in science and innovations – Increasing the potential of scientific research and innovative projects in Poland in order to provide patients with the most effective diagnostic and therapeutic measures

Scope 5

Investing in the cancer care system – Improvement of cancer care system structure through providing patients with organizational conditions enabling the highest quality of diagnostic and therapeutic processes as well as comprehensive care across the entire "patient path"

Figure 5. Choosing Priorities for Initial Cancer Control Activities



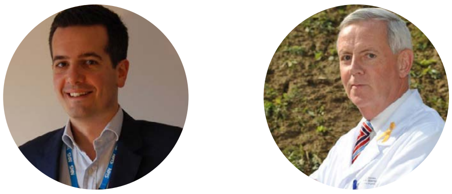
Ensuring Cancer Plans Become Reality

The East-West Divide session was co-chaired by Linda Gibbs, Oncology Lead for Central/Eastern Europe, Pfizer.

“Despite encouraging advances in science and technology, the inequality gap between CEE and Western European countries continues to rise. This is highlighted by mortality rates for disease such as lung and cervical cancer, as well as breast and rectal cancer, being distinctly higher in CEE countries.”

“Making effective change a reality in cancer control across Europe will require collaboration between stakeholders, including policy experts, patient groups, government and industry, alongside robust cancer data. The momentum created by Europe’s Beating Cancer Plan and the experiences of countries such as Slovenia, Poland and Croatia must also be harnessed. Working together, we can drive change in cancer control, improve patient outcomes and close the inequality gap.”

Tackling Inequalities Across the Cancer Care Spectrum



Nicolò Matteo Luca Battisti and Hendrik Van Poppel, European Cancer Organisation Inequalities Network Co-Chairs

The Community 365 Roundtable on Inequalities focused on Treating Ageing Patients with Cancer and the East–West Divide, which are important aspects of how inequalities in cancer care play out across Europe. However, there are a number of other inequalities in cancer care that, taken together, constitute a form of discrimination of patients of all kinds.

These relate to ethnicity, gender, including sexual and gender minorities, disability and socioeconomic factors such as literacy and language, income and social and family support. There are also geographic inequalities in cancer care that extend beyond the east–west divide.

The impact of these inequalities is felt across the whole of the cancer care continuum, from screening and early detection, over diagnostic procedures and treatment, to survivorship and quality of life and access to supportive care. There are also inequalities in possible inclusion in clinical trials, as well as in access to cancer prevention.

Geography

While the geographical inequalities between eastern and western European countries were explored in-depth at the Roundtable (see Page 2), there exists also a north-south divide, as well as one between European Union (EU) and non-EU countries.[1]

Looked at as a whole, there is a series of inequalities between high-, medium- and low-income countries, with a broad gradient running from north and west to south and east. This is revealed in the stark disparity between cancer incidence and mortality rates. Overall, rates of cancer incidence are highest in northern and western European countries and lowest in eastern and southern European, with the opposite pattern seen for mortality rates.

Moreover, there is often a ‘postcode lottery’ within countries. That means that individuals living in different regions, or those living in rural versus urban areas, face inequalities in access to cancer care.

Ethnicity

An individual’s ethnicity affects their risk for several types of cancer. Moreover, it plays a role all along the care pathway, with ethnicity-related differences in screening uptake and routes to diagnosis, as well as access to treatment and survivorship.

Together, these lead to ethnicity-related disparities in mortality rates for a whole range of cancers, including lung, breast, prostate, colorectal and liver cancer; an effect that is likely to be exacerbated by the increase in migration across the European region.[2,3]

Gender

There are also actionable disparities in cancer care between men and women that are expressed in, for example, mortality rates in breast versus prostate cancer, differences of early detection, for example between screening for breast and cervix versus prostate cancer, and in take-up of the human papillomavirus vaccination programmes.[4]

These gender inequalities affect screening and early detection, risk factors and prevention, presentation, stage at diagnosis and even access to treatment and clinical trials.

Sexual and Gender Minorities

While studies have shown that lesbian, gay, transgender, queer or questioning (LGBTQ+) individuals have higher rates of several viral-related cancers, there is a general lack of data on the prevalence of other cancers among sexual and gender minorities.[5,6] The impact of health behaviours such as smoking and obesity, as well as exogenous hormone exposure, is also unclear.

What is known is that LGBTQ+ individuals access healthcare services less than other people due a fear of discrimination, and have less uptake of cervical screening programmes due misconceptions about risk factors.[6] Individuals have also experienced a lack of understanding of their needs from healthcare staff.[5,7]

Disability

Individuals with disabilities face a number of barriers to accessing cancer services that result from a range of inequalities. These include a lack of preparation among healthcare professionals and institutions and, in some cases, physical accessibility, as well as a lack of acknowledgement of disability-related needs. In addition, cancer decision-making often does not take into account an individual's disabilities.[8]

In one example, this has left women with disabilities significantly less likely to participate in breast cancer or colorectal cancer screening than their able-bodied counterparts.[9]

Socioeconomic Factors

Literary and language isolation

Poor health literacy affects screening uptake, shared decision-making and risk perception, including fears for cancer progression, as well as medication adherence, perioperative care and follow-up compliance. Yet this is a valuable and highly actionable target to help address inequalities.[10]

Income

Income disparities in access to cancer management play out across the care spectrum and have an ongoing impact on patient survival. This is demonstrated by the persistently delayed uptake of novel cancer treatments among, for example, poorer women with breast cancer or men with rectal cancer. While the resulting deprivation gap in survival for individuals with breast cancer appears to have narrowed in recent decades, it has continued to increase for recall cancer patients, with no sign of reducing.[11]

Social and family support

Social support is a crucial aspect of cancer care, from screening to survivorship or end-of-life care. It includes patient mobility, help with practical tasks and attending medical appointments, as well as personal care, looking after children and other dependents and patients' emotional needs.[12]

All of this can have a substantial impact on cancer outcomes, particularly among certain age groups and ethnicities. The social support needs of patients may also correlate with income levels and deprivation, as well as geographic factors such as rural versus urban areas. With many of these patients already experiencing inequalities, addressing their social support needs becomes all the more important.

Tackling cancer inequalities

There are a number of ways that the myriad inequalities faced by cancer patients can be addressed. These include earlier cancer detection and better access to treatment through the improved affordability of medicines and devices, and through linking to treatment optimisation networks. There also needs to be improved access to innovation and to digitalisation of healthcare.

While there have been several initiatives to tackle inequalities at a European level in recent years, the upcoming EU Cancer Plan offers a unique opportunity to place these at the heart of the agenda.

Change needs to happen not just on a regional level, however, but also within countries and between centres, and this is where every healthcare professional involved in cancer care can make a difference.

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Inequalities Network Participants

Member Organisations Part of this Network

- EANM European Association of Nuclear Medicine
- eau European Association of Urology
- ECL Association of European Cancer Leagues
- European Oncology Nursing Society
- ESOI European Society of Oncologic Imaging
- ESOP
- European Society of Pathology
- ESR
- esso The European Society of Surgical Oncology
- ESTRO
- OECI Organisation of European Cancer Institutes European Economic Interest Grouping
- IPOS International Psycho-Oncology Society
- SIOG International Society of Geriatric Oncology

Patient Organisations Part of this Network

- Childhood Cancer International
- European Cancer Patient Coalition
- IBTA International Brain Tumour Alliance
- LuCE Lung Cancer Europe
- MPE Myeloma Patients Europe
- World Bladder Cancer Patient Coalition

Charities and Foundations Part of this Network

- Anticancer Fund
- EMANUELE Cancer Research Foundation Malta
- ABC Global Alliance
- InoMed Centre for Innovation in Medicine

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If you would like to find out more about the Inequalities Network, please contact us at: info@europeancancer.org

As the not-for-profit federation of member organisations working in cancer at a European level, the European Cancer Organisation convenes oncology professionals and patients to agree policy, advocate for positive change and speak up for the European cancer community.

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