CancerWatch

CancerWatch Sector Review

Discussion paper
June 2023

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About this project, and CancerWatch

i. CancerWatch is an organisation made up of people whose lives have been affected by cancer, who are passionate about eliminating preventable cancers in the future. We were founded by Jill Clark, whose husband died suddenly at the age of 46 from oesophageal cancer, leaving her with two small children. She has campaigned tirelessly since then for more research and earlier diagnosis for cancer, but above all to prevent cancer happening in the first place. We are working towards registration as a charity in England and Wales in 2023.

ii. This discussion paper accompanies a call for evidence about the current state of play on cancer prevention. We want to hear from charities and other organisations about how they feel the current policy framework is delivering, what more might be done, and what the priorities for future change should be. We will present our findings in a report in the autumn of 2023.

iii. With this project, we hope to generate insight that will be of use to the voluntary sector and other organisations that work on cancer prevention and public health. We will also use the findings in our own policy development, and in our strategic planning as we develop our organisation. We hope this will be an opportunity for dialogue with the wider sector, and to identify where CancerWatch can add value and make a difference in future efforts to improve cancer prevention.

CancerWatch

The need for improved prevention

i. CancerWatch exists to campaign for more and better action to prevent cancer. This isn't a contentious aim: there is no serious argument for better cancer prevention being anything other than a desirable thing. Yet the UK is nowhere near to doing all it could on cancer prevention.

ii. The importance of prevention is so generally recognised that it risks being a platitude. It is worth remembering why improvements in this area are so desirable. The figure of around 40% of cancer cases being preventable is well established and widely cited.[1] The biggest causes are lifestyle factors: smoking tobacco; diet, in relation to obesity, processed and red meat, and insufficient fibre; and drinking alcohol. The most preventable cancers are of the lung, bowel, skin (melanoma), breast, oesophagus, bladder, kidney, stomach and pancreas.

iii. All of this implies a very considerable prize, in terms of years of life, years of healthy life, economic productivity, and reduced pressure on public services, if prevention can be improved; and a very considerable penalty if it is not.

iv. This paper outlines our view of cancer prevention, and what the future could hold for it. We are an organisation in our formative stages, so this view is a tentative one, and we want to hear how it compares to what other organisations think. In particular, we want to explore how the cancer charity sector can contribute to improving prevention, and the role we will be able to play as a charity dedicated to campaigning on this issue.

Individual responsibility or structural change?

i. It appears that progress on cancer prevention is stalling. In some respects, the progress we have made has been remarkable, most notably in terms of smoking reduction. Over the first couple of decades of the current century, smoking prevalence almost halved, from 27% to 16%, and this continued a long trend of reduction.[2] However, it may be that we have achieved most of the easy wins: we cannot repeat major falls in smoking rates, and the remaining level of smoking is closely associated with entrenched socio-economic inequalities. Achieving change in respect of other lifestyle factors – food and alcohol – is likely to be considerably harder.

ii. The policy response in recent years has focused on individual choices, and not on structural change. While individual responsibility must be part of

[1] https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers

[2] https://reader.health.org.uk/addressing-leading-risk-factors/trends-in-smoking-diet-physical-activity-and-alcohol-use#smoking

the mix, it will only be a successful approach for those who are well placed to incorporate healthy choices into their lives: the modest decline in people categorised as overweight since the 1990s, while numbers of obese people have increased, may suggest that those who readily can make healthy choices such as eating a balanced diet and exercising regularly are to a large extent doing so, while those who cannot are faring worse and worse.[3]

iii. Structural change is an altogether harder policy avenue to pursue. It means changing legal and regulatory frameworks to restrict what products may be sold, and how; it means incentivising changes to commercial practices, such as the reformulation of food and drink products; it means re-shaping supply chains; and it means shaping personal behaviour at scale, through incentives or even prohibitions. It requires decision-makers to face up to vested interests, and possibly to expend political capital in enduring a backlash from an affected group.

iv. Examples of these approaches can nonetheless be found in policy over recent decades: the marketing, display and packaging of tobacco products have been progressively restricted; restrictions on how supermarkets promote unhealthy food items are arriving in autumn 2023 (albeit after much delay); the Soft Drinks Industry Levy prompted the reformulation of many products; and of course smoking was banned in workplaces and indoor public spaces in 2006 and 2007 (Scotland being the first of the home nations to introduce a ban, and England the last).

Cancer prevention policy

i. Cancer prevention policy at the UK level of government (albeit largely affecting only England in respect of numerous policy areas) currently lacks focus, partly as a result of the political turbulence of 2022, with considerable turnover of ministers and much chopping and changing of plans. The 10 Year Cancer Plan proposed by Sajid Javid when he was Secretary of State for Health and Social Care will not now be published. His successor Steve Barclay has opted instead to roll it into a single Major Conditions Strategy.

ii. While the consultation on the Javid plan had prevention as the first of its six priorities, it viewed it purely as a matter of personal responsibility, and made no suggestion at all of any structural change:

> *Prevention – while innovation and new technology can help identify those of us who are at more risk of cancer for genetic reasons, we can all do*

[3] https://researchbriefings.files.parliament.uk/documents/CBP-9049/CBP-9049.pdf

more to reduce our risk of getting cancer through making healthier choices:

- *taking exercise*
- *watching what we eat and how much alcohol we consume*
- *stopping smoking.*[4]

iii. What little we currently know about the proposed approach of the Major Conditions Strategy comes from Steve Barclay's written parliamentary statement, which made no direct reference to prevention, although it did speak of, "shifting our model towards preserving good health."[5]

iv. This apparent drift towards reliance on personal responsibility and rejection of structural change is not a new pattern in UK government, however.

v. In respect of diet, government policy has focused on approaches that rely on people's ability to engage with information and advice since at least the 1990s; structural or regulatory approaches have seldom been used.[6] Recently this has been seen in the 2020 obesity strategy, with its 'Better Health' information campaign and NHS weight loss app.

vi. In respect of alcohol, the Government had announced plans in 2012 for a range of interventions, including minimum unit pricing, restrictions on promotion in shops and new duties to consider public health in alcohol licensing decisions, but then quickly scrapped them all. No strategy on alcohol harm has been published in England since, and the scrapping of the duty escalator that was in place from 2008 to 2014 caused the price of alcohol to resume its previous trend of increasing affordability: it is now 72% more affordable than it was in 1987.[7] In Scotland, Wales, Ireland and imminently Northern Ireland, minimum unit pricing has been introduced; England is a laggard in this respect.[8]

vii. In respect of tobacco, the Government has largely declined to adopt the strong measures for structural change recommended by the Khan Review.

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[4] https://www.gov.uk/government/consultations/10-year-cancer-plan-call-for-evidence/10-year-cancer-plan-call-for-evidence

[5] https://questions-statements.parliament.uk/written-statements/detail/2023-01-24/hcws514

[6] https://reader.health.org.uk/addressing-leading-risk-factors/addressing-the-leading-risk-factors-for-ill-health-in-england-review-of-the-uk-government-s-policy-p#policy-to-improve-diet-and-address-obesity

[7] https://www.ias.org.uk/factsheet/price/

[8] https://reader.health.org.uk/addressing-leading-risk-factors/addressing-the-leading-risk-factors-for-ill-health-in-england-review-of-the-uk-government-s-policy-p#policy-to-address-harmful-alcohol-use

Instead, it has continued its focus on approaches based around personal responsibility, with an emphasis on stronger messaging and smoking cessation (although even here its spending commitments fall short of Khan's recommendations, made in the context of smoking cessation services having already had their funding cut considerably[9]).

viii. It is possible that there could be a change of government in Whitehall in 2024. If this happens, the new administration will be formed largely or wholly by the Labour Party. Labour's approach currently seems hard to read: it is being careful not to leave itself open to attacks about 'nanny state' policies or similar, but it is unclear whether this indicates its likely approach once in office, or merely a cautious electoral strategy.

ix. It therefore currently blows somewhat hot and cold on structural approaches that would improve cancer prevention, and public health generally. It has supported the Soft Drinks Industry Levy and attacked the Truss administration over rumoured plans to scrap it. But it also agreed with the same government that cost of living pressures warranted delaying restrictions on 'buy one get one free' deals on junk food.

x. Labour is clearly comfortable when talking about public services. Perhaps as a result, its view of 'prevention' at times seems to be narrowly defined in terms of early care interventions. Wes Streeting, Shadow Secretary of State for Health and Social Care, wrote in a column for The Guardian:

> *"The truth is that we spend far too much money in our hospitals because we don't focus enough on prevention, early intervention and social care. As a result, patients end up in A&E because they can't get a GP appointment, reach crisis point because they can't get mental health support, or are trapped in hospital because there is no social care available."*[10]

xi. Labour's recent Policy Forum consultation paper in places took a broader view, however:

> *"Britain needs to be a far healthier society, with an approach to public health based on the fundamental principle of prevention. We need to turn the tide on rising health inequalities and improve health for everyone by tackling problems at source, and considering health not just as a*

[9] https://ash.org.uk/uploads/2019-LA-Survey-Report.pdf

[10] https://www.theguardian.com/commentisfree/2022/dec/08/people-in-pain-private-hospitals-nhs

standalone policy issue but one that is embedded in, and impacted by, everything that government does."[11]

Identifying priorities

i. Even assuming a more favourable policy approach from government in future, prioritisation will always be necessary. There is only so much time available in Parliament for legislation, and only so much capacity in government departments and agencies for developing and delivering new policies. The scale of policy change needed to improve cancer prevention is considerable, and while time is of the essence, realistically it can't all happen at once.

ii. That being the case, what should the priorities for change be? And, before we can even answer that question, how should they be decided?

iii. Would it be best to focus on the things that will be hardest, and take the longest time, to achieve? The later we leave it to start, the longer we will continue living with the problems they are meant to address. Then again, can prioritisation be readily justified for something that won't show results soon over something that will? Would it be better to start with the relatively quick and easy wins?

iv. The question can be approached another way: what benefits should be prioritised? Should there be a focus on outright gains in terms of years of life, or of healthy years of life? And if the latter, measured how – a QALY-based approach, or something else? Or should health inequalities be tackled first: this might mean rooting out the worst and least defensible inequities in society, but wouldn't automatically translate to the biggest aggregate gains.

v. Another dimension to consider is the type of intervention. Prohibitions can be relatively straightforward to legislate for, but by definition they impinge most heavily on personal freedoms: the Khan Review's proposal of a rolling ban on tobacco purchase by age would be an example of this. Many possible interventions could similarly face objections on grounds of personal liberties: restrictions on smoking in social housing, for example, might have a strong effect in social groups where smoking is a stubborn problem, but would also impinge on the rights of those people in a way that other groups in society do not experience.

vi. Commercial regulation would often avoid concerns about personal freedom, but might attract strong opposition from powerful and well

[11] https://www.policyforum.labour.org.uk/commissions/securing-first-class-public-services-for-all

resourced lobby groups. Measures such as tighter licensing of tobacco sales, to reduce the number of outlets that sell tobacco products, or fiscal measures to prompt product re-formulation, could be politically harder to implement.

vii. In turn, this raises the question of whether changes that might be identified as policy priorities will also make sense as campaigning priorities, or whether the two might sometimes be different. These are dilemmas that campaigning charities wrestle with regularly, and they apply equally here. Should charities straightforwardly campaign for what their members and supporters value most, or incorporate other perspectives into their prioritisation? Should they prioritise feasible wins, that can be achieved with the resources to hand, or more ambitious aims that are less certain to yield results? For a charity that works on a specific type of cancer, how should it prioritise interventions that would bring wide aggregate benefits across many cancers versus something that would make a big difference for that cancer but less impact across the board?

The role of the voluntary sector

i. Cancer charities have had roles in bringing about previous interventions to prevent cancer. Among those who reflect on their role in bringing in the smoking ban in 2007 are Cancer Research UK and the Roy Castle Lung Cancer Foundation.[12] The ban on tanning salons serving minors arose from a campaign supported by charities (CRUK being in the mix again, along with Melanoma UK) with the slightly unusual leadership of a tabloid newspaper.

ii. However, cancer charities' campaigning often focuses more on care and treatment, alongside research issues. This is not a criticism: there may be a very natural dynamic whereby members and supporters of charities are strongly supportive of those priorities. A focus on prevention might feel a bit beside the point to people whose lives have, very often, already been affected by cancer. The high prevalence of cancer, with the much-publicised statistic that one in two people will develop it during their lifetime, can make treatment seem like a natural or compelling focus.[13] Prevention, by contrast, might seem a challenging or even unachievable aim, being long term and even relatively abstract in nature. While many charities have strong a positive positions on prevention, it may be very understandable if much of their campaigning activity focuses in practice on care, treatment and research.

[12] https://www.cancerresearchuk.org/get-involved/campaign-for-us/our-campaigning-successes/smokefree-workplaces and https://roycastle.org/about-us/our-history
[13] https://www.nhs.uk/conditions/cancer/

iii. It is also the case that cancer holds a particular power in respect of politics and the public discourse. It regularly attracts high profile political pledges in a way that few disease areas do, with dementia recently emerging as probably the only other condition that comes close. This translates into priorities within the NHS, certainly in England: currently there are targets of diagnosis within 28 days of referral, and of treatment starting within 62 days of referral and 31 days of agreeing a treatment plan with a doctor. While seeing that these targets are met in practice may be an ongoing battle, they are far beyond the prioritisation attached even to other 'big killer' disease areas such as respiratory illness, where no comparable pathways or targets have been established.

iv. There may therefore be scope to boost the cause of public health as a whole by framing it in terms of cancer prevention: if the totemic nature of cancer could be harnessed in this way, could the public discourse around prevention and public health as a whole be shifted to secure broad-based support for meaningful structural change? What could the role of cancer charities be in this, and what would it take to make it happen in terms of resources, leadership and alliances?

Conclusion

i. The discussion above offers our provisional reading of the situation as it currently stands, and of possible opportunities for the future. In our call for evidence, we invite views on these issues: what have we missed or got wrong, and where can we find shared understanding and common cause with other organisations? We look forward to hearing the views of as many organisations as possible.