

"Of all the forms of inequality, injustice in health care is the most shocking and the most inhumane"

Martin Luther King, 1966

**Equal and Inclusive:
Government policy
aimed at reducing
health inequalities**





Contents

Executive summary	3
Recent cancer and health inequalities policy	4
History of health inequalities policy	7
Themes within health inequalities policy	8
History of cancer policy relating to health inequalities	10
Lifestyle Policy and health inequalities	12
Has policy reduced health inequalities?	13
Conclusion: Key policy themes	14
What is Cancer Research UK currently doing to reduce health inequalities?	15

Executive summary

Since 1997 health inequalities have been increasingly recognised as an area requiring government intervention. Consequently, there has been a wealth of policy in the area of health inequalities. The aim of this report is to give the reader an introduction to the key policies and themes within these subject areas, specifically outlining the key themes which relate to health inequalities, within the Cancer Reform Strategy and other recent government policy.

This report is accompanied by *Understanding cancer inequalities: Current health inequalities relating to cancer within the UK* which focuses upon the health inequalities experienced by a range of communities and groups within the UK population.

Recent cancer and health inequalities policy

The Cancer Reform Strategy, published in 2007, is aimed at taking forward the improvements in cancer services and outcomes following the NHS Cancer Plan. This section of the report details the key themes within the strategy; as well as other recent policy developments which relate to cancer inequalities.

History of health inequality policy

In the UK there is a substantial body of policy related to health inequalities going back as far as the 1980s. The second section of this report looks at the previous policies that attempted to reduce health inequalities as well as those policies that are impacting upon such inequalities currently.

Cancer inequalities

A range of policy documents have focused upon reducing the gap between those with the poorest health outcomes and those with the best. This section of the report details specific policy related to inequalities within cancer services, incidence and outcomes.

Lifestyle

A number of behaviours are known to increase an individual's lifetime risk of cancer. Such behaviours have been found to be more common amongst particular groups and communities within the UK population. With this in mind, the Government has introduced a range of policies aimed at encouraging and enabling the population to undertake healthy lifestyles. This chapter details such policy and concludes by looking at the available evidence regarding the effect policy has had upon health inequalities.

Conclusion

The report concludes by drawing together the overarching themes of policy in the area of health inequalities relating to cancer. These are:

- The importance of tailoring and targeting programmes to the needs of communities and groups.
- The need to set targets which can effectively measure the impact that policies are having upon health inequalities.
- Partnership working is viewed as the most effective way of reducing health inequalities.
- Further research is required which develops the evidence base relating to inequalities in cancer and our understanding of how to effectively address such issues.

The role of Cancer Research UK, within the wider health inequalities agenda, is then considered.

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Recent cancer and health inequalities policy



The Cancer Reform Strategy

The Cancer Reform Strategy¹ (2007) was created as a progression of the NHS Cancer Plan² (2000) and sought to deliver further improvements in cancer services and outcomes up to the year 2012 in England. This section of the report details the key themes within the strategy relating to cancer inequalities.

Improved information for the public and health professionals

'Better information will enhance quality, inform commissioning and promote choice.'

(Cancer Reform Strategy, DH, p.10)

Improving information provision is a key part of the Cancer Reform Strategy. Enabling patients to make decision about their health care is viewed as only possible when they are provided with high quality information. Further to this, information should be tailored to effectively meet the needs of patients. The partnership between Cancer Research UK and, the newly merged Macmillan Cancer Support and Cancerbackup to provide tailored and individualised 'information prescriptions' is viewed as effective partnership working in this regard. Using information prescriptions health professionals will be able to generate individualised information for patients which utilises both national and local content.

The Cancer Reform Strategy also seeks to ensure that cancer patients are given the information they require about the financial support they can receive and what their rights are under the disability legislation.

An improvement and expansion of communication training for health professionals is also recommended in order to ensure that those patients, who require information face-to-face, are provided with it in a way effective at meeting their needs.

Information gathering

In order to better understand delays in patient diagnosis and support health professionals in enabling patients to receive their diagnosis sooner, a national audit of newly diagnosed cancers will be implemented. The National Cancer Equality Initiative (discussed below) will also aim to:

- Better understand current cancer/ health inequalities, through seeking the views of a range of stakeholders
- Develop research, interventions and policy to reduce such inequalities.³

- The gathering of information relating to ethnicity and cancer is also recommended.

Greater information sharing and collaboration is also acknowledged as an effective way of enabling the performance of UK cancer services to be compared to those of other countries.

New initiatives

The Cancer Reform Strategy also introduced a number of new initiatives. There are two that specifically relate to health inequalities. The first is the National Awareness and Early Diagnosis Initiative (NAEDI) which aims to "support local interventions to raise public awareness of the signs and symptoms of early cancer and encourage people to seek help sooner." (DH, 2007, p.8). This work is especially focussed upon raising awareness among groups with particularly low awareness as reducing such inequalities is perceived to be an effective way of reducing unequal access to services and differing cancer outcomes. Surveys will also be developed and undertaken nationally in order to better understand the levels of awareness of cancer signs, symptoms and risks (a separate exploration of experiences of cancer services will also be undertaken) among the general public. All of this work will be led by the National Cancer Director with additional input from a variety of stakeholders from within and outside the health service. Specific work in this new initiative includes the development of tools to measure sign and symptom awareness, piloting awareness-raising interventions, and disseminating good practice in awareness-raising and local pilots.

The second area of work, National Cancer Equality Initiative seeks to work with a range of stakeholders in order to develop an understanding of health inequalities, and interventions to address them, in order to develop effective policy. The Cancer Reform Strategy acknowledges that there are gaps in data and primarily seeks to undertake tasks to:

- Collect health inequalities data
- Undertake research to better understand health inequalities
- Share information on good practice
- Set up goals, with the Strategic Health Authorities and PCTs, in relation to reducing health inequalities by 2012.⁴

Partnership working

Following on from previous cancer policy the Cancer Reform Strategy states that "effective local implementation and working in partnership remains the broad approach needed to deliver further improvements in cancer services" (DH, 2007, p.28). At the same time national standards for care, in areas such as waiting times, are seen as the most effective way of ensuring nationwide equity in service and treatment provision.

Both of the new initiatives mentioned above call for the involvement of a range of stakeholders in order to achieve the desired outcomes.

Action points

The Cancer Reform Strategy (2007) set out ten pledges to NHS patients aimed at taking forward the improvements in cancer services witnessed under the NHS Cancer Plan. A number of these pledges, if achieved, could have an impact upon inequalities in cancer incidence, outcomes and service provision.

- More will be done to help you to reduce your risk of developing cancer. (This includes the introduction of the HPV vaccine for girls, tracking of public awareness of cancer and programmes introduced to increase awareness and the tracking of cancer risk factors)
- An increased likelihood of your cancer being detected earlier. (Expansion and improvement of cancer screening programmes and a reduction in screening uptake variation between PCTs, National Awareness and Early Diagnosis Initiative, exploration of primary care services to better understand delays in diagnosis)
- You will have access to high quality treatment at every stage of your cancer journey. (Extension of current waiting time standards to more patients, further reduction of waiting times within cancer services, expansion of radiotherapy services, action undertaken to ensure faster access to effective treatments, monitoring of variations in access to treatment within England and internationally)
- Whether you are living with or beyond your cancer, high quality information and support, tailored to your personal needs will be available. (Information provided to patients to enable them to play an active role in their treatment, ensure adequate provision of Clinical Nurse Specialists, improved support for patients relating to cost of cancer and the introduction of the National Cancer Survivorship Initiative)

- Irrespective of who you are or what your background is, the NHS will work to give you access to the best possible cancer experience and outcomes. (Introduction of National Cancer Equality Initiative and a set of goals to reduce mortality within every cancer network by 2012)
- Your care will be delivered in the most clinically appropriate and convenient setting for you. (Development of fully integrated care, Improving Outcomes Guidance implemented and only service providers who reach these national standards will be used, steps will be taken to reduce the length of cancer patients' hospital stay and reduce use of emergency services)
- You will be able to access information about the performance of your cancer services, enabling you to make informed choices which reflect your priorities. (National Cancer Intelligence Network will gather information about the experiences of cancer patients. This information will then be used to enable patient choice and improvements in service provision).

A further three pledges were aimed at continuing the improvements to cancer services made following the NHS Cancer Plan (2000):

- Your PCT will be supported in ensuring that the best possible cancer services are available for you. (PCTs will be supported by a cancer network to provide appropriate and effective cancer services, development of tools to enable effective commissioning and benchmarking of cancer services, involvement of patients in commissioning of cancer services)
- Your NHS cancer services will continue to be properly funded. (Increased and focused cancer spending on effective interventions with an accompanying reduction in spending on ineffective services, variations in PCT cancer spending will be monitored)
- The government will strive to improve the quality of cancer services available. (Training programmes for cancer workforce, funding made available for investing in cancer equipment, improved awareness of developments in cancer treatment, partnership working with the voluntary sector to ensure cancer remains a priority, the National Cancer Director will continue to provide leadership and annual reports on the delivery of the CRS).

(Cancer Reform Strategy, DH, 2007)



NHS Next Stage Review

A review of the delivery of patient care within the NHS is currently being undertaken, led by Lord Darzi with the aim of building on, and developing good practice. The focus of the review is eight areas of care which are used to represent the points in an individual's life when they may encounter health and social services. The eight clinical pathways are:

- Maternity and newborn
- Children's Health
- Staying healthy
- Long term conditions
- Acute care
- Planned care
- Mental health
- End of life care

Although none of these areas specifically focus upon cancer, it is clear that a number of them relate to the services that would be utilised by a cancer patient.

The interim report, which incorporated the views of clinicians, focused upon the eight clinical pathways listed above. Further to this it compiled four improvement areas that the NHS should be working towards and measuring success against. Two of these could be seen to have an impact upon health inequalities.

Providing care that is equally available to all, while taking account of personal circumstances and diversity

The report states "Someone's social status or where they live should not affect when they die." (DH, 2007, p.19) and recommends improving equity in the provision of GP services, in terms of area distribution, through increasing the range of potential service providers and increasing investment in order to introduce new GP services into the 25 per cent of PCTs with the least provision. Investment should also be made which allows the development GP-led health centres which can be accessed by the local community, whether or not they are registered at the centre. It also states that "we have to focus on improving health and social care services for people in disadvantaged and hard-to-reach groups and those living in deprived areas." (DH, 2007, p.21).

Providing personalised service provision that offers choice over location and time, especially for those in greatest need.

The report states that "designing and delivering services that fit with people's lives will help to reduce inequalities in health and social care outcomes." (Ibid, 2007, p.21).

The further two areas are:

Focusing on the delivery of services that are global leaders and provide quality outcomes for patients

The development of a 'Health Innovation Council' is recommended in order to encourage innovation in order to bring about the delivery care with improved efficiency.

Ensuring that services are provided in a way that is safe and enables public confidence in the NHS.

The Interim report calls for greater support for the National Patient Safety Agency so that it can develop an effective method for health care staff to report incidents. Further to this, a number of policy and programme developments are suggested including legislation that creates a health and social care regulator; giving more power to matrons and providing MRSA screening.

The interim report, as with the Cancer Reform Strategy, follows in the footsteps of earlier health policy by calling upon agencies to work together in order to meet the needs of local communities and address the wider determinants of health.

The second part of the review aims to address four issues which impact upon service delivery and organisational stability. These are:

- Ensuring that clinical decision-making is at the core of the NHS and service delivery
- Improving patient care for those with long term or life threatening conditions and ensuring they are treated with dignity in safe, clean environments
- Delivering services in the most appropriate location that are accessible, cost effective and convenient across primary and secondary providers
- Establishing a vision for the NHS focused upon a reduction in central direction and an increase in local accountability, responsiveness and patient control and choice.⁵



Comprehensive strategy to reduce health inequalities

The Secretary of State announced in 2007 that the department would be developing a comprehensive strategy with the aim of addressing the interlinked issues of "unjustified gaps in health status, fair access to NHS services for everyone and good outcomes of care for all." (Hansard, 29th October: Column 1027W). The strategy will be published in 2008.

History of health inequalities policy

Although it is beyond the scope of this report to discuss every policy related to broad health inequalities, it is appropriate to briefly focus upon some of the major documents that have shaped the political discourse in this area.

The Black Report

The Black Report⁶ (1980) was one of the first documents, authorised by the British government, to attempt to track health inequalities across Britain and make recommendations towards improving them. Although much of what was published and recommended was not implemented by the Government of the day, the impact of the report is evident in many of the subsequent policies relating to health inequalities.

The report recommended a set of wide ranging and interrelated policies, involving a spectrum of government departments, working collaboratively. These included 'upstream' policies (those which are likely to have a broad range of effects) in areas such as income distribution, education, transport and social networks. A set of 'downstream' policies, related more specifically to healthy behaviours, such as the provision of Nicotine Replacement Therapy on prescription, were also suggested.

Although cancer was not a specific focus of the report, it did show an awareness of the socioeconomic differences in mortality, lifestyle behaviours and uptake of cancer screening programmes.

Independent Inquiry into Inequalities in Health (Acheson Inquiry)

Commissioned by the incoming Government the Independent Inquiry into Inequalities in Health⁷ (Acheson Inquiry, 1998) was an attempt to detail the evidence related to inequalities in health, identify trends in inequalities and contribute to the agenda to reduce the problem. Similarly to other commentators in this area it was the view of those responsible for the Acheson Inquiry that a multi-layered, partnership approach would be required to address the issue of health inequalities. The inquiry made 40 recommendations that detailed an overarching programme which would require action to be taken not only within the health sector but also in areas such as education, tax, communities and employment.

The Inquiry found that those most at risk of experiencing negative health outcomes had the worst access to preventative care and that services were not distributed based on the needs of communities in particular areas (the "inverse care law"). The report stated that equitable access

to care based around need should be a key objective of any NHS policy; it also made 39 recommendations, covering a broad array of policy areas, aimed at reducing inequalities in health.

Wanless Report

The Wanless Report⁸ (2002) reviewed future trends in health in the UK and the resources that would be required to both narrow gaps in the performance of the NHS and implement the NHS Plan (2000). The report used three scenarios within which a high quality NHS was, theoretically, provided in the future (the year 2022). The table below illustrates each scenario and its impact upon health inequalities.

Scenario	Impact upon health inequalities
Scenario 1: Solid progress (increase in public engagement in health)	Socio-economic inequalities are reduced. This is achieved through health promotion programmes, targeted at deprived groups, in combination with other policies such as poverty reduction.
Scenario 2: Slow uptake (no change in public engagement in health)	Health inequalities remain unchanged
Scenario 3: Fully engaged (high levels of public engagement in health)	Public health improves as the public take ownership of their own health, matched with access to appropriate information. Reductions in socioeconomic inequalities are achieved through an increase in healthy behaviour

The Wanless report, as with the Black report, viewed health inequalities within the context of wider societal inequalities stating that "there is a strong correlation between health inequality and socio-economic inequality." (Wanless, 2002, p.46). Its two key themes were a reduction in overall deprivation and child poverty. The existence of the 'inverse care law' was also noted. The report suggested the need for resources to be channelled to improving this

situation and, concurrently, bring the UK in line with other developed nations.

The second Wanless report⁹ (2004) focused upon both improving the health of the whole population and reducing health inequalities. Within the report individuals were seen to be responsible for their own health and behaviours.

Themes within health inequalities policy

There are a number of key themes that run through current policy aimed at reducing health inequalities. This section of the report is based around these themes.

Target setting

There is a specific Public Service Agreement¹⁰ (PSA) focused upon addressing health inequalities and targets have been added to other PSAs in order to address issues related to living in deprivation (Department of Health, 2004). Within the Health Inequalities PSA the target is to reduce inequalities in health outcome by 10 per cent by 2010. Improvements in infant mortality and life expectancy at birth were decided upon as the measures for the PSA. Specifically, the PSA sought to reduce the gap in mortality between manual and non-manual groups by 10 per cent and reduce the gap between areas with the highest and lowest life expectancy by the same amount by 2010.

*Tackling Health Inequalities: A Programme for Action*¹¹ (2003) set out the strategy the Government would use in order to meet the PSA targets. The scope of the report was very broad, with the intention to improve the health of the bottom 30-40 per cent of the population fastest while overall improving the health of the whole population.

The programme was based around four themes:

- supporting families, mothers and children
- engagement of communities and individuals
- prevention and effective treatment
- addressing the underlying determinants of health

The report mirrored the views given within the 2002 *Cross-Cutting Review*¹² (discussed below) in calling for the mainstreaming of health inequalities, tailoring of specific interventions to meet area or group needs and partnership working between government and the private and voluntary sector at local and national level.

At the same time, systematic failures such as a lack of information and engrained social attitudes were seen to influence the health choices an individual made. Inequalities were viewed as “related to socio-economic and sometimes ethnic differences.” (Wanless, p.4, 2004). Echoing the Black Report, Wanless called for joint working to overcome the systematic failures contributing to poor health outcomes.

Partnership working

“Tackling the root causes of health inequality; employment, poverty, housing etc, is only possible when all organisations work together.”

(NHS Confederation, 2007, p.4)

The Government supports the view that, in order to successfully address the complex and interrelated causes of health inequalities, programmes will have to encompass a wide range of policy departments with various policy remits. The policies below are those which attempt to do just this.

The interrelated nature of both health inequalities and social exclusion¹³ has meant that a number of government departments have PSA targets^{14,15} relating to both. For example, Communities and Local Government (formerly the Office of the Deputy Prime Minister) focused upon social housing introducing the target to “bring all social housing into a decent condition with most of this improvement taking place in deprived areas.”¹⁶ by 2010. The Department of Work and Pensions PSA relate to higher employment rates and “the broader target of halving child poverty by 2010 and eradicating it by 2020”¹⁷. Both of these targets should, in the longer term, have an impact upon health inequalities.

Tackling Health Inequalities 2002 Cross-Cutting Review was the first time that a range of stakeholders including government ministers, local government officials and academics had been brought together to address “how better to match existing resources to health need and to develop a long-term strategy to narrow the health gap.” (DH, 2002, p.2). Along with partnership working the Review emphasised the need for health inequalities to be mainstreamed, rather than a policy add-on, in order to ensure sustainable change and effective policy development. Within the Review a long term strategy was developed to address health inequalities. This included:

- Working to break the cycle of health inequalities by focusing upon improving health in children from deprived communities
- Addressing the major killers through providing information and support and improving the skills of groups with traditionally poor health outcomes
- Improving access to public services among those with the greatest need and targeting programmes at vulnerable groups.
- Reducing area based inequalities through partnership working and community level interventions.
- Targeting services at particular vulnerable communities and groups while developing strategies to mainstream these services in the long term.

Local Strategic Partnerships (LSPs) were introduced in the *NHS Plan*¹⁸ (2000) and were an attempt to create a single body with the aim of establishing partnerships between different sections of the public, private and voluntary sectors involved in service provision. LSPs were designed to have the needs of the hardest to reach as their focus and could be set up in a way that best met the needs of the local community. Neighbourhood Renewal Funds were also introduced, to work in collaboration with the LSP, and were a grant made available to the most deprived local authorities in England (with the aim of reducing the gap between the most and least deprived areas).

The White Paper *Strong and prosperous communities*¹⁹ (2006) focused upon attempts to create more effective and accountable local government and increasing the involvement of communities and individuals in local services. It acknowledged that service users did not accept or expect the traditional 'one size fits all' approach to service provision. The white paper also called for mechanisms to be put in place which allowed both individuals and communities more choice and influence over local services. The White Paper also placed the responsibility of enabling multiple agencies to work together, in order to address issues such as community cohesion and health, with local government. In order to meet the needs of local communities the White Paper offered support to those areas experiencing problems with community cohesion.

The White Paper also introduced three year Local Area Agreements (LAAs) focused upon improving quality of life. This was to be achieved through a set of performance targets, tailored for each area, around national priorities such as social exclusion, health and climate change. Health inequalities were also made a mandatory indicator within LAAs from 2007. The key aims of these LAAs was to mainstream public health and health inequalities into local

community planning and allow for greater joint working between agencies. Local Strategic Partnerships were further utilised to bring about greater working between key commissioners, providers and other service stakeholders.

Finally, the *Local Government and Public Involvement in Health Act*²⁰ (2007) and the statutory guidance *Creating Strong, safe and prosperous communities*²¹ (2007) set out a duty on PCTs, in collaboration with local authorities, to undertake an assessment of the needs of their local population. The aim was that these would lead to joint working and shared commissioning priorities which would further reduce health inequalities and improve population outcomes.

New initiatives and investment

In 2004, the then Health Secretary John Reid created the 'Spearhead Group' made up of the 70 Local Authorities and 88 PCTs in England with the worst (the bottom fifth) health and deprivation indicators. The Spearhead Group would be the first to pilot new initiatives such as health trainers, healthier school meals and advanced stop smoking programmes. As with a lot of the policy focusing upon health inequalities, service providers in the Spearhead Group were encouraged to work in partnership with local authorities and the voluntary and private sector in order to encourage those from disadvantaged communities to utilise services.

Through the use of Spearhead PCTs, Health Action Zones and Healthy Living Centres, targeted prevention work and service provision has been taking place in the most deprived areas. Healthy Action Zones encourage partnership working between the NHS, local authorities, the private sector and voluntary organisations. This again illustrates the Government's desire for organisations to work jointly to tackle health inequalities. Healthy Living Centres came out of the *Saving Lives: Our Healthier Nation*²² (1999) White Paper and focus upon reducing health inequalities and meeting the health needs of specific communities. There are around 350 centres based in deprived areas. One example, the Chinese National Healthy Living Centre takes a holistic approach to health care and offers a broad range of services including bilingual support and guidance, English language classes, health seminars and counselling.

The Communities for Health (C4H) initiative aims to "identify and promote local projects that engage communities, especially hard-to-reach groups, in improving their own health." (DH: Health Inequalities Unit, 2005, p.22). One aim of the project was to enable the roll out of pilots and the testing of new ways of working.

There has also been an attempt to invest in cancer services in areas with the most need. For example around two-thirds of new linear accelerators were allocated to the north of England in an attempt to overcome regional inequity in access to such equipment. *The NHS Plan (2000)* also encouraged GPs to practice in deprived areas through

the use of Personal Medical Services (PMS) contracts, which rewarded health workers for tailoring their services to meet the needs of their local communities.

For discussion of the impact that these policies have had upon health inequalities please turn to section six of this report.

History of cancer policy relating to health inequalities

One in three people in the UK will have cancer during their lifetime, making it one of the most common diseases. The Department of Health has therefore set the disease as a key priority within their work; as illustrated by the following policy documents.

Saving Lives: Our Healthier Nation

After the Labour Government came to power, they produced the *Saving Lives: Our Healthier Nation (1999)* White Paper. This set out an overarching target to cut the cancer death rate by 20 per cent by 2010 among those under the age of 75. In terms of health inequalities the aim was to narrow the health gap between the highest and lowest socioeconomic groups, BME communities and the general population (by improving the health of those with the poorest outcomes). The paper also discussed developing a partnership between individuals, communities and government to improve health, with each partner having a particular role and responsibility in this regard.

The NHS Plan

Although not specifically focused upon cancer *The NHS Plan (2000)* placed cancer as a high priority. It also set out a commitment to tackling health inequalities through more effective prevention programmes and improved primary care for disadvantaged communities. Of its ten core principles two could be viewed as addressing health inequalities, these were:

- The NHS will respond to different needs of different populations.
- The NHS will help to keep people healthy and work to reduce health inequalities.

(NHS Plan, 2000)

The NHS Plan also recognised a shortfall in the communication skills of health professionals. New training was introduced and since 2002 a pre-condition of qualification has been competence in patient

communication. This was also made part of all health professionals ongoing career development programmes.

The NHS Cancer Plan: a plan for investment, a plan for reform

*The NHS Cancer Plan: a plan for investment, a plan for reform*²³ (2000) was the first comprehensive strategy (National Service Framework) focused upon national standards for cancer services in England. The Cancer Plan set out the Government's strategy for investing and reforming the NHS. High priority was given to improving the entire care pathway through improving cancer services in the areas of prevention, early detection, screening and providing access to high quality care nationally. Cancer networks were also formally established with the intention of bringing together all the organisations involved in the planning and delivery of cancer services. To improve patient access to information, the Cancer Plan also required NHS trusts and cancer networks to provide information of a high quality for all cancer patients; this included, information in different formats and languages where required.

As the quote below indicates the Cancer Plan showed an awareness of cancer inequalities within the UK and strongly indicated that it was the Government's intention to provide national cancer services of a high standard that would effectively address health inequalities.

The poor are still far more likely to get cancer than the rich, and their chances of survival are lower too. Furthermore there are too many variations in the quality of care and treatment across the country, leaving cancer patients frustrated by a postcode lottery.
(Taken from NHS Cancer Plan, 2000, p.3)

Health inequalities were one of the four overarching aims of the Cancer Plan. It created national and local commitments to improve outcomes in areas such as smoking rates, waiting times, cancer services (including staffing levels and facilities), palliative care and research. The targets set out in the Cancer Plan run to 2010 and currently this policy is being updated with the development of the Cancer Reform Strategy; this will set the cancer

agenda up to 2012 and beyond. It is also one of the first strategies from the Department of Health that will be assessed against the new equality duty which covers discrimination in service provision in terms of religion, sexual orientation, age and gender. Cancer Research UK is currently closely involved in taking forward the initiatives described in the Cancer Reform Strategy.

Department of Health Equality Impact Assessments have also been developed. These enable a process by which service providers can understand how a service or policy is likely to affect the various groups and communities covered by equality legislation. The assessments allow for the gathering of information, through the use of a number of processes such as consultation, which could result in services being altered to better fit with legislation.

To address low uptake of screening among disadvantaged groups the Cancer Plan, through Health Improvement Programmes²⁴, encouraged Primary Care Groups to review and improve access to screening services among groups with traditionally low uptake.

The Cancer Plan addressed inequalities in palliative care provision by committing an extra £50 million to services. Over half of this money has so far gone to the voluntary sector, with the remainder funding additional specialist consultants, nurses and care beds. Palliative care was also addressed through guidance from NICE and the End of Life Care Programme, launched in 2005 as part of the policy *Building on the Best: choice, responsiveness and equity in the NHS* (2003). The aim of the programme was to tackle health inequalities by encouraging improved working between Strategic Health Authorities and PCTs and providing training for staff within palliative services.

NHS Improvement Plan²⁵

This policy set out a number of initiatives within the NHS. The most radical of which that patients would be able to choose between a number of different providers when receiving their hospital care. The final aim is that by 2008 patients will be able to choose from any healthcare provider that meets specific criteria. In order for patients to make real choices about their healthcare, and receive services that would meet their personal needs, the Improvement Plan also committed the NHS to providing high quality information and support to all patients. Further to this, patients with long-term conditions would be given access to personalised support and individually tailored care. It was believed that creating services in this way would allow for the targeting of services; within the Improvement Plan this was viewed as an effective way of reducing health inequalities.

The Improvement Plan also re-committed the Government to meeting the target of reducing cancer mortality by 20 per cent from 1997 to 2010 (initially set out in the *Saving Lives: Our healthier nation* White Paper, 1999).

Spending Review

The 2004 Spending Review²⁶ also set a target for the reduction of inequalities within cancer. The aim was to reduce the gap between areas in the bottom fifth, in terms of health and deprivation indicators, and the rest of the population by at least six per cent. As well as reducing cancer mortality rates by 20 percent in people below the age of 75 by 2010.

Living with Cancer initiative

Another step to reduce inequalities in cancer services was introduced through the UK-wide Living with Cancer initiative²⁷. Funded by £150 million from the National Lottery this programme was set up to target funding at areas with high cancer incidence and mortality and poor access to cancer services. Particular attention was to be paid to services providing information, support and home care, prevention, detection and treatment. At present over half of the projects involved in the Living with Cancer initiative have developed a variety of services for BME communities, with the aim of increasing awareness of cancer among individuals from such communities.

Cancer Policy in the Devolved Nations

In Scotland the cancer strategy *Cancer in Scotland: Action for Change*²⁸ (2001) set out action to prevent, detect and improve cancer treatment. Following this, *Cancer in Scotland: Sustaining Change*²⁹ (2005) reviewed the progress made in these areas and identified the steps that would need to be taken to bring about improved services. In 2007 the Scottish Health Minister announced that the plan was to be updated. The *Better Health, Better Care: Action Plan*³⁰ (2008) detailed the creation of a Minister for Public Health, as well as the expansion of the health portfolio to work across determinants of health such as social inclusion, poverty and housing. Again this illustrates the need for policy to address such issues in order to have an impact on health inequalities.

In Wales the national plan *Improving Health in Wales*³¹ (2001) identified cancer as a key priority. The National Cancer Standards (2005) encompassed the organisation of cancer services and the services that cancer patients should expect. Related to health inequalities, the formal policy statement *Designed to Tackle Cancer in Wales*³² (2006) set out the target of "improving cancer mortality in all groups and at the same time aim for a more rapid improvement in the most deprived groups." (Welsh Assembly, 2006, p.3).

Northern Ireland set out their cancer plan in *A Healthier Future*³³ (2004) which set out a broad range of population health outcomes related to cancer for a 20 year period up to 2025. Cancer Research UK has called upon both Wales and Northern Ireland to keep cancer central to their political agendas by developing and introducing national cancer plans.

Lifestyle Policy and health inequalities

A number of lifestyle behaviours have been focused upon in government policy because of their link to increased risk of cancer, and other diseases. Evidence suggests that a higher proportion of those in poorer communities undertake such behaviours. Because of this, much of the policy in this area has involved the targeting of services in order to reduce health inequalities.

Smoking

The *NHS Cancer Plan (2000)* and the *NHS Plan (2000)* both set out targets to reduce the rates of lifestyle behaviours known to be related to an increased risk of cancer. The *NHS Cancer Plan* set out national targets in the area of smoking stating that “we shall reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010, so that we can narrow the gap between manual and non-manual groups.” (NHS, 2000, p.25). This shows not only a commitment to reducing smoking rates, but also to reducing health inequalities. The *Smoking Kills White Paper (1998)* also set out a programme of action with the aim of reducing the number of smokers by 1.5 million by 2010 through initiatives including cessation services, health promotion campaigns and other tobacco control policies, such as price.

Diet and obesity

The Government recently published a strategy with the overarching aim of reversing the rising rates of obesity.³⁴ The strategy pledged a further £372 million between 2008-11 and focused upon five key policy areas:

- Children, healthy growth and weight (giving parents the information they need to encourage their children to eat healthily and exercise regularly as well as investing in schools to enable them to support parents)
- Promoting healthier food choices (providing individuals with the information they need to make healthy food choices and involving a range of stakeholders in healthy food information provision)
- Building physical activity into our lives (encouraging greater physical activity by providing information about its benefits and environments where it can take place)
- Creating incentives for better health (promotion of good health at work agenda with employers and staff)
- Personalised advice and support (provision of tailored information relating to an individual's diet, physical activity and health in order to enable healthy lifestyle choices).

The *NHS Plan (2000)* introduced policies to improve the diet of the population. The first of these, the ‘five-a-day’ programme, focused upon increasing access to fruit and vegetables (particularly among children). This was backed up by the introduction of the National School Fruit Scheme.

July 2004 saw the introduction of a Public Service Agreement focused specifically upon obesity, with the aim of halting the increase in obesity among children under the age of 11. Responsibility for this lay within a partnership between the Department of Health, Department for Education and Skills and the Department for Culture, Media and Sport.

To help low income families, on certain benefits, the Healthy Start initiative introduced vouchers that could be exchanged for healthy food, such as fruit and vegetables. The initiative also provides health information about diet, infant feeding and broader health issues.

Other areas that have been addressed through policy, partly because of their link to increased risk of developing cancer, include:

- Physical activity (including encouraging more exercise in schools and deprived areas)
- Alcohol (including the *Safe, Sensible Social- Next Steps in the National Alcohol Strategy*³⁵ (2007) which outlines progress made in, and national and local initiatives, reducing the health and crime related harm caused by alcohol consumption)
- Sunlight
- Radon

Running concurrently to these policies, programmes to increase awareness of cancer risks and healthy behaviours were introduced. The *Choosing Health: Making healthy choices easier*³⁶ (2004) White Paper set out how the Government would provide the support and information that individuals require to choose a healthy lifestyle. The report acknowledged that it was easier for some individuals to lead a healthy life and committed the Government to working to personalise services to fit with the realities of people's lives, particularly those in disadvantaged areas. The paper again discussed the need for partnership working in order to meet the needs of the population.

Has policy reduced health inequalities?

There are a number of reasons why it is difficult to measure the impact that policies have upon health inequalities. Firstly, it is difficult to categorically state that a particular policy brought about a specific reduction in health inequality, or improvements in the health of a particular community. Secondly, some policies unrelated to health will have unforeseen impacts upon health inequalities. For example policies to redistribute wealth may go some way to reducing health inequalities. The questions are by how much and in what ways? Finally, changes in health outcomes may not happen instantly and therefore the impact of a particular policy can only be fully understood through longitudinal analysis.

Health inequality is relatively new to the political agenda and, at first, it was often the case that policies introduced piece-meal projects or initiatives with a single goal. As our understanding of health inequalities has improved, so too has the policy around it; with the result that more work is being carried out in a systematic way across government departments, and in partnership with other stakeholders. University College London undertook a study to find out the impact of the Acheson Inquiry on health inequalities policy. They concluded that although a lot of activity had occurred, and that most of the recommendations set out in the inquiry had been addressed, there was still a need to develop assessments that could better judge the impact of policy on health inequalities (Exworthy et al, 2003³⁷). Doing this would further enable the government to develop the most effective initiatives, and tailor policies, to specifically reduce health inequalities.

More people in the UK are living longer and healthier lives and the UK is on target to reach the goal, set out in *Saving Lives: Our Healthier Nation*, of reducing cancer deaths by 20 per cent among those under the age of 75 by 2010 (NHS, 2004). Currently cancer death rates have been reduced by around 10 per cent (DH, 2004). At the same time, there is some evidence that the social gradient to health (the health gap between those at the top and bottom of the socio-economic scale) is actually increasing. For example within the Spearhead areas life expectancy is increasing more slowly than in other areas of the UK population. This has created a situation within which, although life expectancy in all areas is increasing, the gap in life expectancy between the richest and most deprived areas is getting wider and therefore inequalities are increasing. The NHS Confederation found that between 2001 to 2004 there had been a slight narrowing in the gap for male life expectancy, but a widening of the gap relating to female life expectancy.³⁸ Further to this, it was predicted in 2006 that only 19 per cent of PCTs within the Spearhead Group would meet the 2010 Life Expectancy target (DH, 2006).

There are also well documented, and continuing, cancer inequalities between the general population and specific groups. These include later stage diagnosis and consequent higher mortality in deprived areas and wide geographical differences in mortality. This issue is discussed in greater detail in the accompanying report *Cancer Inequalities: Current health inequalities relating to cancer within the UK*.

The Department of Health, using evidence up to 2003, indicated that health inequalities had continued to widen in the areas of life expectancy and child mortality following the introduction of a number of new initiatives. This illustrates the long-term approach that is required to tackle the problem. For example although a reduction in child poverty was achieved, this is unlikely to have an effect upon health inequalities for a number of years. The NHS Confederation, in their first report focused upon health inequalities, stated that “despite substantial investment, key measures [relating to health inequalities] are still widening.” (NHS Confederation, 2007, p.3).

Lifestyle changes also affect the occurrence of different diseases at differing rates. For example, smoking cessation has been found to reduce the incidence of heart disease more rapidly than that of cancer (DH, 2005).

A report detailing the provision of cancer services by the House of Commons Committee of Public Accounts³⁹ (2005), found that the “regional distribution of hospice and palliative care bears no relationship to need or population levels” (HCCPA, 2005, p.4). A second report by the HCCPA⁴⁰ (2006) also found geographical disparities between cancer outcomes and mortality and the use of NICE approved cancer drugs. This indicates that there is still some way to go in terms of addressing the ‘inverse care law’ and area/regional inequality in the provision of cancer services.

At present the National Cancer Registration System (NCRS) does not, nationally, gather information based around BME status; although there is a recommendation in the Cancer Reform Strategy that this be introduced. This means that, at present, there are gaps in our knowledge in terms of any differences in cancer incidence and mortality between different ethnic groups with the UK population, although studies covering smaller areas do indicate that different BME communities experience differing rates of cancer compared to the general population. Improving cancer data collection would enable a better understanding of health inequalities and could be used as part of the evidence base for new policies and initiatives.

The higher rates of smoking and other negative lifestyle practices among deprived communities and some BME groups is also causing health inequalities to continue. It appears that those from lower socio-economic communities are taking up smoking at higher rates and stopping smoking at lower rates, compared to their wealthier counterparts. This is causing the cancer burden created by smoking to become more concentrated in the former communities.

Conclusion: Key policy themes

This introduction to government policy related to health inequalities illustrates the large amount of work that has been developed with the aim of a) reducing health inequalities and b) improving cancer services for the whole population. The effects of these policies should, on the whole, be viewed positively although there are still many challenges ahead. The following themes are those which appear to run through the majority of the policy:

- The need to set targets which can effectively measure the impact that policies are having upon health inequalities.
- The tailoring and targeting of programmes to the needs of specific communities is a positive step and is necessary in order to reduce the number of people in deprived or hard to reach groups who engage in risky behaviours or who do not access health services.
- All stakeholders (public, private and voluntary) have a role to play in reducing health inequalities. Only by working in collaboration will the UK be successful in ensuring that each individual is able to fulfil their potential and take advantage of the opportunities for good health and prosperity around them.
- In some areas it is necessary to develop our understanding of the factors which create health inequalities in order to develop policy which effectively addresses such issues. Research should therefore be undertaken which develops the evidence base relating to inequalities in cancer.

The policies discussed above do illustrate a genuine governmental commitment to reducing health inequalities. At the same time the evidence suggests that there is currently slow progress in this area and that more work is needed if a substantial, and ongoing, reduction in health inequalities is going to be achieved.

Further to this a number of actions need to be undertaken in order to reduce inequalities within cancer. These are:

- Equalising the uptake of cancer screening services between groups with high rates (generally the most affluent) and communities and groups with traditionally low uptake of screening services. This could be achieved through targeted information and support, improving the accessibility of screening services and the communication skills of health care providers who can influence an individual's decision to participate in screening.
- A reduction in the social and demographic gradient of lifestyle behaviours with negative health outcomes, such as smoking and poor diet (that leads to obesity and overweight).
- Ensuring that information and support within cancer services are provided in an appropriate manner to meet the needs of harder to reach communities and groups.
- The underlying causes of health inequalities often relate to income inequality. Therefore the introduction of policies which aim to redistribute financial capital, and reduce poverty rates within the UK population, would be likely to have an impact upon health inequalities.
- The collection of sociodemographic and socioeconomic information within cancer services at a national level; specifically BME status. This would enable the mapping of cancer inequalities and the development of programmes to address them.

What is Cancer Research UK currently doing to reduce health inequalities?

As the largest charity in the UK, Cancer Research UK has a role to play in contributing to the health inequalities policy agenda, especially when such policies are likely to impact upon cancer incidence and outcome. The following section details the work the charity is undertaking in this regard and what our aims are for the coming years.

Our health inequalities goals

In 2007 Cancer Research UK launched ten goals to measure our success in beating cancer over the years up to 2020. A number of these relate to or will have an impact upon health inequalities and the work that Cancer Research UK will be undertaking in this area. Our commitment to achieving these goals means that the charity will work hard to keep cancer related inequalities on the policy agenda. Although these goals are specifically influencing the work of the charity, we have shared them with the wider cancer community and will work collaboratively to achieve them.

The goals with particular relevance to cancer and health inequalities are:

We will especially tackle cancer in low-income communities

The differences in the risk of dying from cancer between the most affluent and the least affluent will be reduced by half.

People will know how to reduce their risk of cancer

Our goal is that three-quarters of the UK public will be aware of the main lifestyle choices they can make to reduce their risk of getting cancer.

The number of smokers will fall dramatically

Four million fewer adults will be smokers, preventing thousands of new cases of cancer every year.

People with cancer will get the information they need

At least nine out of ten patients will be able to access the information they need at the time of diagnosis and during treatment.

Cancer will be diagnosed earlier

Two-thirds of all cancer cases will be diagnosed at a stage when the cancer can be successfully treated.

Our work so far

Increasing uptake of health services

As well as providing information about cancer to groups with traditionally low uptake of health services, Cancer Research UK is carrying out a campaign to increase the number of people accepting an offer to attend cancer screening. For more information go to: <http://info.cancerresearchuk.org/cancercampaigns/>

Information provision and awareness-raising

We aim to increase people's knowledge of cancer through a number of methods including our website CancerHelp (www.cancerhelp.org.uk).

We have a contract with Language Line (which provides a translation service) to ensure that those, who are more comfortable communicating in a language other than English, are able to take advantage of the information and support we provide. Our free-phone number is accessible free of charge to landlines and most mobile phones (unlike traditional 0800 numbers). Deaf, and hard of hearing, individuals can either use type talk operators or minicom when they require our cancer information.

We also have guidelines relating to the provision of information by email to ensure that, when using this format, our health information is free from medical jargon and written (and formatted) in an easy to understand manner. Publicity materials, for our information services, are available via our shops. Providing information in these ways ensures that we reach a diverse demographic with differing needs for information and support.

The anonymous nature of accessing health information by telephone or email means that those who would not normally access face-to-face information are more likely to contact us for assistance. Because individuals can also access our information from their own homes those with mobility issues are able to contact us more easily than traditional health services.

Cancer Research UK's 'Open Up to Mouth Cancer' Campaign worked specifically in the North of England and Tower Hamlets to increase knowledge of mouth cancer among communities with both unmet need and increased risk factors associated with mouth cancer. We are currently looking at ways of increasing the areas this project covers.

As part of our cancer risk reduction work Cancer Research UK introduced cancer awareness units, which specifically aim to travel to areas with high proportions of the population from C2, D, E socioeconomic groups, the units have also been found to be popular among men. Offering advice about the avoidable risks of cancer and the importance of taking part in the screening programmes in this way enables us to offer information and support to communities and individuals who may not be accessing more traditional health services.

All our health information resources and campaigns aim to preferentially target C2, D, E socioeconomic groups, who tend to have lower levels of health awareness combined with higher cancer incidence and mortality. Our Open up to Mouth Cancer, SunSmart and Smoke is Poison campaigns (as well as the majority of our websites and cancer awareness leaflets) were all written using accessible English. We will continue to work in this way in order to ensure that our services can be accessed by the largest percentage of the UK population possible.

Cancer Research UK has funded a research project which created the PROCEED (Professionals Responding to Cancer in Ethnic Diversity)⁴¹ training programme. The resource is a multimedia training tool to be used by those working to develop the communication skills of health professionals so that they are able to respond to the needs of diverse patient populations. By working closely with a variety of health professionals the resource fits with the training needs of those providing services.

In the last year we have made our resources available free of charge to ensure our messages reach the people with the greatest need for information about cancer prevention and early detection.

Working in partnership

The complex nature of health inequalities means that in order to tackle the problem a multi-sector, multi-agency approach is required. Cancer Research UK is taking the opportunities available to the charity to work in partnership and influence government policy. Working in this way also ensures that there is less replication of service provision and will enable good practices to be developed across all agencies. Presently we are involved in a strategic partnership with the newly merged Cancerbackup and Macmillan to develop information prescriptions (this will enable greater individualisation of information which could go some way to meeting the needs, information and support needs of diverse populations). We are also working with a wide range of health and social care organisations to provide policymakers with information about how best to tackle health inequalities.

Encouraging healthy lifestyles

Currently a higher percentage of people from lower socio-economic communities, and some BME communities, are tobacco users. Part of our work has been to lobby the Government to introduce comprehensive smoke-free legislation in public places which is now in place in England, Scotland, Wales and Northern Ireland.

We run mass media anti-smoking advertising campaigns with funding from the Department of Health to raise awareness of the dangers of smoking. Most recently, we have worked to raise awareness of the toxic content of cigarette smoke. We are currently working with Channel 4 to encourage young people to share their ideas with us about smoking and how to encourage other young people not to smoke. This will involve the production of six viral films for use on social networking sites such as Myspace and Youtube. Evidence also suggests high smoking rates among the gay, lesbian, bisexual and transgender communities. In order to raise awareness of the cancer risks related to smoking we have worked in partnership with Gaydar radio to disseminate a positive message about the smoke-free legislation. As with our other campaign work, we are using tailored information and new media techniques to reach our target audience.

We are also committed to supporting research and clinical trials testing the success of cessation methods and programmes.

Supporting research and new initiatives

At present there are gaps in our knowledge in terms of the causes of health inequalities, as well as effective methods of addressing them. Cancer Research UK aims to enable research in these areas and use this to influence government programmes. One particular area of interest is in understanding which methods are most effective in improving health among the least affluent. The setting up of the Cancer Research UK Cancer Inequalities Group allows us to combine our knowledge in related issues to more effectively contribute to the development of policy.

We fund and commission an array of research, as well as being involved in other work related to reducing health inequalities. Recent projects include:

- Michel Coleman and his team undertaking research to better understand why people living in deprivation have lower cancer survival rates than the general population. They are using a variety of analytical methods and sources of information, including exploring the views of patients, carers and health professionals regarding the route to cancer diagnosis.

- A previous study by Michel Coleman sought to understand socio-economic inequalities in cancer survival through analysis of MRC clinical trial populations.
- Neil Campbell and his team are running a programme to explore the potential for primary care to tackle cancer inequalities in colorectal cancer patients and their quality of life and survival rates.
- An earlier project by Neil Campbell aimed to a) assess whether inequalities in cancer survival, between rural and deprived communities and the general population could be explained by later presentation at health services by the former b) what patient factors are associated with such a delay and if these factors influence GP behaviour.
- Anne Taylor's work is an exploration of the needs of patients with cancers of the head and neck, with particular focus on the outcomes and experiences of those from deprived communities. Interviews with patients, carers and health professionals are being used to explore the route to diagnosis and awareness, among professionals, of cancer care referral guidelines.
- The Veronica Project, led by Sheila Hollins is seeking to understand the experiences of those with learning disabilities who have cancer. The project involves interviews with individuals from this cohort and seeks to detail the barriers to cancer and palliative care services, and produce policy guidance to improve access to these services for those with learning disabilities.
- Funding Action on Smoking and Health (ASH). ASH is a campaigning public health charity working towards a sharp reduction, and eventual elimination, of the health problems and inequalities caused by tobacco.
- Contributing to the Prostate Cancer Advisory Group pilot study which seeks to raise awareness of the disease among men over 50, with particular focus on groups with increased risk (such as men of African origin). A further intention of the pilot is to raise awareness amongst groups experiencing health inequalities and reduce the gap between areas with the best and worst disease outcomes.
- Cancer Research UK has funded Warwick Medical School to look at ways of improving the collection of cancer statistics based around BME status. Currently data is not routinely collected linking BME status to cancer incidence and this project aims to gather evidence, identify best practice and produce clear recommendations in order to improve data collection of this nature.
- Cancer Research UK funded a research project which created the PROCEED training tool for health professionals (see above for further information).
- In 2004 Cancer Research UK hosted the conference 'Equality in Cancer Prevention' in order to explore some of the challenges in the provision of cancer prevention to diverse communities (A full report of the conference is available).⁴²

We also frequently carry out qualitative research with our C2, D, E target audiences to ensure that our resources and campaign activities are appropriately targeted and address their needs.

Lobbying government

As this report illustrates, a lot of policy has been developed with the intention of tackling health inequalities. Cancer Research UK continues to play an active role in lobbying UK governments and the EU to introduce policies which address health inequalities as they relate to cancer:

Cancer Research UK will also be closely involved in the work outlined in the Cancer Reform Strategy (the current five year strategy for cancer in England which was published in 2007). This includes the National Awareness and Early Detection Initiative and the National Cancer Equality Initiative.

Our work in all of these areas, and contributing to the wider debate surrounding health inequalities will enable us to achieve our aim 'Together we will beat cancer'.

Annex I: References

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- ² Department of Health (2000) *The NHS Cancer Plan: a plan for investment, a plan for reform* London: Department of Health
- ³ The NHS Confederation also calls for “significant investment nationally and locally in sophisticated data and disease mapping to enable a better understanding of who and where the missing people are.” (NHS Confederation, 2007, p.). The term ‘missing people’ refers to those within the population who are not accessing health services when they need them.
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- ²⁴ Health Improvement Programmes (HIP) were strategies developed by each Health Authority to deliver national targets on health. These programmes were another way of encouraging partnership working as they required the Health Authority to consult with a range of stakeholders including the NHS, PCTs, the public and doctors.
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