

more likely to smoke themselves.^v We also know that smoking is a key contributory factor to child poverty.^{vi}

5. Although the desire and motivation to give up smoking does not have a socio-economic gradient, those in deprived areas have lower long term success rates,^{vii} possibly due to greater external life pressures. The NHS should continue to provide targeted information and support services within deprived communities. However, further research is needed to make these targeted approaches as effective as possible.
6. Treating smoking related diseases costs the NHS an estimated £1.5 billion per annum.^{viii} At the same time, a one per cent decline in the smoking rate could save around 60,000 lives in only ten years and reduce the cost to the NHS by hundreds of millions of pounds (NICE also found that smoking cessation services were cost effective).^{ix} Examples of where this money would be saved include reductions in the average amount of time spent in hospital following an operation, fewer premature and low weight babies, and fewer heart attacks and strokes. A comprehensive and targeted approach is needed that builds on recent policy success and works to reduce smoking incidence and encourage quit attempts. Total funding for a comprehensive tobacco control strategy to reduce smoking prevalence, not including the cost of smuggling initiatives, would be under £250 million a year. This should include spending on social marketing at double the current levels (£50 million a year instead of the current spend of around £25 million a year). It would also require maintenance of effective funding of the NHS Stop Smoking Services, currently £56 million per annum, and their extension to ensure effective smoking cessation provision in hospitals.
7. Smoking rates are higher among some BME communities, for example tobacco consumption could be as high as 60 per cent among the Bangladeshi community.^x Cancer Research UK has been working with this community, in the Tower Hamlets area of London, to raise awareness of the risks of tobacco consumption; evaluation of the pilot found an increase in awareness of the campaign and its key messages.^{xi} The NHS could work collaboratively with the charitable and private sectors to deliver health messages that meet the needs of the UK's diverse communities.

8. The provision of information and support to patients and health service providers

Early diagnosis of cancer is positively correlated to survival rates and it is therefore essential that the public have high rates of cancer symptom awareness. Current research suggests that this is not the case, for example:

- Grunfeld et al^{xii} (2002) found low levels of breast cancer symptom recognition among older women, despite the risk of developing the disease being highest amongst this group^{xiii}
- Cancer Research UK^{xiv} (2007) found that those from less privileged backgrounds were around 20 per cent less likely to recognise cancer symptoms compared to those from a more affluent background.
- Breast Cancer Care^{xv} (2005) found that 38% cent of BME women questioned thought that a lump was the only symptom of breast cancer compared to just over twenty per cent of women in the general population.

9. Appropriate information and support is essential if individuals are to increase their knowledge of, and make, healthy lifestyle choices. Such information also enables individuals to access services appropriate to their needs and act upon treatment advice. For harder to reach communities it is often necessary to tailor information and support to meet their needs and the NHS is well placed to provide such information, in collaboration with other stakeholders if required.
10. Health inequalities could remain unchanged if translated information is inappropriate to the needs of BME communities, and other groups that require additional information and support. The NHS could undertake research to better understand the effectiveness of translating health information into languages other than English and other formats. As well as establishing good practice in providing information and support to harder to reach communities and groups.
11. At the same time, health care providers need to be enabled to communicate effectively with individuals from harder to reach groups. This could be achieved by the NHS carrying out research to better understand the effectiveness of training programmes for health care providers, in terms of increasing their ability to successfully communicate health information. Such training could then be rolled out, where appropriate, to ensure that health care providers feel confident when communicating with harder to reach communities.

12. Increasing access and uptake of services among harder to reach groups

As mentioned previously, early diagnosis of cancer is likely to increase an individual's chance of surviving the disease, for example women who are diagnosed at the earliest stage of breast cancer are 26 times more likely to survive than those diagnosed at the latest stage.^{xvi} Screening is one such way that earlier diagnosis can be achieved. There are currently inequalities in uptake within all three cancer screening programmes based around socio-economic^{xvii} and or BME status^{xviii}, disability^{xix}, sexual orientation^{xx}, and age^{xxi}. All English screening centres undertake their own awareness raising programmes and the NHS could disseminate information about best practice relating to the needs of communities and groups with traditionally low screening uptake. Research could also be undertaken to better understand, and reduce, the barriers that exist to uptake of screening services among the groups mentioned above.

13. The NHS could specifically address inequalities in uptake between regions; London consistently has uptake rates ten per cent lower than the UK average. The targeting of messages, which illustrate the importance of attending screening, to harder to reach groups could also be developed by the NHS.
14. Cancer Research UK is currently running a campaign, called Screening Matters, to promote screening for cancer.^{xxii} Through this campaign we are calling on the Government to develop methods to increase the uptake of cervical, bowel and breast screening. Studies indicate that a range of policies, running alongside the screening programmes, including community-based and GP education programmes and improved participation of GP services can have an impact.^{xxiii, xxiv, xxv} Furthermore, sending second invites to patients with fixed appointments may be helpful.^{xxvi}

15. Cancer Research UK is aware of the difficulties of compiling accurate figures relating to the number of adults not registered with a GP. This group is often made up of the hardest to reach, for example transient populations, those who do not speak English, the homeless and new migrants to the UK. The NHS could reduce health inequalities between such groups and the rest of the population by increasing registration with GPs, through awareness raising and improved service provision, and by developing alternative access routes to health services for those not registered with a GP. Examples of this could include culturally appropriate mobile health units or providing services to rural communities. The NHS could also establish ways of encouraging GPs to practice in deprived/ rural areas, for example through incentives, to ensure that such communities have equal access to primary care.
16. The annual GP survey undertaken by DH^{xxvii} revealed wide variations in the numbers of GPs across England, with particularly acute problems in deprived areas. For example, Barking and Dagenham PCT in London had 43 GPs /100,000 population, compared with Northumberland PCT – 88 GPs /100,000 population with an English average of 61/100,000 population.
17. Studies have shown that the standardised mortality ratio for all-cause mortalities at 15 – 64 years of age is lower in areas with a greater supply of general practitioners;^{xxviii} and that each additional general practitioner per 10,000 population is associated with about a 6% drop in mortality.^{xxix} Furthermore the supply of general practitioners is more closely associated with lower in-hospital standardised mortality than is the total number of physicians per 100 hospital beds.^{xxx}
18. Practice based commissioning should enable groups of GPs to accurately assess the needs of their practice populations and commission services that meet those needs. For example, practices situated in areas with a large Afro-Caribbean male population might commission prostate awareness and prevention services, in order to tackle the higher rates of the disease among this group.

19. Conclusion

Although a number of the causes of health inequalities are outside the remit of the NHS there are also a number of programmes that it could be undertaking, in collaboration with other stakeholders, to dramatically reduce health inequalities within the UK population. These relate to:

- Providing patients with the information they need in order to raise awareness of healthy lifestyles (particularly smoking prevention and cessation) and encourage the uptake of such behaviours.
- Enabling health service providers to communicate effectively with patients from harder to reach groups in order to disseminate health information.
- Ensuring that services are provided in a way that is accessible by harder to reach groups and reduces inequalities in uptake.
- Reducing the number of individuals who are not registered with a GP and establishing alternative access routes to health services.
- Reducing tobacco consumption among harder to reach groups through ensuring policies will reduce inequalities and providing targeted smoking cessation services.

- Working in collaboration with a range of stakeholders to ensure that services are provided in a way that meet the needs of the hardest to reach communities and groups.

20. Cancer Research UK funds and collaborates with a number of leading researchers in the field of health inequalities. We would be delighted to have the opportunity to contribute to any future sessions being undertaken by the Health Committee in relation to gathering information about health inequalities, and effective methods of reducing them.

21. Our Goals

In order to support our vision 'together we will beat cancer' Cancer Research UK created ten ambitious new goals that, together with our partners, we are aiming to achieve by 2020. The goals are wide ranging and seek to clarify our priorities and enable us to demonstrate our progress and impact in a range of areas including reducing cancer incidence, ensuring patients have access to the information they need and reducing cancer inequalities.^{xxxii}

22. We are currently embarking on a new area of work, including the publication of two health inequalities reports in early 2008. Should you require copies of these reports, or further information about any of our health inequalities related projects please do not hesitate to contact:

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References

- ⁱ Registered charity no. 1089464
- ⁱⁱ Cancer Research UK (2007) CancerStats Factsheet Men's Cancers
http://publications.cancerresearchuk.org/WebRoot/crukstoredb/CRUK_PDFs/CSFSMENS.pdf
- ⁱⁱⁱ Office for National Statistics (2005) Cancer Atlas of the UK and Ireland
- ^{iv} Coleman M et al (2004) Trends and socioeconomic inequalities in cancer survival in England and Wales up to 2001, British Journal of Cancer, 90
- ^v Farkas et al (2000) Association between household and workplace smoking restrictions and adolescent smoking. Journal of American Medical Association 284:717-22
- ^{vi} BMA Board of Science (2007) Breaking the cycle of children's exposure to tobacco smoke
[http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFbreakingthecycle/\\$FILE/Breakingcycle.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFbreakingthecycle/$FILE/Breakingcycle.pdf)
- ^{vii} Bauld et al (2003) Impact of UK National Health Service smoking cessation services: variations in outcomes in England. Tobacco Control 2003; 12: 296-301
- ^{viii} Parrott S, Godfrey C, Raw M, West R, McNeill A. Guidance for commissioners on the cost effectiveness of smoking cessation interventions. Thorax 1998; 53 Suppl 5 Pt 2:S1-38.
- ^{ix} NICE Public Health Programme Draft Guidance
http://www.nice.org.uk/nicemedia/pdf/Smoking_Cessation_Programme-Draft_Guidance-11_5_07.pdf
- ^x Department of Health (2004) Health Survey for England: Health of ethnic minorities
- ^{xi} Croucher, R. and Gamboa, A. (2006) CR-UK Open up to Mouth Cancer campaign in Tower Hamlets: Final Report Queen Mary University of London/ Cancer Research UK
- ^{xii} Grunfeld et al (2002) Women's knowledge and beliefs regarding breast cancer. British Journal of Cancer (2002) 86, 1373-1378
- ^{xiii} A Cancer Research UK funded study by Oxford University also found that less than one per cent of women knew that women over 80 are of greatest risk of developing breast cancer.
<http://info.cancerresearchuk.org/news/archive/pressreleases/2007/may/318252>
- ^{xiv} Cancer Research UK: Reduce the Risk
<http://info.cancerresearchuk.org/news/archive/pressreleases/2007/june/332451>
- ^{xv} Breast Cancer Care (2005) Same Difference: Policy Briefing
http://www.breastcancercare.org.uk/docs/same_difference_final_0.pdf

-
- ^{xvi} Ugnat et al (2004) Survival of women with breast cancer in Ottawa, Canada: variation with age, stage, histology, grade and treatment *British Journal of Cancer* 22; 90 (6) 1138-1143
- ^{xvii} Henley et al. (2005) Does deprivation affect breast cancer management *British Journal of Cancer*; 92: 631-633
- ^{xviii} Breast Cancer Care (2005) Same difference: policy briefing London: Breast Cancer Care
- ^{xix} Stein and Allen (1999) and Biswas et al (2005)
- ^{xx} Bailey et al (2000) Lesbians and cervical screening *British Journal of General Practice*; 2000: 481-482
- ^{xxi} National Statistics Online (2005)
http://www.ic.nhs.uk/webfiles/publications/brstscrnprogeng2005/BreastScreeningProgramme280206_PDF.pdf
- ^{xxii} (www.cancercampaigns.org.uk)
- ^{xxiii} Majeed et al (1997) Impact of follow up letters on non-attenders for breast screening: a general practice study *Journal of Medical Screening*; 1997: 4: 19-20
- ^{xxiv} Sharp et al (1996) Breast screening: a randomised controlled trial in UK general practice of three interventions designed to increase uptake *Community Health* 1996; 50: 72-6
- ^{xxv} Thomas V.N. (2005) Barriers to effective uptake of cancer screening among black and minority ethnic groups *International Journal of Palliative Nursing*, Vol. 11, 11, p. 562-571
- ^{xxvi} Stead M.J.1; Wallis M.G.1; Wheaton M.E.1 (1998) Improving uptake in non-attenders of breast screening: selective use of second appointment *Journal of Medical Screening*, 5:69-72
- ^{xxvii} Department of Health (2007) GP Patient Survey: Your doctor, your experience, your say London: DH
- ^{xxviii} Gulliford, M.C. (2002) Availability of primary care doctors and population health in England: Is there an association? *Journal of Public Health Medicine* Vol. 24, No. 4. p.252-254
- ^{xxix} Ibid
- ^{xxx} Jarman B, Gault S, Alves B, Hider A, Dolan S, Cook A, Hurwitz B & Iezzoni LI. Explaining differences in English Hospital Death rates using routinely collected data *BMJ* 318: 1515 – 711999
- ^{xxxi} A full list of our goals is available at:
<http://www.cancerresearchuk.org/aboutus/howweare/ourgoals/>