Supporting Early Cancer Detection

Marie Keating FOUNDATION

We are with you. Every step.

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Background

1 in 2 of us will get cancer at some point in our lives and cancer is now the leading cause of death in Ireland.

Cancer has become more prevalent in Ireland over the last two decades, and the incidence of cancer is expected to increase substantially by 2045 if current rates continue.[1]

Early diagnosis is essential to improving cancer survival rates.[2]

Lack of symptom awareness, long waiting lists to access healthcare and treatment, the impact of COVID-19, inequalities in access to treatment, poor uptake of existing screening programmes and lack of other screening programmes as well as an overcrowded health system are all contributory factors meaning that cancer patients in Ireland are not being given the best chance of surviving cancer.

This publication outlines actionable policy recommendations that will transform cancer outcomes for people across Ireland.

Incidence

In Ireland, the incidence of cancer has been increasing over recent years. Potentially, between 2015 and 2045, we could see a doubling of the number of cases diagnosed annually if current cancer rates continue to apply.[3]

This increase in cancer rates has been attributed to a number of causes, including:

- Demographic change, including population growth and population ageing,
- Increases in risk factors (e.g. obesity, alcohol consumption, ultraviolet radiation exposure), and
- The impact of screening.[4]

The importance of diagnosing cancer early

Early detection and diagnosis of cancer, followed by effective treatment, improves survival for nearly all cancer types.

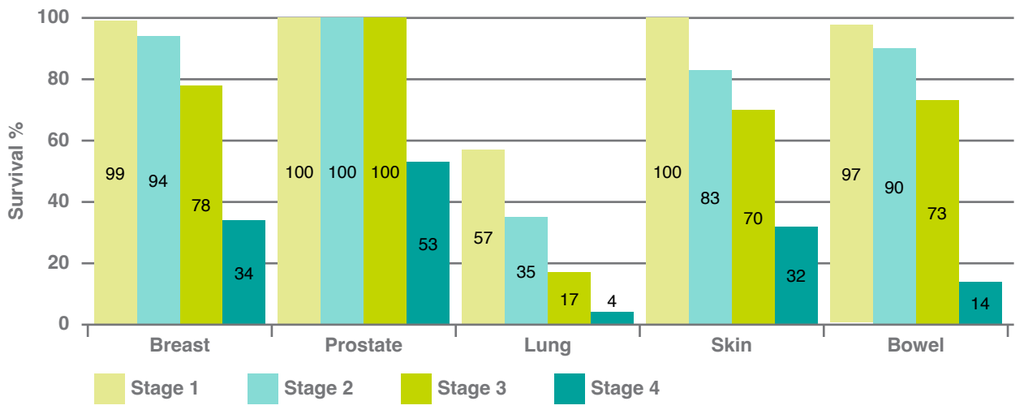
A high proportion of some cancers (e.g. melanoma, uterine and prostate cancers) present at early stage with overall consequent 5-year net survival of up to a maximum of 93% at the time of this report for melanoma, 78% for uterine and 93% for prostate cancer.

Cancers with a population screening programme (Breast, Bowel and Cervical cancers) also experience high 5-year net survival when detected in early stages.[5]

However, late presentation (stage IV) remains common for some other cancers (e.g. head and neck, pancreatic, ovarian, lung and liver cancers) with consequent poorer survival outcomes. Head and neck cancers reported as oral and related cancers only have a 5-year survival of 37%, followed by oral and pharynx at 53%, pancreatic at only 14%, ovarian at 37%, lung with a 24% 5-year survival and liver as low as 19% 5-year survival.[6]

The following graph demonstrates this by comparing the rates of survival of the five most common cancers in Ireland at 5 years after diagnosis for people diagnosed at stages I – IV.

5-year net survival of cancer patients by stage and cancer type: 2014-2018[7]



More than 30% of invasive cancers detected in Ireland are diagnosed at advanced stages (stages III and IV), showing significant differences across tumour categories.

For instance, around 60% of lung cancer cases are identified at late stages, contrasting sharply with the less than 20% rate for breast cancers.[8]

This also has a demonstrable impact on rates of survival with just 4% of people surviving stage IV lung cancer in Ireland compared with 34% of people with stage IV breast cancer or 53% of people with stage IV prostate cancer at 5 years.[9]

In addition to the obvious health benefits for patients, early detection and treatment of cancer can yield clear social and economic advantages.

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Early diagnosis of cancer, before it has grown, locally advanced or metastasised, offers increased chances of curative treatment and optimal health outcomes for patients, in addition to significant cost savings for health and social care systems.[10]

Early cancer diagnosis is a more cost-effective approach for the public health system.[11]

Although Ireland-specific data is lacking, a study undertaken by Cancer Research UK found that, if all areas in England diagnosed colon, ovarian, rectal and lung cancer as early as the best performing regions, the National Health Service (NHS) could save over £44 million in treatment costs and benefit over 11,000 patients each year.[12]

Barriers to getting diagnosed

Lack of knowledge of symptoms

Lack of knowledge and awareness of the signs and symptoms of the common cancers often acts as a significant obstacle to getting checked early and subsequently an earlier diagnosis of cancer.

A survey by Ipsos MRBI for the National Cancer Control Programme found low levels of spontaneous recognition of the signs and symptoms of cancer, with all but one (an unexplained lump or bump) cited spontaneously by less than 50% of respondents.[13]

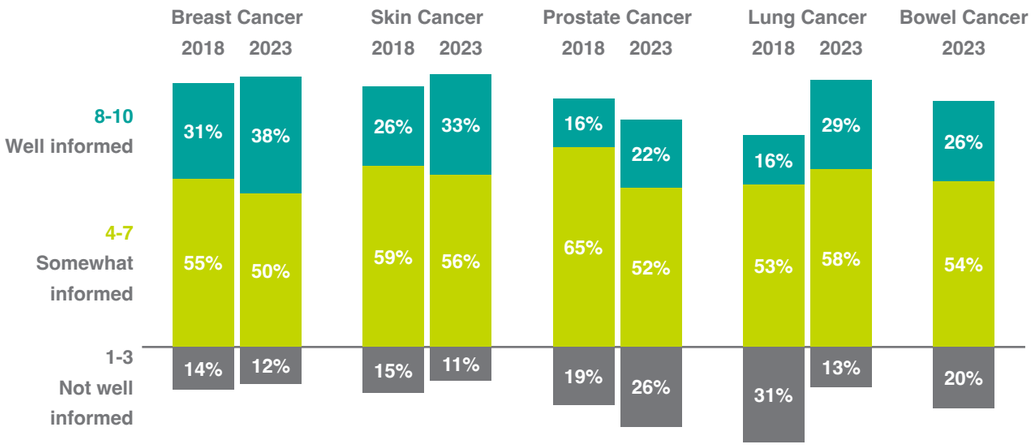
Stigma also inflicts undue guilt and shame and may delay an individual to visit their GP especially in relation to lung cancer and smoking. Research carried out by the Marie Keating Foundation outlined how some patients who have smoked will often blame themselves for their diagnosis, and were reluctant to go to their GP as a result of negative perceptions that may exist.[14]

Sociodemographic variation in spontaneous symptom recognition was also observed, with lower prevalence of recognition among men, people aged 65 years and older and people with lower levels of education.[15]

Moreover, research commissioned by the Marie Keating Foundation in 2018 and again in 2023, carried out by Empathy, shows that while rates of knowledge of certain types of cancers has improved in five years, these rates are still very low.

Rating of knowledge of symptoms for each type of Cancer

How well informed would you say you are in relation to the signs and symptoms to watch out for in relation to the following types of cancer?[i]

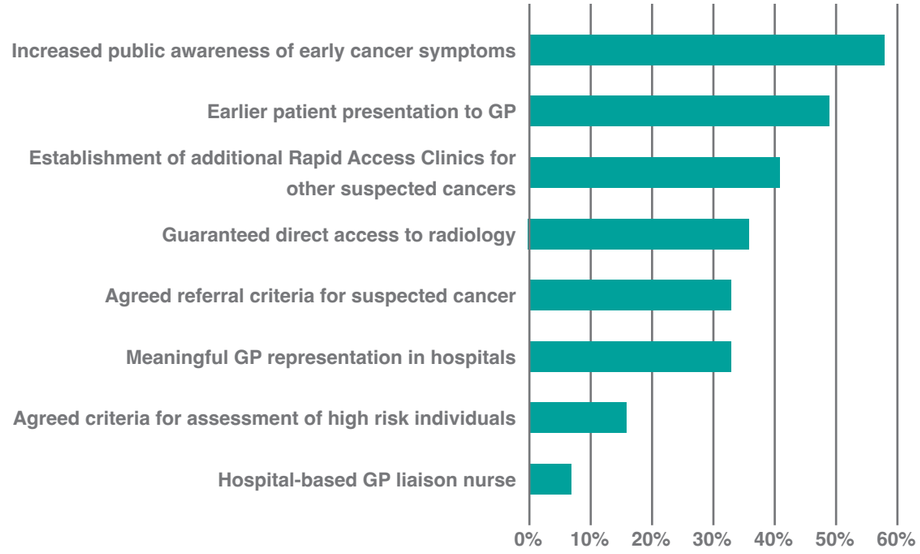


i. (Base: All adults 18+ n=1,023)

Increasing public awareness about the signs and symptoms of cancer has also been cited by GPs as critically important.

In 2015, the Irish College of General Practitioners undertook a survey of its members to document their experience of NCCP developments. Over 500 GPs responded. They identified a number of factors which they believe would help in the early detection of cancer, as outlined in the figure below.

Factors which would assist in the early detection of cancer in primary care (2015 GP survey)[16]



Increasing knowledge of cancer signs and symptoms is key to improving early diagnosis of cancer, particularly among people aged 50 years and older, as advancing age is the leading risk factor for the majority of cancers.

Poor health literacy

Health literacy is the ability to obtain, read, understand and use healthcare information.

Poor health literacy can be overwhelming, conflicting and can also be a contributor to lack of awareness of signs and symptoms of common cancers and can therefore be a factor in late diagnosis.

The degree to which people will act on a potential sign or symptom of cancer differs by age and medical literacy, with younger age groups and those with lower levels of medical literacy less likely to attend and discuss with a doctor first.[17]

A recent international health literacy survey found that about one in four people (28 per cent) in Ireland have “limited” health literacy and struggle to find and evaluate health information. The same survey found that one in five people in Ireland find it difficult to judge whether they need a second opinion from another doctor on their health condition.[18]

People with an Intellectual Disability have complex needs and often experience significant health inequalities in relation to health care access (eg. access to screening, health literacy). People with Intellectual Disabilities are more likely to have their cancer diagnosed at a later stage and more likely to die from their cancer than the rest of the population.[19]

People with poor social supports and those with financial difficulties or in poor health, between the ages of 18 to 35 years old were among those with lower than average levels of general health literacy. [20]

Social deprivation

People living in more disadvantaged areas are also more disproportionately affected by cancer. A National Cancer Inequality Registry report assessing the effect of deprivation on cancer highlighted that those in the most deprived areas had a 28% higher mortality risk due to cancer within five years of cancer diagnosis compared to those in the least deprived areas, having adjusted for age, gender, and cancer type.

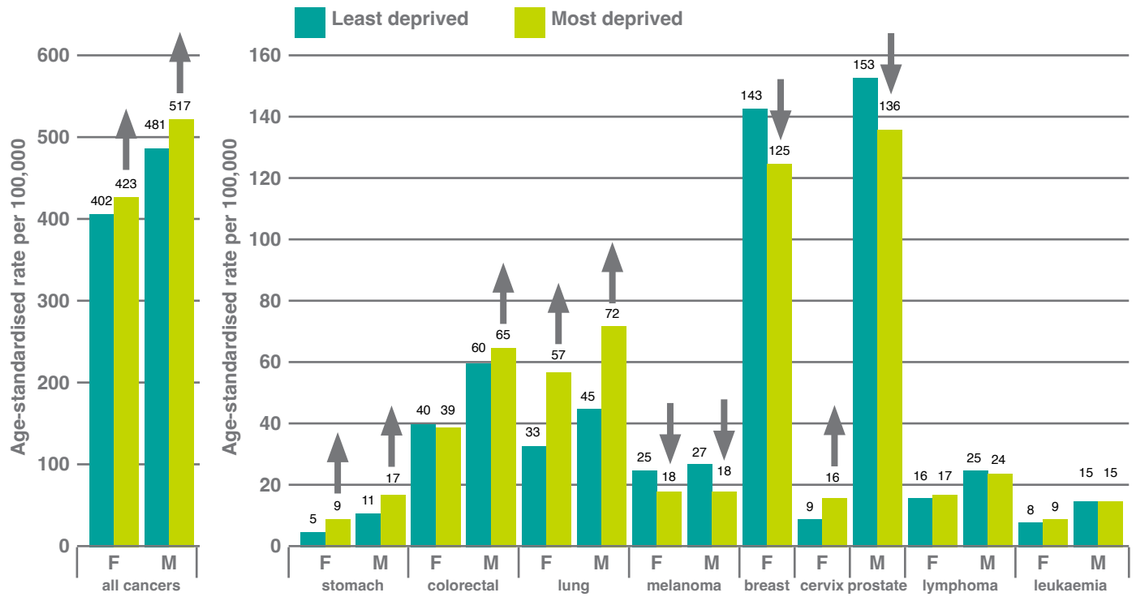
There are also differences in the types of cancers diagnosed in the most and least deprived areas, with a higher incidence of stomach, lung and cervical cancer in people living in most deprived areas, while those living in least deprived areas show a higher incidence of breast, prostate, and melanoma and non-melanoma skin cancer.

People living in the most deprived areas also had a higher risk of late-stage presentation for breast and prostate cancers than those living in least deprived areas.

The report also found that although cancer survival rates have improved over time across the majority of cancers and for all sectors of society, there is no evidence of any reduction in disparities in stage of presentation for lung or colorectal in particular between those living in the least and the most deprived areas.[21]

Cancer inequalities in Ireland 2004-2018

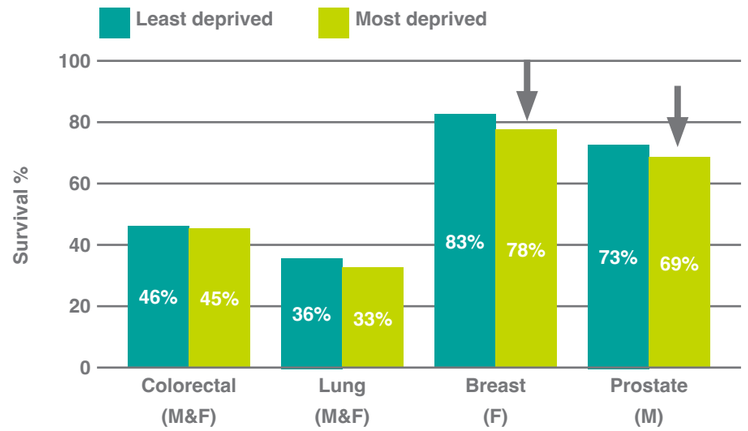
Age-standardised cancer incidence, Ireland, 2014-2018: comparison between the most and the least deprived quintiles. Arrows indicate direction of difference and significance at the 95% confidence level.[22]



Of the four cancers examined for stage, people in the most deprived quintile had a higher risk of later stage at presentation for breast and prostate cancer, compared with those in the least deprived quintile.

Percentage of patients presenting at stages I or II (early stage), Ireland, 2014-2018

Comparison between the most and the least deprived quintiles. Arrows indicate direction of difference and significance at the 95% confidence level (adjusted for age and sex).[22]



Screening

Ireland's three current cancer screening programmes (BreastCheck, BowelScreen and CervicalCheck) are vital tools for detecting asymptomatic cancers.

The purpose of these programmes is to facilitate the identification and treatment of cancer at the earliest possible stage, which is also the most efficient point, from both a public health and public finances perspective.[23]

Investment in population-level screening services for Breast, Cervical and Bowel cancers, combined with other factors such as new treatments and better awareness of symptoms has been effective in reducing associated mortality.[24]

As noted by the National Cancer Registry Ireland (NCRI), these screening programmes increase the chances of detecting the relevant cancers at an earlier stage, thereby reducing the complexity of treatment, and increasing long-term survival prospects.[25]

The European Commission also made proposals to update the Council Recommendation on cancer screening, which were adopted in December 2022. Among the recommendations include a new suggested lower age limit of 45 years for breast cancer screening, expanding the screening age for bowel cancer from 50 – 74, the exploration of gradual introduction of lung cancer screening, prostate cancer testing in men up to 70 and screening for Helicobacter pylori and surveillance of pre-cancerous stomach lesions in places with high gastric cancer incidence and death rates.

There also needs to be specific national screening programme for people at increased risk of cancer, due to an inherited cancer gene e.g. BRCA 1, BRCA 2.

The case for expanding the screening age for Bowel Cancer in Ireland

In Ireland, 2,560 people each year develop colorectal cancer (CRC).[26]

60% of these people are diagnosed at late stage. CRC is the second most common cause of cancer death in Ireland with an average of 1,012 deaths per year.[27]

CRC has a 5-year survival rate of 97% in those with stage I disease and 14% in those with metastatic disease; hence survival is strongly linked with early detection.[28]

The HSE's Programme report for 2020- 2021 shows that the uptake of BowelScreen remains low at 46.6%.[29]

While the Marie Keating Foundation raises awareness of CRC signs and symptoms, risk factors and promotes early detection, it is vital that screening is optimised to increase the number of patients who are diagnosed earlier.

Worryingly, rates of CRC in under-50s are rising rapidly. The NCRI database shows that the incidence of CRC among those under 50 has almost doubled in just 25 years, between 1994 and 2019.[30] [31]

This trend is mirrored around the world. According to the National Cancer Institute in the United States the incidence of CRC in those under the age of 50 has increased by 51% since 1994.[32]

1 in 5 diagnoses of colorectal cancer in Ireland is to someone under 60.[33]

1 in 10 diagnoses of colorectal cancer is to someone under 50.[34]

This is also something the Marie Keating Foundation has seen mirrored within its Positive Living support group for those living with stage 4 or metastatic cancers. We have seen a significant increase in the number of participants under 50 with a late-stage CRC diagnosis. Since COVID-19, the Foundation has supported 8 members with metastatic CRC, all under the age of 50, of whom sadly three have died in the past year.

Most countries globally begin screening for CRC at the age of 50 as recommended by the European Code Against Cancer.[35] Notably, both the US and Australia have lowered the screening age to 45 years given the increase in EOCRC.

1 in 5 diagnoses of colorectal cancer in Ireland is to someone under 60.

The European Commission has also made proposals to update the Council Recommendation on cancer screening. Among the recommendations is to include the expansion of CRC screening for all adults between 50 and 74.[36]

Ireland's bowel screening programme must remain in step with these European and International developments. Screening and early detection are crucial to avoid late diagnosis, thus saving lives. Further work must be done to improve the uptake rate of the existing Bowel Screen programme as well as to extend the age eligibility.

This is not only a disease of older age, CRC can and does affect those under the existing screening age of 59.

Together, the Marie Keating Foundation and the patient advocacy group Bowel Cancer Ireland are united in their plea to Government, urging them to prioritise the well-being of its citizens and prevent avoidable deaths by expanding the age threshold for bowel cancer screening to 50 -74.

The case for introducing a Lung Cancer screening Programme in Ireland

Excluding non-melanoma skin cancer, lung cancer is the fourth most common cancer in Ireland, with 2,690 cases diagnosed each year. More Irish men & women die from lung cancer than any other type of cancer. Lung cancer rates are increasing every year and lung cancer has overtaken breast cancer as the leading cause of cancer related deaths in women.

Over 40% of lung cancer cases in Ireland are now diagnosed in rapid access clinics, but the cancer remains Ireland's most fatal. We know most people with lung cancer present late to their GPs / hospitals and as a result more people in Ireland die from lung cancer than any other type of cancer. Those diagnosed with lung cancer are typically in their late 60s or early 70s, male and female with a history of smoking or smoke exposure.

Lung cancer in Ireland has only a 24 per cent 5-year net survival rate (compared with e.g. 93% for prostate cancer), one of the lowest of the common cancers.[37]

The survival rate is merely 4% after a Stage IV diagnosis, while it rises to 57% following a Stage I diagnosis.[38]

There is an urgent need for the early detection of lung cancer through a specialised screening programme, given the substantial difference in survival rates based on the diagnosis stage. Initially, it is proposed that a screening programme be available for those deemed most at risk, individuals aged between 55 and 74 who currently smoke or who have previously smoked.

The EU Council has also recommended that Member States explore the feasibility and effectiveness of screening with use of low-dose computed tomography (LDCT) for lung cancer,[39] language which was significantly diluted from the European Commission's Group of Chief Scientific Advisors.[40]

Considering the current data, we propose implementing LDCT screening for high-risk individuals in the 55-74 year age group with a PLCOm2012 ≥1.51%.[41] The PLCOm2012 model predicts incident lung cancers within 6 years of screening using 11 predictors: age, race or ethnicity, education, body-mass index, history of chronic obstructive pulmonary disease, personal history of cancer, family history of lung cancer, and smoking status, and intensity (mean number of cigarettes smoked per day), duration, and quit-years in patients who used to smoke.

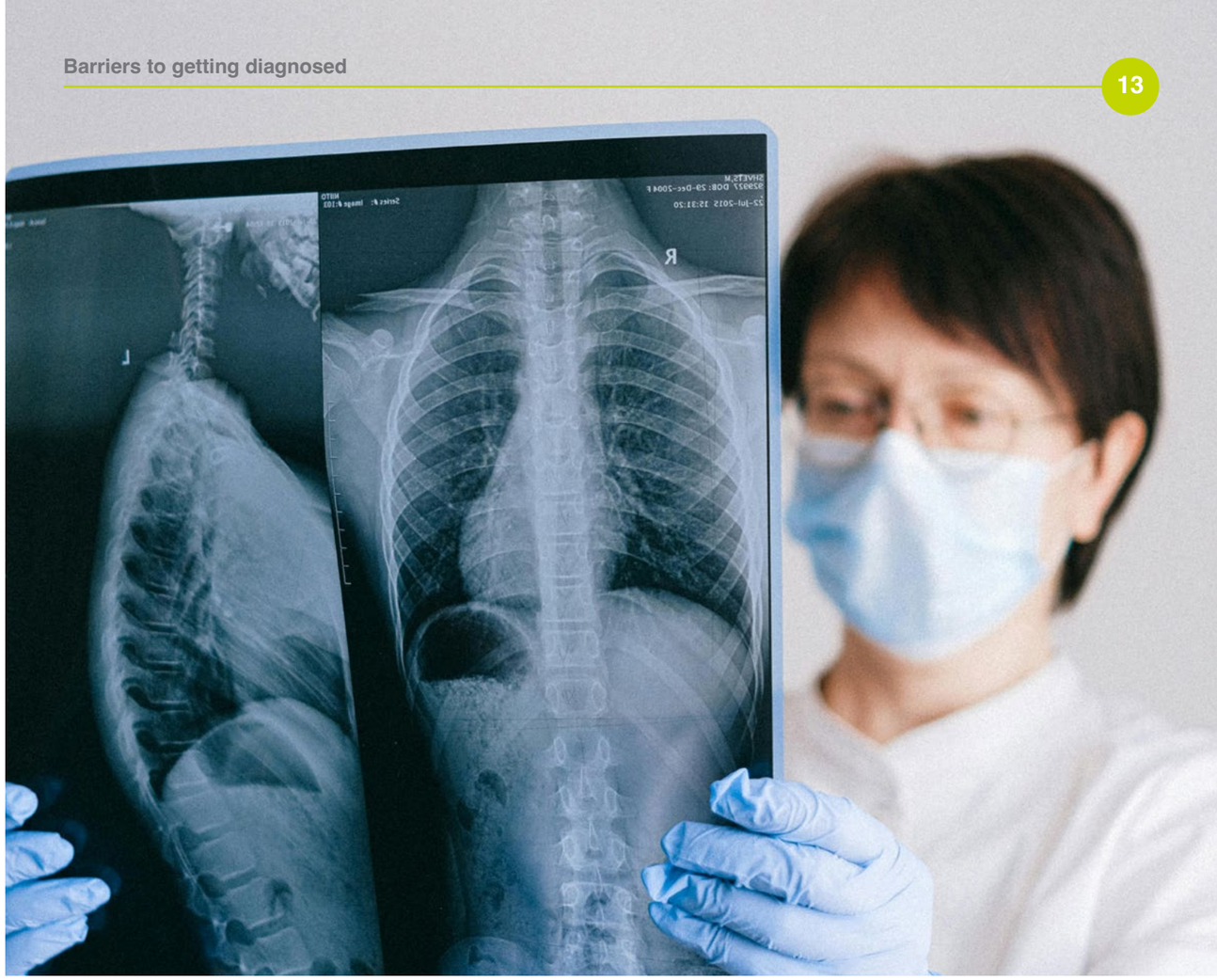
The UK has demonstrated, through a targeted lung health check scheme, that in those where lung cancer was detected, over 75% were diagnosed with early-stage disease.[42]

This notable shift in the stage of diagnosis could have a substantial real-world impact on individuals at risk of lung cancer in Ireland.

A lung cancer screening programme for at risk individuals needs to be a priority.

The Marie Keating Foundation in partnership with the Irish Lung Cancer Coalition are advocating for a lung cancer screening programme using LDCT, which initially starts in a targeted fashion directed to those deemed at high risk of the disease through the use of existing algorithms (i.e., PLCOm2012).[43] This needs to start as a matter of urgency given that over 60% of people impacted by the disease are diagnosed at later stages (Stage III/IV), where outcomes are much poorer.[44]

Subsequently in years to come, this programme should evolve to include additional risk factors relevant to an Irish population to ensure that those without a smoking history but still deemed at high risk are also included within the programme. A specific example of this is the TALENT study from Taiwan, which recruited people with no



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smoking history.[45] In Ireland, approximately 10-15% of lung cancers are diagnosed in those with no smoking history.

Trials

There are a number of trials, which have proven the benefit of screening in those at high risk of lung cancer. Here we highlight two major studies (i) The US National Lung Cancer Screening Trial (NLST) (2011; PMID: 21714641)[46] and (ii) the European NELSON study (2020 - PMID: 31995683),[47] in addition to a meta analysis that examined nine studies that included almost 97,000 individuals (2020: PMID: 32583338).[48] The NLST study showed that LDCT significantly reduced lung cancer and overall mortality compared with screening with chest radiography alone.

In NELSON, the screened population saw a 26% lower risk of dying from lung cancer. The meta-analysis demonstrated that screening with LDCT significantly reduced lung cancer mortality, with women appearing to benefit more than men.

The Irish Government should transform and optimise existing cancer screening programmes and accelerate the roll-out of a targeted lung cancer screening trial in Ireland.

Access to diagnostics

Early diagnosis of cancer with more timely access to diagnostics will inevitably increase early-stage presentation significantly.[49]

The current National Cancer Strategy outlines the “significant deficiencies” in access to diagnostics and specialist opinion in the public health system.

GP access to diagnostics in the public system is variable around Ireland. There are fewer GPs in deprived areas and there are often long wait times for some specialist services. There is also greater demand on primary health care services because of the recent increase in our population due to world wide conflict and the settlement of refugees. The resulting protracted patient pathway contributes to late diagnosis.

Urgent attention must be paid to resolving these problems, particularly as the requirement for diagnostics, referral and specialist investigations and equipment is predicted to increase substantially over the next ten years. This is particularly challenging, given the current shortage of diagnostic specialists, equipment and other allied health and social care professionals such as radiographers and ultra sonographers.[50]

Moreover, a recent report by TASC (Think Tank for Action on Social Change) found that people from socioeconomically deprived backgrounds are particularly likely to experience barriers to accessing a timely cancer diagnosis. Barriers to access services are ‘two-fold’.

First, more deprived areas and communities have much less readily available access to local GP services than others. Second, marginalised communities face barriers, such as lack of culturally sensitive knowledge, confidence and embarrassment which may impede them accessing health care services.

The report also highlights the cost barrier of attending a GP and accessing GP services in general is a barrier to early cancer diagnosis for people from lower socio-economic areas and marginalised communities.[51]

A 2019 report found that just two in five Irish patients had a medical card at the time of their diagnosis which outlines that a significant portion of patients will not have their GP and other medical costs covered.[52]

Good progress has been made with the National Cancer Strategy to date, with Rapid Access Clinics and early diagnosis pathways receiving almost €3.5m new development funding in 2022 and a 6% increase in electronic referrals from GPs for suspected lung, breast and prostate cancers between 2021 and 2022.[53]

However, despite this, target waiting times for cancer diagnostic tests are not being met and surgeries are “frequently delayed” due to shortages in staffing, beds and theatre space. There has been insufficient investment in infrastructure despite rising cancer cases, with many diagnostic and radiotherapy services operating significantly below capacity.[54]

Early treatment

If our goal is to ensure that more people are diagnosed with cancer early, it is important that the healthcare system provides the best treatment modalities - surgery, radiotherapy, chemotherapy and targeted therapies or a combination of treatment options. The approach to cancer treatment is evolving with new and advanced medicines, once reserved for late-stage (metastatic) cancer, now being used earlier.

Innovative and new medicines have the power to transform patients’ lives, however Irish patients often do not get the newest medicines when they are available to patients in other European countries. Among Western European countries, Ireland has the lowest rate of new cancer medicines available to treat patients.[55]

Ireland currently lags behind its European neighbours in making innovative cancer treatments available to patients, this needs to change, we need to be on a par with our European neighbours.

The latest data from European Federation of Pharmaceutical Industries and Associations (EFPIA) shows that it takes an average 673 days from EMA licensing before new cancer medicines are made available to Irish patients. This ranks Ireland in 28th place out of 37 countries with Portugal the only Western European country that is slower.[56]

Beyond delays in reimbursing medicines, other challenges in the healthcare system could affect access to early-stage treatments. To provide these treatments to more eligible patients, oncology day wards will need more physical space and staffing capacity, which in turn will require more inpatient facilities.

Access to medicines

Ireland’s system for assessing and reimbursing medicines needs to be transformed as a matter of urgency in order to keep pace with innovations in cancer care.

Moreover, there is now a significant and concerning disparity between public and private patients in Ireland. As of June 2023, all three of the main private health insurance providers in the country now give access to innovative new cancer drugs from the date of approval by the European Medicines Agency, whereas public patients still face lengthy delays before these treatments become available.[57]

The publication of the Mazars Review into the governance and resourcing of the medicines reimbursement system is welcome.

Key recommendations in the report include:

- Increasing resourcing for the National Centre for Pharmaco-economics (NCPE) in order to improve the process of drug approval and reimbursement
- Introduction of an application tracker to show when an application for reimbursement is received and how it is progressing through the process.[58]

Assurances from Minister for Health, Stephen Donnelly in March 2024 that €30 million has been found to cover the cost of new approvals in 2024 and that funding will be allocated for 34 new staff agencies dealing with drug reimbursement is also welcome.[59]

However, more needs to be done to ensure that new and innovative treatments are made available to all Irish cancer patients and to remove the current inequity of access to new medicines between public and private health care providers.

Respect for the patient voice

Respect for public and patient involvement (PPI) in cancer research, care and treatment is critical as it ensures that healthcare decisions are patient-centred, reflecting the unique needs, preferences, and values of those directly affected by cancer.

Engaging patients in the decision-making process enhances the relevance and effectiveness of existing infrastructure and treatment options, leading to better adherence and outcomes. Furthermore, public patient involvement fosters transparency and trust between patients and healthcare providers, empowering patients with a sense of agency and control over their care. This collaborative approach also helps identify and address barriers to access, promoting equity in treatment availability and improving overall healthcare quality. By valuing and incorporating patient insights, the healthcare system can become more responsive, personalised, and compassionate.

The National Cancer Strategy 2017-2026's commitment to maximise patient involvement and to strengthen the role of patients in the planning and delivery of cancer care, including through the establishment of structures for patient involvement is welcome.

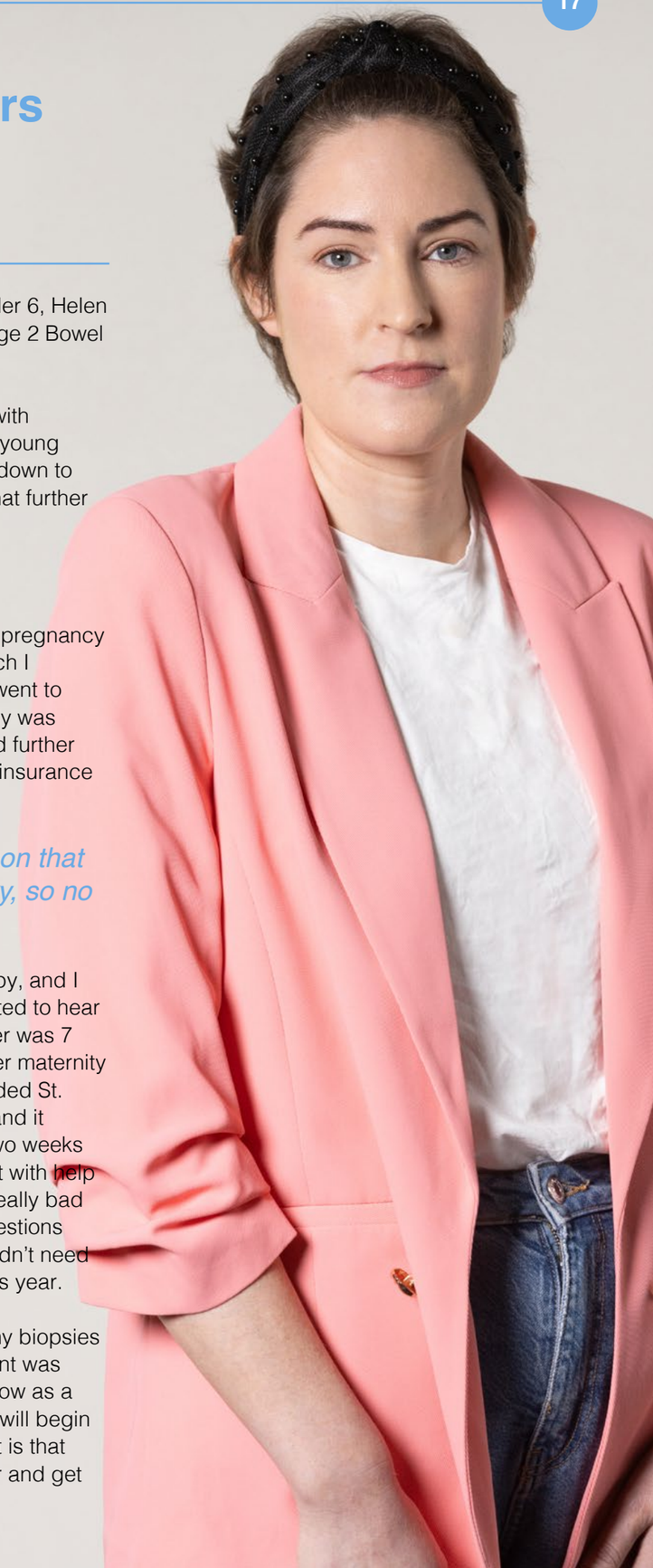
While overdue, the Marie Keating Foundation strongly welcomes the issuance, by the Department of Health, of a draft 'Patient Voice Partner Policy' for consultation in January 2023.

There is a clear need for a policy to make a strong commitment to embed patient participation in health policy and service development. Furthermore, this policy should set out a framework to ensure that patient representatives are recognised and valued for their contributions. The policy should clarify how patient representatives will be reimbursed for any expenditure and compensated for their input and participation.

The Marie Keating Foundation urges the Department of Health to publish this Patient Voice Partner policy as a matter of urgency.

Patient ambassadors

Helen Dunne
Age at diagnosis: **36**
Diagnosed: **Stage II**



School teacher and mum of 3 daughters under 6, Helen Dunne was just 36 when diagnosed with Stage 2 Bowel Cancer (Colorectal Cancer).

Hailing from Cavan but now living in Dublin with her husband Jamie and their daughters, the young mum thought that her initial symptoms were down to haemorrhoids but thankfully her doctor felt that further investigation would be beneficial.

This is Helen's story.

"I was experiencing bleeding during my last pregnancy and after. I was told I had haemorrhoids which I did. The bleeding turned a little darker, so I went to my GP she examined me and said it probably was haemorrhoids but said any bleeding required further investigation. Thankfully I had private health insurance and was seen very quickly.

"I was told in February by my surgeon that my biopsies were clear after surgery, so no more treatment was needed."

They found something during my colonoscopy, and I had to wait a week for results. I was devastated to hear it was rectal cancer as my youngest daughter was 7 months old. I had just gone back to work after maternity leave, I am a primary school teacher. I attended St. Vincent's Private Hospital for my treatment, and it happened very quickly. I got chemo every two weeks for 6 months. It was tough but I got through it with help of family and friends. Losing my hair was a really bad time for me because my girls had a lot of questions etc… I responded very well to chemo and didn't need radiation so had my surgery in January of this year.

"I was told in February by my surgeon that my biopsies were clear after surgery, so no more treatment was needed. I am dealing with bad neuropathy now as a side effect of my treatment. I am hoping this will begin to go soon. If I were to make one final point it is that you are never too young to get bowel cancer and get checked if you have symptoms."

Patient ambassadors

Jane McCoy
Age at diagnosis: **38**
Diagnosed: **Stage IV**

Jane McCoy, a mum of 4, was diagnosed in October 2021 with Stage 4 Bowel (Colorectal) cancer with metastases to her liver and two lungs. Jane was only 38 years old.

This is Jane's story.

"My name is Jane, and I am 41 years old. I have 4 kids aged between 6 and 15 - all boys! I was diagnosed with metastatic colon cancer in Oct 21 aged 38. I only had 3 weeks of symptoms which included bloating and stomach pain. After a trip to the GP, I was sent to A & E as my liver bloods were off and they suspected I had gallstones. There, they discovered I had a bowel obstruction. I was hospitalised and further testing showed I had stage 4 colon cancer with numerous metastases to my liver peritoneal, lymph nodes and my two lungs. I was told the cancer was very advanced (incurable and inoperable) and while I needed surgery on my bowel there was no time - I had to go straight on chemotherapy.

A few weeks later I was devastated to learn that I had the BRAF mutation. This effects 10% of people with bowel cancer and has the poorest prognosis. It means the cancer is very aggressive and becomes resistant to treatment quickly.

I continued chemotherapy for 10 months which successfully shrunk my tumours and got me stable. I then moved onto targeted therapy for almost a year. After this I trialled a new immunotherapy drug with chemo. This worked for a while, but unfortunately, 8 months later, I now have growth in my liver and lungs, so I am back on the very first chemo again. One of my lungs has partially collapsed so we are hoping that the chemo will resolve this.

"At the end of the day, that is all I want - more time."

"Over the two and a half years, while going through treatment, I have chosen to live as well as I can. I took up golf, I go walking in the woods with my dog, I travel and go on trips as much as I can!

"My priorities have changed and all I want to do now is spend time with my family and friends. I truly know what it means to live now and am genuinely loving life.

"I do my best to stay as healthy as I can throughout treatment and I make the most of my good days. I am so grateful to my oncologist and all the team at St Vincent's Private who have looked after me so well over the last couple of years. I am blessed to have had access to life saving drugs that only became available a few years ago. My hope is that more treatment options will become available for my particular cancer type which will allow me precious more time with my husband, kids, family and friends.

"At the end of the day, that is all I want - more time."

Our asks

Commit to multi-annual funding of the National Cancer Strategy

The National Cancer Strategy 2017-2026 outlines a comprehensive approach to cancer prevention, treatment and care in Ireland.

While there has been much progress since its launch, the strategy has only received dedicated funding in two Budgets since its publication in 2017, meaning many of the recommendations have yet to be implemented.

A strategy without proper funding is merely words on paper. This chronic underfunding has resulted in a stagnation of cancer services, severely hampering our ability to provide optimal care and improve outcomes for cancer patients and people at high risk of cancer in Ireland.

With just two years remaining in the current Strategy's timeline, it is crucial to commit to multi-annual funding to ensure that the goals of the strategy are fully realised.

- Commit multi-annual, ring-fenced funding to ensure that the goals of the National Cancer Strategy are realised.
- Commit funding to plan and develop a national modelling exercise to anticipate future demand and need for services beyond the current National Cancer Strategy.

Improve awareness of early cancer symptoms

- Fund targeted culturally sensitive health-promotion campaigns with dedicated resources focusing on cancer signs and symptoms. Along with cancer prevention initiatives, this will lead to cost-effective, sustainable means of reducing the cancer burden in the long term.
- Fund the Marie Keating Foundation's Schools Cancer Awareness programme to educate first to sixth year students on cancer prevention and the signs and symptoms of the most common cancer types. This programme was evaluated and culminated in a report in 2023 which highlighted the positive impact which this programme has on younger adults.
- Resource education and outreach campaigns targeting specific populations who may be less aware of cancer symptoms, including older people, people with limited education and literacy skills and people from marginalised communities. Tackle inequality of cancer incidence among underserved communities in particular with investment in direct community interventions and support.
- Develop health literacy training programmes for adults who are vulnerable to low health literacy, such as older people, people with hearing and intellectual disabilities or people from marginalised groups.

- Continued investment and focus on public health promotion e.g. hitting our Smoke Free Ireland target, initiating and monitoring on the sale of cigarettes to under 21's and greater control and legalisation of e-cigarettes, extension of the HPV vaccination programme for all people up to the age of 25 (consider extension of the Laura Brennan Catch-up Programme which will help Ireland reach its target of eliminating cervical cancer by 2040).
- Funding of other Healthy Ireland initiatives such as targeted exercise and nutrition programmes.
- Fund and support early detection cancer charities such as the Marie Keating Foundation who support and educate people in underserved and disadvantaged communities on bespoke health promotion campaigns on the signs and symptoms of the most common cancers and also risk factors.
- Resource national partnership collaboration with other community groups such as Healthy Cities and Communities where exercise, fitness and connection are important aspects of maintaining health; Local Development Companies where social inclusion is a priority particularly as more refugees are present in our communities and integrating Social Prescribing (using the HSE Social Prescribing Framework) into all aspects of our community, bringing communities together where there are complex social issues, frequent GP attendance, etc.[60]
- Fund nursing outreach services to educate people on cancer prevention and the signs and symptoms of the most common cancers and highlighting importance of early detection. Fund education at Third level e.g. Survivorship, Health Promotion.

Screening programmes

- Provide funding to deliver best in class screening services.
- Provide funding to promote higher uptake of all existing screening programmes.
- Implement measurable oversights and governance of cancer screening programmes.
- Lower the age limit for breast cancer screening to 45 years, as per the updated European Council Recommendation on cancer screening.
- Include adaptations to the breast screening programme for people with a BRCA1 or BRCA2 alteration.
- Expand the screening age for Bowel Cancer from 59 - 69 to 50 – 74, as per the updated European Council Recommendation on cancer screening.
- Establish a lung cancer screening pilot programme targeting high-risk people, as per the updated European Council Recommendation on cancer screening.

Faster access to a cancer diagnosis

- Identify the geographical areas where there is less access to GP services and further invest in GPs/primary care for marginalised groups in deprived areas.
- Invest in improving access to cancer diagnostics.
- Increase the resourcing of Health Care Specialists and clinicians all along the patient pathway from diagnosis to treatment to aftercare addressing the huge shortage of diagnostic specialists and other health and social care professionals such as radiographers and ultra sonographers.
- Update the National Cancer Control Programme (NCCP)'s GP Referral Pathway for Suspected Colorectal Cancer, providing access to guidelines and diagnostic pathways to address the needs of patients below 59 years of age who are not served by a bowel screening programme in Ireland.

Faster access to treatment

- Fund and Implement the NCCP Early Diagnosis of Symptomatic Cancer Plan 2022-2025.
- Continue to increase the investments in new medicines in upcoming Budgets, to ensure sufficient funds are available to swiftly adopt new innovations in cancer treatment such as early-stage care.
- Invest in development of an efficient, transparent and responsive system with shorter timelines for patients to access new and effective treatments.
- Develop a system of faster, equitable access to medicines that is comparable to other European countries as per the ambition of the Sláintecare Report.
- Fund the implementation of the recommendations in the Mazars report.
- Introduce an Early Access/Conditional Access Scheme for oncology medicines that addresses areas of significant unmet medical need, to reduce inequities between public patients and private patients.
- Invest in the expansion of oncology day wards, including increasing bed numbers and staffing capacity.
- Conduct a cancer services workforce review to assess current and future staffing capacity requirements, given the changing nature of cancer treatment and increasing cancer case numbers.

Respect the Patient Voice

- Publish and fund the implementation of the Patient Voice Partner policy as a matter of urgency.
- Develop other PPI initiatives to embed patient participation in health policy and service development.

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