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Advancing cancer equity in seven high-income countries: an analysis of policy levers and national cancer control plans

— A report by the G7 Cancer Working Group on Cancer Outcome Inequities

Advancing cancer equity in seven high-income countries: an analysis of policy levers and national cancer control plans

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Foreword

G7 Cancer is an international cooperation mechanism that brings together organisations representing the G7 countries—Australia, Canada, France, Germany, Japan, the United Kingdom, and the United States—to strengthen collective action in cancer control through shared evidence, coordinated policy, and mutual learning. Within this partnership, **Working Group 3 (Cancer Outcome Inequities)** was established to identify policy levers and evidence-informed strategies that reduce avoidable and unjust differences in cancer outcomes and support governments and partners to embed equity across national cancer control efforts.

This report, *Advancing Cancer Equity in G7 Cancer Countries: An Analysis of Policy Levers*, was commissioned by Cancer Australia on behalf of the Working Group to map the current state of cancer equity policy across member countries. Drawing on comparative analysis of more than fifty policy frameworks, ten National Cancer Control Plans, and interviews with representatives from all member countries, the report provides an evidence base to guide policy development and implementation.

Findings highlight a strong and shared commitment to advancing equity yet also reveal persistent gaps between aspiration and measurable action. Definitions of equity differ across countries; operational frameworks and data systems remain incomplete; and accountability for outcomes is often implicit rather than explicit. The report identifies key levers to strengthen progress: clear and shared definitions, robust data infrastructure, participatory and accountable governance, multisectoral collaboration, and sustainable investment.

Building on these insights, the report presents a Policy Framework for Equity in Cancer Control as a tool to assist G7 Cancer countries and other high-income jurisdictions to embed equity in cancer systems. It also presents a structured roadmap that supports countries in translating equity commitments into actionable steps across five cross-cutting enablers—participatory governance, communication and advocacy, multisectoral collaboration, sustainability, evidence generation – and a phased approach to implementation across three stages: Foundations, Integration, and Consolidation.

This work reaffirms the collective determination of the G7 Cancer Working Group 3 and its partners to translate evidence into sustained, measurable change. By aligning policy, practice, and accountability, G7 Cancer countries can advance more equitable outcomes across the cancer continuum—improving health, strengthening systems, and realising the full potential of international cooperation for public good.

We would like to thank Professor Adam Elshaug and Rebecca Zosel for their diligent efforts in leading this project, including undertaking analysis and drafting the report. Our thanks also extend to all past and current members of G7 Cancer Working Group 3 for their active contributions and input to this work.

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Executive Summary

This research, exploring policy levers to advance cancer equity in G7 Cancer countries, was commissioned by Cancer Australia on behalf of G7 Cancer Working Group 3 (WG3).

G7 Cancer is an international cooperation mechanism that brings together countries committed to advancing cancer control through shared expertise and coordinated action. Member countries include Australia, Canada, France, Germany, Japan, the United Kingdom[1], and the United States of America. Four working groups address G7 Cancer's current priorities, with WG3 focusing on cancer outcome inequities.

Building on the work of G7 Cancer WG3, the study synthesises insights from across G7 Cancer countries to analyse policy levers and identify initiatives that advance cancer equity.

The study was conducted in three phases.

Phase 1 involved a desktop review and documentary analysis of 53 international, national, and subnational frameworks and data sources relevant to cancer equity. The analysis found strong rhetorical and strategic commitment to equity but significant gaps in operationalisation, measurement, and implementation. While equity is widely recognised across frameworks, it is rarely explicitly defined, translated into actionable strategies and measurable goals, or systematically monitored, highlighting a gap between aspirational commitment and practical action to reduce cancer disparities.

Phase 2 comprised analysis of G7 Cancer country National Cancer Control Plans (NCCPs). It found that health and health services are consistently prioritised policy domains across all G7 Cancer Plans. While all Plans reference equity – often emphasising improved access – there is potential to strengthen explicit definitions, set measurable targets, and adopt more comprehensive approaches to further advance equity within G7 Cancer countries.

Phase 3 involved semi-structured interviews with representatives from each G7 Cancer member country. The findings highlighted that conceptualisations of equity vary both across and within countries, and that most countries are still at early stages of translating awareness and commitment into actionable strategies. Prevention, screening, and early detection were identified as key levers for improving cancer outcomes and reducing inequities, while international collaboration was recognised as a valuable means of sharing practical solutions and evidence-based strategies to advance cancer equity.

Across all three phases, the study underscores a strong strategic commitment to cancer equity across G7 Cancer countries, alongside clear opportunities to translate intent into measurable actions. Key insights from each phase are summarised below.

Examples of practical policy approaches supporting commitments to address cancer inequities in G7 Cancer countries are provided. Insights from the research have enabled the development of a framework for equitable cancer policy which aligns with the study's aims to illuminate drivers of cancer inequities, identify actionable policy imperatives, and establish measurable outcomes.

The report sets out policy recommendations aimed at translating equity commitments into coherent, actionable, and measurable steps – delivering benefit not only for those most affected

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[1] For the purposes of this study, the United Kingdom was analysed as four separate nations: England, Scotland, Wales, and Northern Ireland.

but also for society as a whole. A summary of these recommendations is provided at the end of this Section.

Phase 1 Key Insights

- 53 frameworks were identified across G7 Cancer countries and international organisations, published between 2005 and 2025.
- Of the 53 frameworks, 40 were developed by a single country for national application, eight frameworks were global, four were regional, and one was multi-regional.
- Most of the frameworks were cancer equity or health equity focused, reflecting G7 Cancer member countries' strong emphasis on embedding equity across cancer care and broader healthcare policy.
- G7 Cancer countries have strong policy frameworks for equity, but not all frameworks address implementation, measurement, or institutionalisation, highlighting a gap between strategic intent and practical action in cancer and health systems.
- Most frameworks address priority populations, with greatest attention to geographically remote communities, culturally and linguistically diverse (CALD) groups, and children. People who identify as Immigrants, refugees and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual (LGBTIQA+) people are less frequently recognised.
- Most frameworks recognise the influence of health determinants – particularly cultural, economic, environmental, and structural factors – highlighting the need for equity-focused policies that extend beyond clinical care to address drivers of cancer outcomes.
- While equity is widely recognised across frameworks, it is rarely explicitly defined, operationalised through measurable goals, or monitored.
- Most frameworks include a limited number of policy components and offer evaluation guidance, reflecting a focus on both targeted interventions and broader system-level approaches.

Phase 2 Key Insights

- Ten NCCPs, or equivalent policy documents, were identified across the G7 Cancer countries for analysis.
- Three countries - Scotland, Canada, and Australia - provide explicit definitions of equity. All countries, however, use equity-related terms, with the framing shaped by culture, language, and context.
- The most consistently articulated dimension of equity is access to services, resources, and opportunities. All Plans include commitments to improving access, typically framed around reducing geographical, financial, cultural, or systemic barriers to cancer care.
- Equity is positioned as an underlying principle in most Plans, expressed through both strengths-based framing (positive goals and principles) and deficit-based framing (problems and gaps).
- All G7 Cancer countries except England include an explicit statement or goal on cancer-related health equity. These goals are expressed as qualitative statements of intent (e.g.,

improving access, reducing inequities). While some refer to concepts that could, in principle, be quantified (such as earlier diagnosis or improved survival), none include specific numerical targets or quantifiable indicators.

- All G7 Cancer countries adopt a blended approach to equity, combining universal goals with targeted actions to address varying levels of need.
- Health and health services are consistently prioritised policy domains across all G7 Cancer Plans.
- Across the cancer care continuum, prevention and early detection, as well as treatment, are universally prioritised.
- Priority population groups vary across countries, reflecting national contexts and equity priorities. Some countries adopt a broad approach across multiple groups, while others focus more narrowly and explicitly on selected populations.
- Social determinants of health are addressed in all Plans, reflecting widespread recognition of their importance.
- Cross-sector collaboration is a common feature across all Plans, though the scale, diversity, and clarity of roles vary.

Phase 3 Key Insights

- Twelve interviews were completed with 20 participants, representing all seven G7 Cancer countries.
- There is no shared definition of cancer equity across the G7 Cancer countries, and national conceptualisations vary considerably. Most definitions emphasise access to care as a central component. In several countries, the emphasis is on creating equal opportunities and services rather than explicitly addressing and reducing cancer inequities.
- Tensions exist between advancing equity and treating people equally, and there is variation in awareness, perceived drivers, and urgency to act.
- While NCCPs provide a formal structure for cancer control, their maturity and emphasis on equity vary.
- Implementation of NCCPs is uneven, with tensions between high-level commitment and practical operationalisation at scale.
- The success of efforts to advance cancer equity is influenced by multiple, interacting factors. Enablers include an explicit commitment to equity and a clear program logic and theory of change.
- Formal policies to address health inequities remain limited or absent, despite numerous initiatives and examples of action.
- Factors beyond cancer care - such as education, poverty, housing, employment, and other social, economic, and commercial forces - play a central role in driving inequitable cancer outcomes. Despite widespread recognition, the complexity, scale, and cross-sectoral nature of the structural determinants of health often places them beyond the direct control of cancer organisations and policymakers, limiting the translation of awareness into tangible action.

- Prevention, screening, and early detection are critical levers for improving cancer outcomes and addressing inequities.
- Persistent inequities exist in access to cancer treatment across G7 Cancer countries.
- Inequities in research prioritisation, access to clinical trials, and translation of innovation into practice may perpetuate disparities in cancer outcomes.
- Specific populations are identified as priorities for cancer equity, with recognition of intersectionality emerging as increasingly important.
- Many countries remain at an early stage in building comprehensive, equity-focused cancer data systems; no national system fully measures inequities in cancer.
- Measuring and monitoring cancer inequities is essential, with clinical and social indicators critical for addressing cancer inequities, though gaps in equity-relevant measures remain.
- Structured data frameworks, comprehensive cancer registries, and effective data linkage are essential enablers of both cancer control and equity.
- Engaging policymakers across all sectors of government is crucial to ensure equity-relevant data informs decision-making; fragmented systems, limited interoperability, and data gaps are barriers to translating evidence into action.
- Engaging a broad range of stakeholders, including people with lived/living experience, is crucial to advancing person-centred cancer control in an equitable way.
- International collaboration is valued to exchange practical solutions and evidence-based strategies for addressing cancer inequities.
- Creating enabling social and policy environments, along with horizon scanning and measurable targets, is essential to translate awareness of inequities into actionable outcomes that can be implemented in the field.

Insights from each phase of the study have been used to develop a *Policy Framework for Equity in Cancer Control* designed to support G7 Cancer member countries – and others in comparable situations – in advancing equitable cancer policy. This evidence-informed model aligns with the study's aims to illuminate drivers of cancer inequities, identify actionable policy imperatives, and establish measurable outcomes.

Policy recommendations

The report sets out policy recommendations designed to translate equity commitments into coherent, actionable, and measurable steps.

The recommendations provide guidance for all policy makers seeking to advance equitable cancer control, with a focus on individual G7 Cancer member countries as well as suggestions for collective actions by G7 Cancer Working Group 3 (WG3).

Advancing equity requires a combination of enabling conditions that span the entire policy cycle and sequenced actions that build cumulatively over time. Accordingly, the recommendations are organised in two complementary categories:

- **Cross-cutting enablers** – foundational conditions that underpin policy recommendations in the phased roadmap.
- **Phased roadmap** – three stages: Foundations, Integration, and Consolidation.

Cross-cutting enablers

1.1. Promote participatory governance through engagement of patients, communities, and citizens
1.2. Build and strengthen authorising environments through sustained communication and advocacy
1.3. Ensure long-term resourcing for sustainable equity initiatives
1.4. Build understanding and evidence on what works to advance cancer equity
1.5. Foster multisectoral partnerships to address upstream determinants

Phased roadmap

Stage 1: Foundations – Establishing clarity and commitment
2.1.1. Adopt clear and shared definitions of equity
2.1.2. Build a shared framework for cancer equity
2.1.3. Establish a consensus statement on equity in cancer control
Stage 2: Integration – Embedding equity into systems
2.2.1. Embed equity explicitly in NCCPs and related strategies
2.2.2. Integrate program logic models and theories of change into equity initiatives
2.2.3. Strengthen data infrastructure for equity monitoring and accountability
2.2.4. Reorient health systems towards prevention and equity
Stage 3: Consolidation – Shared learning and sustained progress
2.3.1. Document implementation practices and strategies of effective equity-promoting interventions to support timely scale and for adaptation to locally contexts.
2.3.2. Leverage international collaboration for shared learning and strengthen capacity for evidence-informed policy

Background

Commissioning, contributions and authorship

This study was conceptualised by members of the G7 WG3, co-led by Dr. Ambreen Sayani and Mr. David Meredyth. The study questions were jointly developed by working group members and

Professor Adam Elshaug. Thereafter, data collection and analysis were conducted independently by the research team, led by Professor Adam Elshaug and Rebecca Zosel, who also drafted the report with the support of a core writing team, including Dr Ambreen Sayani, Mr Daniel Chaji, Ms Merilyn Penn, and Mr David Meredyth. Dr Ambreen Sayani drafted the Introduction, and, together with Mr Daniel Chaji, Ms Merilyn Penn, and Mr David Meredyth, contributed as co-authors through study design, interpretation of results and the editorial process. All WG3 members provided project guidance and oversight and reviewed contributed content. Members of WG3 approved the final manuscript.

The analysis of cancer and health equity frameworks and G7 Cancer NCCPs was informed by equity-related questions developed by the International Cancer Control Partnership (ICCP).

G7 Cancer

G7 Cancer[2] is an international cooperation mechanism that brings together countries committed to advancing cancer control through shared expertise and coordinated action, comprising the following members:

- Australia (represented by Cancer Australia)
- Canada (represented by the Canadian Institutes of Health Research)
- France (represented by the French National Cancer Institute)
- Germany (represented by the German Cancer Research Center)
- Japan (represented by the National Cancer Center Japan)
- United Kingdom (represented by Cancer Research UK)
- United States of America (represented by the National Cancer Institute)
- International (International Agency for Research on Cancer, World Health Organization)[3].

G7 Cancer officially launched on 9 May 2023 at the initiative of the French National Cancer Institute. At this first meeting, the organisations' representatives signed a Memorandum of Understanding to set the cooperation framework. G7 Cancer provides a unique forum for participating organisations to share expertise, improve knowledge of cancer mechanisms, accelerate the transfer of scientific discoveries into clinical applications, and stimulate innovation on an international scale [1]. It strives to build upon existing international programs and focuses its efforts primarily on complex topics in need of international cooperation [2].

The six principles of G7 Cancer are:

1. G7 Cancer members act as representatives of their organisations, which may be of different types (governmental, non-governmental, international).
2. G7 Cancer is open to other organisations, with membership granted based on the mutual consent of participant organisations.

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[2] G7 Cancer is distinct from the Group of 7 (G7) intergovernmental forum. While the G7 includes Italy and the EU, G7 Cancer comprises cancer agencies from Australia, Canada, France, Germany, Japan, the UK, and the USA.

[3] The International Agency for Research on Cancer (IARC) is an observer to the G7 Cancer initiative, not a member.

3. G7 Cancer deals primarily with complex topics needing international cooperation and especially with blind spots.
4. The secretariat and presidency are established on a rotating basis.
5. Activities are financed on a program-by-program basis.
6. G7 Cancer builds on what already exists, particularly on the strategies and programs of participating organisations [1].

Four working groups address G7 Cancer's current priorities:

- Working Group 1: International data strategy, focused on pediatric cancers as a model
- Working Group 2: Poor prognosis cancers
- **Working Group 3: Cancer outcome inequities**
- Working Group 4: Cancer Prevention

G7 Cancer Working Group 3: Cancer outcome inequities

This research falls under the portfolio of the G7 Cancer Working Group 3: Cancer Outcome Inequities.

Members of G7 Cancer Working Group 3 represent the following organisations (current as of March 2026):

- Canadian Cancer Survivor Network
- Canadian Institutes of Health Research
- Canadian Partnership Against Cancer
- Cancer Australia
- Cancer Research UK
- French National Cancer Institute (*Institut National du Cancer*, abbreviated INCa)
- German Cancer Research Center (*Deutsches Krebsforschungszentrum*, abbreviated DKFZ)
- International Agency for Research on Cancer (IARC)
- National Cancer Center Japan
- Vanderbilt University Medical Center.

To better understand the challenges and identify promising policy approaches to addressing cancer inequities, Working Group 3 conducted a survey across G7 Cancer member countries in 2024. Respondents were asked about:

- Priority populations affected by cancer inequities
- Inclusion of health equity in national cancer plans
- Existing initiatives addressing inequities
- Evaluation methods used
- Barriers to progress
- Opportunities for G7 Cancer collaboration.

This research builds on the initial survey findings and expands the evidence base to support collective action on cancer equity.

Terminology

This report reflects an international collaboration involving seven countries. Variations in terminology exist across participating jurisdictions, including differing uses of terms such as *inequity*, *inequality* and *disparity*. To preserve contextual accuracy and nuance, terminology has been retained as used in source materials, including national policy documents and stakeholder interviews.

1. Introduction

Cancer is one of the leading causes of morbidity and mortality worldwide and represents a growing public health priority. In 2022, there were an estimated 20 million new cases and 9.7 million deaths globally [3], a burden projected to rise to more than 35 million new cases by 2050 as populations grow and age [4]. While advances in cancer prevention, early detection, and treatment have contributed to declining mortality in some settings, these gains have not been equitably realised across or within countries [5, 6]. Persistent inequities in cancer outcomes remain patterned along social and economic lines [7-9], reflecting the cumulative effects of several factors, including colonialism, systemic racism, austerity, and other structural legacies [10, 11] .

Individuals who experience structural marginalisation often carry the largest burden of cancer [9]. However, cancer inequities extend across the entire population. When evidence is available, it consistently demonstrates a clear socioeconomic gradient in cancer outcomes, particularly mortality, across countries and for most cancer types [12]. This gradient indicates that virtually every individual could improve their health and reduce their risk of dying from cancer, not solely those in the most disadvantaged groups. Already socioeconomic inequalities account for a substantial share of cancer deaths [12]. Consequently, the overall population-level burden of cancer cannot be substantially reduced without addressing inequalities in cancer [13-15]. Recognising this concept highlights a key “equity rationale”: a practical and evidence-based imperative for action that complements the equally important ethical rationale of justice and fairness.

Equity-focused health policy has been shown to reduce health inequities *AND* strengthen social cohesion and improve overall population health generating wider benefits for society, including economic resilience [16-18]. Within this framing, it is useful to distinguish between ***equity in health*** – the absence of avoidable differences in health outcomes such as incidence, survival, and quality of life; and ***equity in access to health care*** – which relates to the fair opportunity to have healthcare needs met in a way that is approachable, acceptable, available, affordable, and appropriate [19-23]. While equitable access is essential, focusing only on service provision obscures the deeper drivers of inequities in health outcomes, which arise from structural determinants of health. These determinants shape the social gradient in cancer risk, forming a ***staircase of inequities*** that is reinforced at each step of the cancer care pathway (from prevention through to survivorship) by inequitable service design and delivery [24, 25].

The urgency of advancing equity in cancer control is heightened by the complex and interrelated challenges facing health systems. Factors such as climate change, economic austerity, cost-of-living pressures, and population ageing intersect with the growing burden of non-communicable diseases, including cancer. Together, these dynamics generate conditions that intensify vulnerability and destabilise health systems [26]. In such conditions, inaction carries high costs: delayed diagnoses, escalating treatment expenditures, productivity losses, and worsening social instability [27, 28]. By contrast, equity-oriented action yields wide-ranging returns: earlier detection reduces the need for costly late-stage interventions, healthier populations support economic productivity, and more equitable systems foster social cohesion and resilience [17].

National Cancer Control Plans (NCCPs) remain the principal instruments through which countries coordinate cancer prevention, treatment, and care, in line with World Health

Organization (WHO) recommendations for comprehensive cancer control [29]. Yet, NCCPs vary widely in the extent to which they embed equity in their framing, governance, implementation, and monitoring mechanisms [30, 31]. Even where equity is recognised as a priority, translating commitments into measurable action remains an ongoing challenge. Comparative analyses show that while high-level goals are often articulated, explicit objectives, indicators, and accountability mechanisms to improve outcomes for priority populations—defined as groups experiencing social, economic, or structural disadvantage and framed in public health policy through proportional action on disease burden, tailored interventions, and resource allocation [32] —are often absent or underdeveloped [30]. This reflects broader tensions between evidence and policymaking: while research demonstrates the value of proportionate universalism and upstream intervention, policy decisions are mediated by competing narratives and fiscal constraints [33].

This report is situated within this complex landscape. Building on the work of the G7 Cancer Working Group 3, it synthesises insights from across seven high-income countries to identify initiatives that advance cancer equity. The study was conducted in three phases: documentary analysis of cancer and health equity frameworks, analysis of G7 Cancer country NCCPs, and semi-structured qualitative interviews. The report highlights practical policy approaches supporting commitments to address cancer inequities in G7 Cancer countries, and introduces a framework for equitable cancer policy, developed through analysis of international frameworks. The report concludes with a set of policy recommendations designed to support governments in translating equity commitments into coherent, actionable, and measurable steps—advancing outcomes that benefit both those most affected and societies as a whole.

Study Objectives

- To examine equity-related policies, practices, and challenges across G7 Cancer countries.
- To identify innovative and effective strategies for addressing cancer inequities, including real-world efforts to address inequity with potential for adaptation and application across G7 Cancer countries.
- To provide practical, adaptable recommendations to inform future health policy and cancer control strategies that promote more equitable outcomes across G7 Cancer countries and other similar contexts.

2. Methods

The study employed a qualitative descriptive approach, appropriate for policy-focused research aiming to capture and synthesise stakeholder perspectives without imposing a specific theoretical lens. The approach was selected to provide a rich, contextualised understanding of the policy levers influencing cancer equity across G7 Cancer countries.

The study was informed by a constructivist/interpretivist paradigm, *recognising that knowledge is socially constructed and shaped by political, institutional, and contextual factors* [34]. This paradigm supported the use of semi-structured interviews to explore diverse views and interpretations, acknowledging the influence of participants' institutional roles and national contexts.

A formal guiding theory was not applied; however, the research was conceptually informed by principles of health equity and public policy analysis. This enabled the identification of practical and transferable insights across jurisdictions while maintaining sensitivity to context.

The chosen approach and paradigm aligned with the study's aim to generate policy-relevant insights grounded in the lived realities and professional expertise of policy leaders involved in the study.

The study was conducted in three phases, incorporating a documentary analysis of cancer and health equity frameworks, an analysis of National Cancer Control Plans, and semi-structured qualitative interviews.

2.1 Phase 1 - Documentary analysis: Cancer and health equity frameworks

A desktop review and documentary analysis were undertaken to examine international, national, and subnational frameworks and data sources relevant to cancer equity (see Appendix 1a for full dataset).

The objectives of the analysis were to:

- Identify theoretical foundations, policy approaches, and evaluation frameworks for addressing cancer outcome inequities
- Develop a menu of practical policy approaches and evaluation mechanisms with potential cross-country applicability to support the operationalisation and embedding of equity within cancer control policy
- Contribute evidence to the development of a framework for advancing cancer equity.

The review focused on national and subnational cancer and health equity frameworks from G7 Cancer countries - Australia, Canada, France, Germany, Japan, the United Kingdom, and the United States - as well as selected international examples. For the purposes of this analysis, the United Kingdom was considered as four separate nations: England, Scotland, Wales, and Northern Ireland.

Searches were conducted using grey literature databases, government websites, and institutional repositories.

Documents were screened for relevance and included if they provided insights into national cancer control planning, evaluation frameworks, or equity-oriented policy approaches in high-income settings (see Table 1 below for inclusion and exclusion criteria). Relevant data were extracted into a structured template to enable cross-source comparison and were summarised narratively to support synthesis and integration with findings from expert interviews (Phase 3).

Table 1 - Inclusion and exclusion criteria

Inclusion criteria	• Frameworks relevant to at least one of the G7 Cancer countries • Explicit focus on cancer and/or health equity • Inclusion of strategies, goals, policies, or indicators related to reducing inequities or improving equity in cancer prevention, detection, treatment, or survivorship
Exclusion criteria	• Not published and/or available to the research team in English. • No focus on equity in cancer or health outcomes • Primarily focused on non-cancer conditions

The analysis captured both high-level design features and deeper qualitative insights across the identified frameworks. Key variables supporting the analysis are presented below in Table 2:

Table 2 - Key variables for cancer and health equity frameworks analysis

Variable	Definition	Response Options
General information		
Framework title	The title of the identified framework. Open-text response.	
Authoring organisation	Organisation(s) responsible for developing or publishing the framework. Open-text response.	
Authors	Individual(s) responsible for developing the framework. Open-text response.	
Date produced	Year the document was published. Open-text response.	
Country/Region	The geographic scope of the framework. Response(s) selected from a pre-defined list of options.	Australia Canada England France Germany Global

		Japan Northern Ireland Scotland United Kingdom United States Wales Europe Other
Scope	The scope of the framework refers to the overall focus or domain to which the framework applies. Response selected from a pre-defined list of options.	**Cancer equity** *Frameworks that specifically focus on addressing inequities in cancer prevention, diagnosis, treatment, survivorship, and outcomes.* **Noncommunicable Diseases (NCDs) equity** *Frameworks that address equity across NCDs (excluding cancer-specific focus), addressing risk factors, care pathways and outcomes.* **Health equity** *Frameworks that focus more broadly on reducing inequities across the entire health system, spanning multiple diseases, services, and determinants of health.* **Equity** *Cross-sectoral frameworks that address equity in a general sense, extending beyond health to encompass cultural, social, economic, environmental, commercial, structural or other domains.* **Other** *Frameworks that do not fit within the above categories, such as those centred on specific sub-populations, settings, or thematic issues.*
Typology of equity framework	The classification of frameworks according to the functions or mechanisms they use to advance equity, rather than the subject matter or scope they cover. Response selected from a pre-defined list of options.	**Policy frameworks** *Policy frameworks set out high-level principles, values, and strategic commitments to equity.* Implementation and communication tools *Tools that provide practical guidance, instruments, or messaging strategies to embed equity in practice.* **Data, monitoring, and evaluation frameworks** *Frameworks that establish systems and indicators for tracking, assessing, and reporting on equity.* **Organisational frameworks** *Frameworks that define governance*

		arrangements, leadership roles, and accountability structures to support equity.
Equity definition	Definition of equity employed by the framework. Open-text response.	Open text definition as specified in the report Not defined in report Not equity focused
Priority populations	Priority populations identified in the framework. Response(s) selected from a pre-defined list of options.	People in lower socio-economic groups People living with mental illness People living with disability People from culturally and linguistically diverse (CALD) backgrounds Racialised people Lesbian, gay, bisexual, trans and gender diverse, intersex, queer, questioning, and asexual (LGBTIQA+) people Indigenous Peoples Older people Adolescents and young adults Children People living in geographically remote areas Immigrants and refugees Other
Determinants of health	Determinants of health associated with differences in cancer outcomes identified in the framework. Response(s) selected from a pre-defined list of options.	Cultural Social Commercial Environmental Economic Structural Other
Equity Commitment		
Does the framework define equity?	Whether the framework provides an explicit definition of equity, either its own or one adopted from an external source. Response selected from a pre-defined list of options.	Yes No
Does the framework include an explicit statement or overall goal related to health equity?	Whether the framework clearly articulates health equity as a stated objective or overarching aim. Response selected from a pre-defined list of options.	Yes, plan includes an explicit statement about the importance of cancer-related health equity Yes, plan includes a goal related to health equity No

Is the explicit statement or overall cancer-related or health equity goal qualitative, quantitative, or both?	Identifies whether the framework's equity goal is expressed in descriptive terms (qualitative), measurable targets (quantitative), or a combination of the two. Response selected from a pre-defined list of options.	Qualitative Quantitative Both
Does the framework specify how success of the cancer-related or health equity goal is designed and monitored?	Whether the framework outlines indicators, processes, or mechanisms to measure and track progress toward achieving its equity goal. Response selected from a pre-defined list of options.	Yes No
Does the framework include any objectives to reduce disparities in any cancer outcomes or address cancer-related inequities?	Whether the framework sets specific goals or targets aimed at minimising inequities in cancer incidence, care, survival, or other related outcomes. Response selected from a pre-defined list of options.	Yes Yes, and objectives are measurable No
Policy Components and Evaluation for Success		
Policy components	The actions, strategies, or interventions proposed in the framework to address cancer control and related health system priorities. Open-text response.	Open text description of action, strategy or intervention
Does the framework have guidance on evaluation for success of the framework?	Whether the framework provides instructions, criteria or methods for assessing the overall success of the framework. Open-text response.	Open text description

The documentary analysis employed a five-step strategy to identify and analyse cancer and health equity frameworks. The primary objective was to capture frameworks that explicitly

addressed cancer equity or embedded equity as a core component of cancer control or broader public health strategies relevant to G7 Cancer countries.

Step 1: Identification of key international organisations

A preliminary scan was conducted of major international cancer and health organisations, including the World Cancer Research Fund, International Cancer Research Partnership, World Health Organization (WHO), International Agency for Research on Cancer (IARC), Organisation for Economic Co-operation and Development (OECD), United Nations (UN), and the Union for International Cancer Control (UICC). These bodies were reviewed for relevant reports, frameworks, strategies, or initiatives that align with cancer and/or health equity themes.

Step 2: G7 Cancer country-specific framework search

Each G7 Cancer country was then searched individually to identify national and subnational cancer and health equity frameworks. This included reviewing government health department websites, national cancer control plans (NCCPs) or equivalent policy documents, research institutions, and public health agencies for documents that meet the inclusion criteria.

Step 3: Structured search strategy

A detailed and reproducible search strategy was developed using Google Scholar, and targeted website queries. Keywords and Boolean operators were customised to include combinations of terms. The full search strategy is in Table 3 below. The final search was conducted on 21 July 2025.

Table 3 - Search strategy for the cancer and health equity frameworks analysis

Search	Keywords						
Search 1 (general)	*Cancer*	*AND*	*Equity*	*AND*	*Framework*		
Search 2 (with G7 Cancer countries)	*(Cancer OR Health)*	*AND*	*Equity*	*AND*	*Framework*	*AND*	*(Australia OR Canada OR England OR France OR Germany OR Japan OR 'Northern Ireland' OR Scotland OR 'United Kingdom' OR 'United States' OR Wales)*
Search 3 (with institutions)	*(Cancer OR Health)*	*AND*	*Framework*	*AND*	*('World Cancer Research Fund' OR 'International Cancer Research Partnership' OR 'World Health Organization' OR WHO OR 'International*		

					Agency for Research on Cancer' OR IARC OR 'Organization for Economic Co-operation and Development' OR OECD OR 'United Nations' OR UN OR 'Union for International Cancer Control' OR UICC)		
Search 4 (with synonyms for framework)	*(Cancer or Health)*	*AND*	*(System OR Structure OR Blueprint OR Model)*				
Search 5 (with synonyms for framework and countries)	*(Cancer or Health)*	*AND*	*(System OR Structure OR Blueprint OR Model)*	*AND*	*(Australia OR Canada OR England OR France OR Germany OR Japan OR 'Northern Ireland' OR Scotland OR 'United Kingdom' OR 'United States' OR Wales)*		

Step 4: Review of National Cancer Control Plans

Each G7 Cancer country's most recent NCCP or equivalent strategic document was reviewed to identify embedded equity frameworks, goals, and/or initiatives that address inequities in cancer outcomes (Phase 2). While NCCPs were not directly included in the Phase 1 frameworks analysis, they were reviewed to identify additional frameworks for inclusion in Phase 1.

Step 5: Frameworks from interviews and surveys

Additional frameworks were identified through responses to the 2024 survey of G7 Cancer member countries, as well as qualitative interviews with key stakeholders, researchers, and policymakers within G7 Cancer countries (Phase 3). These sources provided insight into lesser-known or emergent frameworks that are not widely published.

The purpose of the analysis was to describe the scope and content of identified frameworks, rather than to assess their quality, implementation, or impact.

2.2 Phase 2 - Documentary analysis: National Cancer Control Plans

NCCPs are increasingly central to directing national efforts to address the growing burden of cancer, consistent with WHO recommendations [35, 36].

The objectives of the NCCP analysis were to:

- Examine how equity is articulated and embedded within the NCCPs of G7 Cancer countries.

- Identify policy approaches, priorities, and accountability mechanisms related to cancer equity across the NCCPs of G7 Cancer countries.
- Highlight the diversity of approaches to equity integration and operationalisation across G7 Cancer NCCPs.
- Support the identification of relevant frameworks for inclusion in the broader documentary analysis of cancer and health equity policy frameworks (Phase 1) and provide critical background to guide qualitative data collection in Phase 3.

A structured review was conducted of the NCCPs or equivalent national strategy documents across all G7 Cancer countries. For the purposes of this analysis, the United Kingdom was considered as four separate nations - England, Scotland, Wales, and Northern Ireland - each with its own plan, analysed individually alongside the plans from the remaining six countries.

The most recent publicly available NCCPs or equivalent policy documents, up to July 2025, were identified through a combination of reviewing 2024 survey responses, targeted web searches, official government portals, and consultation of grey literature. In cases where no formal NCCP was published, the most comparable national strategy documents related to cancer prevention and control were selected for review.

The review assessed thirteen distinct areas:

1. NCCP/Plan overview: Basic information about the plan, including title, publication date, coverage period, type, and lead agency.
2. Equity definitions: whether equity is explicitly defined and how it is described.
3. Equity keywords: Presence and frequency of terms related to equity, inequity, equality, inequality, fair/fairness, access, experience, priority population group, and determinant.
4. Equity expression: how equity is conceptualised, e.g., in terms of access, outcomes, vulnerability, or societal value.
5. Equity-specific commitments: explicit statements or goals in the Plan that address equity.
6. Equity principles: guiding or overarching principles, including those addressing equity.
7. Data strategies and equity metrics: inclusion of data strategies and measurable indicators to monitor equity progress.
8. Strategic approach to equity: use of universal, targeted, or blended approaches to address inequities.
9. Policy areas prioritised: health, income, living, social, and employment dimensions targeted for equity improvement.
10. Cancer continuum stage focus: points along the cancer care continuum (prevention and early detection, diagnosis, treatment, survivorship, palliative and end-of-life care, and overall cancer burden and outcomes).
11. Priority population groups: population subgroups identified for action to reduce inequities.
12. Determinants of health: social, cultural, economic, structural, environmental, and commercial dimensions considered in the plan.
13. Key actors: stakeholders involved, including cross-sector collaboration, roles, responsibilities, and typology of actors.

These thirteen areas enable a nuanced understanding of national efforts to be developed and identify both common challenges and innovative practices. Each area was further divided into a set of dimensions and subcategories, outlined in Appendix 2. The analysis of the Plans' equity-specific commitments was conducted in two tiers, as detailed in Appendix 3.

NCCPs not published in English (those from Japan and Germany), were translated using automated translation tools. These translations were not subject to professional or human verification, and as such, interpretation of language-sensitive content may be limited by this constraint.

Data were extracted and organised using a standardised template capturing the thirteen distinct areas, along with their related dimensions and subcategories (Appendix 2), to enable comparison across countries. Although the findings are not intended to be evaluative, they offer important insights into how cancer control is conceptualised, operationalised, and monitored within G7 Cancer countries.

2.3 Phase 3 - Qualitative interviews

Building on the contextual insights gathered in the desktop and NCCP reviews, Phase 3 involved semi-structured interviews with representatives from each G7 Cancer member country.

The objectives of the interviews were to:

- Understand **national perspectives** on cancer inequities, including key policies, practices, and contextual factors
- Explore **common enablers and challenges** faced by G7 Cancer countries in addressing cancer inequity and operationalising equity-focused cancer control policies
- Identify **practical policy approaches** being implemented in G7 Cancer countries to support commitments to address inequity.

Sample and recruitment

Participants were purposively selected through nominations by G7 Cancer Working Group 3 members, based on their recognised expertise and leadership in cancer control within their respective countries. Demographic data (e.g. age, gender, ethnicity) were not collected, as the study focused on institutional perspectives and national policy approaches rather than individual experiences. Participants were selected based on their professional roles, expertise, and organisational affiliations relevant to cancer control and equity policy. Although participants did not speak on behalf of their organisations, the analysis draws on insights informed by their professional, institutional, and system-level experiences, rather than personal or identity-based perspectives.

Of the 27 individuals invited across G7 Cancer member countries, 20 participated in interviews, resulting in a participation rate of 74%.

This sample size was deemed sufficient to achieve the project's aim of gathering high-level qualitative insights from experts directly involved in cancer control policy and equity. Data collection continued until thematic saturation was reached—that is, no new concepts or

categories were identified in subsequent interviews. Saturation was assessed and monitored during weekly debriefs by the research team.

Data collection

Interviews were conducted virtually via video conference (e.g. Zoom/Teams) and lasted approximately 45–60 minutes.

Data were collected using a semi-structured interview guide developed specifically for this study.

The guide was designed to ensure consistency across interviews while allowing flexibility to explore emerging themes in depth. It covered seven core areas:

- Introductions and context
- Background information
- Equity definitions and national context
- Current policy approaches
- Data, monitoring, and evaluation
- Key actors
- Enablers, challenges, and future directions.

Prompts were included to facilitate rich, reflective discussion and to support comparability across country responses. The guide was informed by the documentary analyses conducted in Phases 1 and 2, as well as input from the research team and members of the G7 Cancer Working Group 3.

Data analysis

Interview recordings were transcribed then returned to participants for optional review, comment, and correction prior to coding. Interview data were analysed using a combination of thematic and narrative approaches to develop a rich understanding of participants' perspectives and experiences.

A coding framework was developed using both deductive (informed by literature and project objectives) and inductive (emerging from the data) approaches. Analysis was iterative and comparative, with continuous refinement of themes to ensure rigour. Narrative and content analysis techniques were applied to explore patterns in how participants framed cancer inequities and policy responses.

Reporting framework

This report drew on both the Consolidated Criteria for Reporting Qualitative Research (COREQ) [37] and the Standards for Reporting Qualitative Research (SRQR) [38] to guide transparent, rigorous, and comprehensive reporting of the qualitative components. COREQ's 32-item checklist provided detailed guidance on interview design, data collection, and researcher reflexivity, while SRQR offered a broader framework emphasising contextual information, ethical considerations, and trustworthiness. This combination ensured both detailed transparency (COREQ) and a high-level overview of methodological rigour (SRQR).

While these frameworks informed the development, conduct, and documentation of participant recruitment, data analysis, and reporting processes, they were used flexibly rather than prescriptively, allowing adaptation to the specific context of this study. This approach enhanced the credibility and clarity of the findings and aligned with best practice standards in qualitative research reporting.

Ethical approval and considerations

Ethical approval was granted by the University of Melbourne Human Research Ethics Committee (Reference Number 2025-32638-66386-2). All participants provided written informed consent. Participation was voluntary and uncompensated, and confidentiality and anonymity were maintained.

3. Results

3.1 Phase 1 Findings - Documentary analysis: Cancer and health equity frameworks

This section presents findings of the documentary analysis of relevant cancer and health equity frameworks, including their relevance to G7 Cancer member countries.

3.1.1 Frameworks Overview

As of 21 July 2025, 53 frameworks relevant to cancer equity were identified across G7 Cancer countries and international organisations, published between 2005 and 2025. Three of these frameworks did not include a listed publication date [39-41] and one was still under development [42]. Most were produced by government agencies, public health institutes, charities, or international organisations.

Supplementary results of the documentary analysis are provided in Appendix 1b, detailing a full reference list of the 53 frameworks, definitions of equity, health equity and cancer equity related statements, policy components, and evaluation methods.

These frameworks provide the policy context for cancer equity action across G7 Cancer member countries, highlighting shared priorities, diverse approaches, and evidence-informed policy and evaluation components.

3.1.2 Frameworks by Country and Region

Frameworks were categorised along two dimensions: origin (developed by a single country versus an international/multi-country group) and geographical scope of application (country-specific, regional, multi-regional, or global).

- **Country-specific frameworks** are developed for, and applied within, a single country.
- **Regional, multi-regional, and global frameworks** encompass multiple G7 Cancer member countries, and are listed in increasing order of geographical scope from smallest to largest.

Table 4 summarises the frameworks by country and region, in order of geographical reach, alongside the G7 Cancer member countries to which each framework applies. This classification highlights substantial variation in the number and scope of equity frameworks across G7 Cancer countries.

Table 4 - Frameworks by G7 Cancer Member Country and Region

Category	Country or Region	Number of Frameworks	Relevant G7 Cancer Member Countries
G7 Cancer country-specific	Australia	11	Australia
	Canada	5	Canada
	France	0	France
	Germany	1	Germany
	Japan	2	Japan
	United Kingdom, of which: - England: 4 - Scotland: 3	16	United Kingdom

	- Wales: 3 - Northern Ireland: 1 - UK: 5		
	United States	5	United States
Regional	Europe	4	France and Germany
Multi-regional		1	Australia, Canada, France, Japan, United Kingdom, United States
Global		8	All member countries
Total		**53**	

3.1.3 Frameworks by Scope and Typology

Frameworks were then categorised by scope to identify the breadth of healthcare covered by each one, and ordered from narrowest to broadest as follows:

- **Cancer** equity frameworks covering cancer policy only
- **Non-communicable disease** frameworks covering cancer as part of a broader disease category
- **Health** equity frameworks covering generalisable aspects of healthcare
- **Broader** equity frameworks covering non-health-specific factors such as social determinants and structural drivers.

Table 5 quantifies frameworks by scope and shows a predominance of cancer-specific frameworks among the 53 frameworks identified. This classification underscores the priority placed on reducing disparities in cancer outcomes among G7 Cancer member countries. It suggests a shared commitment to embedding equity principles within cancer policy, as well as in healthcare policy more generally.

Table 5 - Frameworks by Scope

Framework scope	Number of Frameworks n (%)	Relevant G7 Cancer Member Countries
Cancer equity	24 (45%)	All member countries
Noncommunicable Diseases (NCDs) equity[1]	2 (4%)	Australia
Health equity	18 (34%)	All member countries
Broader equity	8 (15%)	All member countries
Other[2]	1 (2%)	Japan
Total	**53**	

[1.] The analysis did not specifically assess NCD plans for equity content, additional frameworks with components relevant to equity may exist. This apparent scarcity should be interpreted with caution.

[2.] One framework [40] was classified as 'Other' because, although it outlines the planning-doing-checking-acting cycle and serves as a broad quality improvement tool, it does not explicitly address equity.

Table 6 illustrates the typology of equity frameworks and reveals the varied approaches adopted across G7 Cancer countries. Examples of all framework types were found in the global frameworks.

- **Policy** frameworks reflect a strong emphasis on strategic direction-setting and the integration of equity principles into health systems.
- **Implementation and communication tools** demonstrate efforts to translate equity goals into practical action.
- **Data, monitoring and evaluation** frameworks highlight the use of evidence and metrics to track progress and identify gaps.
- **Organisational** frameworks indicate attempts to embed equity objectives within institutional structures and processes.

Many of the 24 policy frameworks likely also incorporate elements of the less common typologies, such as implementation, communication, data, and evaluation, even if these components are not explicitly classified as standalone frameworks.

Overall, this distribution suggests that policy direction for equity is well-established across G7 Cancer member countries, while comparatively fewer frameworks focus on the operationalisation, measurement, and institutionalisation of equity within cancer control and health systems.

Table 6 - Typology of Equity Frameworks

Typology of Equity Frameworks	Number of Frameworks n (%)
Policy Frameworks	24 (45%)
Implementation and Communication Tools	15 (28%)
Data, Monitoring, and Evaluation Frameworks	9 (17%)
Organisational Frameworks	5 (9%)
Total	**53**

3.1.4 Identification of Priority Population Groups

Most frameworks (all except three [40, 43, 44]) addressed the unique needs of one or more priority population groups, which included:

- People in lower socio-economic groups
- Adolescents and young adults
- People from culturally and linguistically diverse (CALD) backgrounds
- People living in geographically remote areas
- Children
- People living with mental illness
- People living with disability
- Racialised people
- Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual (LGBTIQA+) people
- Older people
- Immigrants and refugees
- Indigenous peoples.

Some frameworks explicitly identify priority population groups. For example, Canada's *Advancing Health Equity Through Cancer Information and Support Services* names 2SLGBTQI+ communities, adolescents and young adults with cancer, advanced cancer, communities that don't speak English or French, Indigenous communities, newcomers to Canada, older adults, racialised communities, rare cancer, and rural and remote communities [45].

While most frameworks reference priority populations, the extent and specificity of focus vary. Some provide detailed lists and dedicated strategies tailored to these groups, recognising that targeted action is essential to reducing disparities in cancer outcomes and improving access to care. Others mention priority populations more generally.

Table 7 is ordered from the most to least frequently recognised priority population groups across frameworks. Across the 53 frameworks, people in geographically remote areas (n = 37/53, 70%), those from CALD backgrounds (n = 34/53, 64%), children (n = 34/53, 64%), and adolescents and young adults (n = 32/53, 60%) are most commonly identified priority populations. In contrast, immigrants and refugees (n = 16/53, 30%), LGBTIQA+ people (n = 18/53, 34%), and Indigenous peoples (n = 22/53, 42%) were less frequently recognised, highlighting variation in how equity priorities are defined across frameworks. This variation also likely reflects contextual differences. For example, not all G7 Cancer countries have Indigenous populations (only Australia, Canada, and the USA); disparities among some groups, such as immigrants and refugees, have only recently been documented [46]; and CALD populations may subsume immigrant and refugee groups. There is also overlap with other groups. For example, actions concerning racialised people may indirectly address Indigenous peoples without explicitly naming them. All G7 Cancer countries addressed each of these priority population groups either directly or indirectly through globally applicable frameworks.

Table 7 - Frequency of Priority Population Groups Across Frameworks

Priority Population Groups	Number of Frameworks n (%)
People living in geographically remote areas	37 (70%)
People from CALD backgrounds	34 (64%)
Children	34 (64%)
Adolescents and young adults	32 (60%)
People in lower socio-economic groups	31 58%)
People living with mental illness	30 (57%)
People living with disability	29 (55%)
Older people	25 (47%)
Racialised people	24 (45%)
Indigenous peoples	22 (42%)
LGBTIQA+ people	18 (34%)
Immigrants and Refugees	16 (30%)

3.1.5 Determinants of Health

Most frameworks (all except four [40, 43, 44, 47]) acknowledge the role of determinants of health in shaping cancer outcomes, either explicitly or indirectly, often without using that exact term. These determinants are incorporated across national, regional, multi-regional, and global frameworks, reflecting a broad understanding of the societal factors influencing cancer risk, healthcare access, and disparity in outcomes.

Determinants of health can be understood at three interconnected levels, each indicating the level at which these determinants operate:

- **Upstream determinants**: Cultural, social, and structural factors such as social and economic policies that shape housing, income, and education.
- **Midstream determinants***:* Community- or environmental-level conditions influencing choices and opportunities, such as tobacco pricing or access to healthy food
- **Downstream determinants***:* Micro-level individual factors, including genetics, health behaviours, and personal healthcare access [48].

The identified frameworks emphasise the complex interplay of social, cultural, economic, structural, environmental, and commercial determinants, extending strategies beyond clinical care to acknowledge that there are broader influences contributing to cancer and health equity.

Table 8 summarises how frequently each determinant category is referenced across the frameworks. Cultural and economic determinants are the most frequently referenced (41 frameworks each, 77%), followed by environmental (40, 75%), followed by structural determinants (37, 70%) and social (36, 68%). Commercial determinants are least cited (15 frameworks, 28%). Many determinants span multiple levels—for instance, economic factors can reflect both structural policies (upstream) and community-level interventions (midstream). While the table shows prevalence across frameworks rather than mapping each determinant to a specific level, it highlights where policy levers may act across the cancer control continuum and informs priority areas for targeted, equity-focused policies.

Table 8 - Determinants of Health by Number of Frameworks

Determinants of Health	Number of Frameworks n (%)
Cultural	41 (77%)
Economic	41 (77%)
Environmental	40 (75%)
Structural	37 (70%)
Social	36 (68%)
Commercial	15 (28%)

3.1.6 Equity Analysis

The equity analysis examined frameworks across five different dimensions: whether equity was explicitly defined; whether a framework included a statement or goal on health equity; the type of goal (qualitative, quantitative, or both); whether success of the goal was designed and monitored; and whether specific objectives were included to reduce disparities in cancer outcomes.

There was considerable variation in how equity is defined, embedded, and measured across national cancer and health equity frameworks. Only 18 (34%) of 53 frameworks explicitly define equity. These span all G7 Cancer member countries, indicating broad recognition of equity, albeit with varying levels of articulation.

Regarding commitment, 21 (40%) frameworks include general statements affirming the importance of **cancer-related health equity**; while these may also address broader health equity, they are categorised here primarily as they have cancer-related health equity goals. In contrast, only one framework (2%) – the Australian National Strategic Framework for Chronic

Conditions - includes a specific **health equity goal** that is not cancer-specific, aiming to improve health outcomes for priority populations with or at risk of chronic conditions through targeted action and community empowerment [49]. The remaining 31 (58%) frameworks lack an explicit equity statement or goal, although some may address equity implicitly.

Of the frameworks which contained explicit equity statements or goals, these were most often expressed in qualitative terms (15/22, 69%)), three employed quantitative measures, and four employed a combination of both. This suggests that commitments to equity are more frequently articulated as aspirational rather than operationalised through measurable targets.

Monitoring and evaluation were also underdeveloped; 14 (26%) frameworks specify how the success of identified equity goals will be monitored, highlighting limited integration of formal monitoring and evaluation approaches, despite equity being embedded in frameworks across all G7 Cancer countries.

Only a small subset of frameworks (10, 19%) included objectives to reduce cancer disparities, with even fewer (3, 6%) including measurable objectives. The majority (40 frameworks; 75%) lack such objectives. This indicates that, while equity is often acknowledged in principle, it is less frequently translated into concrete, actionable commitments.

Table 9 summarises these results across all five dimensions of equity commitment. It highlights how definitions, statements, goals, monitoring mechanisms, and objectives vary across G7 Cancer countries, showing both the breadth of recognition of equity and the persistent gaps in its operationalisation.

Table 9 - Framework Equity Analysis

Equity Commitment	Number of Frameworks	Relevant G7 Cancer Member Countries
Does the framework define equity?	Yes: 18/53 (34%)	All member countries
	No: 35/53 (66%)	All member countries
Does the framework include an explicit statement or overall goal related to health equity?	Yes, plan includes an explicit statement or overall goal about the importance of cancer-related health equity: 18/53 (34%)	All member countries
	Yes, plan includes a goal related to health equity: 4/53 (8%)	All member countries
	No: 31/53 (58%)	All member countries
Is the explicit statement or overall cancer-related or	Qualitative: 15/22 (69%)	All member countries
	Quantitative: 3/22 (14%)	Canada, France, Germany, and United Kingdom[4]

[4] There are three quantitative frameworks that apply to four countries because the *European Cancer Inequalities Registry (ECIR) Framework* covers both France and Germany.

health equity goal qualitative, quantitative, or both?	Both: 4/22 (18%)	Australia, Canada, France, and Germany
Does the framework specify how success of the cancer-related or health equity goal is designed and monitored?	Yes: 14/22 (64%)	All member countries
	No: 8/22 (36%)	
Does the framework include any objectives to reduce disparities in any cancer outcomes or address cancer-related inequities?	Yes: 10/53 (19%)	All member countries
	Yes, and objectives are measurable: 3/53 (6%)	
	No: 40/53 (75%)	

3.1.7 Policy and Evaluation components

Table 10 summarises the frequency of policy and evaluation components across the 53 identified frameworks. These components are not limited to equity but capture the broader policy scope and evaluation mechanisms embedded in each framework.

Most frameworks (39, 74%) include no more than five policy components, while the remaining 14 (26%) include more; both groups are represented across all G7 Cancer countries. Policy components range from targeted issues - such as screening, prevention, early detection, and promoting healthy behaviours - to broader, systems-oriented approaches addressing upstream determinants, social supports, and structural reforms.

Evaluation guidance was provided in 38 (72%) frameworks, spanning all G7 Cancer countries. This often includes monitoring mechanisms, performance indicators, or evaluation frameworks to assess progress toward cancer and health equity goals, while also capturing evaluation of broader framework implementation. In some cases, these evaluation components overlap with mechanisms for tracking equity goals (see previous section), though the focus here is on general framework implementation rather than equity alone. This explains why the number of frameworks reporting evaluation guidance (38, 72%)) differs from counts in Table 10.

Table 10 - Framework Policy Components and Evaluation for Success

Category	Number of Frameworks	Relevant G7 Cancer Member Countries
Policy components	5 or less: 39/53 (74%)	All member countries
	More than 5: 14/53 (26%)	
Does the framework have guidance on evaluation for success of the framework?	Yes: 38/53 (72%)	All member countries
	No: 15/53 (28%)	

3.2 Phase 2 Findings - Documentary analysis: National Cancer Control Plans

This section presents findings from the documentary analysis of G7 Cancer member countries' National Cancer Control Plans (NCCPs), or equivalent policy documents, with a particular focus on how equity is articulated, embedded, and operationalised within these policy documents.

3.2.1 NCCP Overview

Table 11 presents the most recent publicly available NCCPs, or equivalent policy documents, identified across G7 Cancer countries for this analysis. Key details are summarised, including plan title, year of publication, coverage period, status, plan type and history, lead agency, and agency type.

Ten policy documents were identified across the G7 Cancer countries for analysis [50-59]. At the time of the analysis, all G7 Cancer countries had a NCCP, except England, where cancer policy was embedded within the broader health strategy [55]. This is a dynamic policy environment England's 10 Year Health Plan was published on 3 July 2025, with a dedicated National Cancer Plan published on 4 February 2026 [60]. In the United States, the full National Cancer Control Plan (PDF) is no longer publicly available; however, a high-level overview of the plan remains accessible online [59].

Australia, Japan, Northern Ireland, Scotland, Wales, and the USA have released their first dedicated NCCPs within the past five years, suggesting a recent emphasis on stand-alone national cancer strategies. In contrast, Canada, France, and Germany have longer policy histories, with NCCPs dating back to 2006, 2003, and 2008, respectively. Japan was the first G7 Cancer country to adopt a NCCP, launching its inaugural strategy in 1984.

Leadership of Plans varies across countries. Canada's plan is led by the Canadian Partnership Against Cancer, an independent federally funded not-for-profit organisation, while Australia, France, and the USA have cancer-specific lead agencies. Germany, Japan, England, Northern Ireland, and Scotland house responsibility within broader health ministries or departments. Wales has a hybrid model, with leadership located in a health service executive body rather than a government ministry or dedicated cancer agency.

Plan timespans differ across G7 Cancer countries. Most span ten years; exceptions include Wales (three years), France (four years), and Japan (six years). Germany's NCCP has been ongoing since its initial release in 2008, with updates in 2017. Coverage information for the USA plan was not specified in the document.

Table 11 - Summary of National Cancer Control Plans and Lead Agencies in G7 Cancer countries

Country		NCCP/Plan title	Year published	Coverage period (start and end date)	Plan type and history	Lead agency	Lead agency type
Australia		Australian Cancer Plan	2023	2023-2033	First dedicated NCCP	Cancer Australia	National statutory government agency
Canada		Canadian Strategy for Cancer Control 2019-2029	2019	2019-2029	Dedicated NCCP; builds on previous plans. First NCCP published in 2006	Canadian Partnership Against Cancer	Independent federally funded not-for-profit organisation.
France		France Ten-Year Cancer-Control Strategy 2021–2025: Roadmap Progress for All, Hope for the Future	2021	2021–2025	Dedicated NCCP; builds on previous plans including Cancer Plan 2003–2007, 2009 - 2013, and 2014 - 2019	National Cancer Institute	Public administrative agency under the French Ministry of Health and Prevention
Germany		National Cancer Plan (Nationaler Krebsplan)	2017	2008 – ongoing	Dedicated NCCP; builds on 2008 original National Cancer Plan	Federal Ministry of Health	National government ministry
Japan		The 4th Basic Plan for Promotion of Cancer Control	2023	2023 - 2029	Dedicated NCCP; builds on previous plans. First NCCP published was the Comprehensive 10-year Strategy for Cancer Control (1984-1993)	The Ministry of Health, Labour and Welfare	National government ministry
UK	England	Fit for the Future: 10 Year Health Plan for England	2025	2025-2035	Cancer strategy embedded within broader health strategy; first dedicated NCCP launched 4 February 2026*	Department of Health and Social Care	National government department

	Northern Ireland	A Cancer Strategy for Northern Ireland 2022-2032	2022	2022-2032	First dedicated NCCP	Department of Health (Northern Ireland)	National government department
	Scotland	Cancer Strategy 2023 to 2033	2023	2023-2033	First dedicated NCCP	Scottish Government, Population Health Directorate	National government directorate
	Wales	A Cancer Improvement Plan for NHS Wales 2023-2026	2023	2023-2026	First dedicated NCCP; previously cancer priorities integrated within NHS plan	NHS Wales Executive	National support function, working with Welsh Government to assist NHS Wales organisations.
USA**		National Cancer Plan	2023	N/A	First dedicated NCCP	National Cancer Institute	National research Institute (USA Department of Health and Human Services).

* Note: Analysis is based on England's health plan as at July 2025.

** USA National Cancer Plan PDF was accessible on 3 April 2023 but has since been taken down from the official website. Our analysis is based on the version obtainable on that date.

Table 12 summarises publicly available documents designed to support or complement G7 Cancer country NCCPs. These documents include explicit and standalone implementation or action plans, monitoring and evaluation frameworks, and costing or budget documents. This analysis was limited to publicly available materials; internal or unpublished documents were not included, and only the presence - not the quality - of supporting materials was recorded, with quality defined as evidence-informed, justified, and well-referenced. While some NCCPs specify commitment to developing implementation plans and supporting documents, these were not publicly accessible and are therefore not reflected in this review.

Only a small number of G7 Cancer countries have publicly available supporting documents accompanying their NCCPs. Australia and Scotland are the only countries with both an implementation or action plan and a monitoring and evaluation framework. Across the G7 Cancer countries, costing appears to be a limited area of focus with Northern Ireland being the only country to publish a dedicated costing or budgeting document alongside its NCCP.

By contrast, most countries (eight out of ten per category) lack publicly available supporting documents accompanying their Plans, constraining the detail and accountability embedded within their national cancer control policy frameworks.

Table 12 - Publicly Available Supporting Documents Accompanying NCCPs in G7 Cancer Countries

Supporting Documents	Number	Relevant G7 Cancer countries
Implementation / Action Plan	Yes: 2/10 (20%)	Australia [61], Scotland [62]
	No: 8/10 (80%)	Canada, France, Germany, Japan, England, Northern Ireland, Wales, USA
Monitoring and Evaluation Plan	Yes: 2/10 (20%)	Australia [63], Scotland [64]
	No: 8/10 (80%)	Canada, France, Germany, Japan, England, Northern Ireland, Wales, USA
Costing / Budget	Yes: 1/10 (10%)	Northern Ireland [65]
	No: 9/10 (90%)	Australia, Canada, France, Germany, Japan, England, Scotland, Wales, USA

3.2.2 Equity Definitions

Although equity-related concepts are referenced across all Plans, only three G7 Cancer country plans - Australia, Canada, and Scotland - explicitly define equity within their documents (see **Table 13**).

Across these three NCCPs, equity is consistently framed around common goals, such as improving access and eliminating unjust health disparities, reflecting a shared commitment to enabling all individuals to achieve their best possible health outcomes. However, differences emerge in how equity is conceptualised: Australia and Canada adopt broad definitions, while Scotland provides a narrower, cancer-specific and service-oriented definition.

Table 13 - How Equity is Defined in select NCCPs (Australia, Canada, Scotland)

G7 Cancer country		Definition of equity in NCCP	Comment
Australia		"Health equity in cancer outcomes is the absence of disparities for people with different levels of social advantage." [31, 50] "Health equity means all Australians are supported by our national systems in the ways most suited to their cultural, socioeconomic, geographic, environmental, and personal situation to achieve the best possible cancer outcomes." [50]	Definition uses strengths-based language, emphasising attainment of equity rather than merely reducing inequities.
Canada		"The World Health Organization defines equity as the absence of avoidable or unfair differences among groups of people, whether defined socially, economically, demographically, geographically or by other means of stratification. Equity in health means everyone should have a fair opportunity to attain their full health potential and no one should be prevented from achieving it." [51, p15]	Adopts the World Health Organization definition of equity.
UK	Scotland	Equity of access to services is defined as "the treatment and care that people with cancer can access does not vary in quality depending on where they live, or because of characteristics including gender, ethnicity, disability, or socio-economic status." [57, p11]	Provides a cancer-specific, service-oriented definition.

3.2.3 Equity Keywords

Equity can be articulated in multiple ways, with terminology varying across cultures, languages, and national contexts. It is therefore important to look beyond the literal use of the term 'equity' and consider systematically identified related keywords - including plural forms, as well as strength- and deficit-oriented terms - that capture equity-related themes within NCCPs.

Keyword searches were conducted across eleven equity dimensions, and their related terms:

1. Equity – also equities, equitable, equitably
2. Inequity – also inequities, inequitable, inequitably
3. Equality – also equal, equally, equalise, equalisation, equalising
4. Inequality – also inequalities, unequal, unequally, disparity, disparities
5. Fair/fairness – also just, justly, fairly, fairer
6. Unfair/unfairness – also unjust, unjustly
7. Deprivation – also deprive, deprived
8. Access – also accessible, accessibility, accessing
9. Experience – also experiences, experienced, and experiencing
10. Priority population group – also vulnerable, vulnerabilities, marginalised, underserved, underserviced, disadvantaged, disadvantages, high-risk populations, high risk populations, at risk populations, minority groups, minoritised groups
11. Determinant – also determinants

Table 14 summarises the frequency of equity-related keywords across all Plans. The most frequent term overall was “access” (645 instances), followed by “experience” (302 instances). “Priority population group” and related terms appeared 138 times across all Plans. “Determinants” was the least used term (24 instances) and was absent from Canada, Germany, Japan, and Scotland. Importantly, terms related to “equity” and “equality” appeared in 176 instances, while terms related to inequity and inequality appeared in 170 instances, suggesting a lack of clear preference across G7 Cancer countries on the polarity relating to how equity is expressed, i.e., strengths- or deficits- based. Overall, these data highlight variation in how equity dimensions are conceptualised across different national contexts.

To further examine how equity concepts were framed, each Plan was systematically reviewed for both strengths-based and deficit-based language. This analysis provides insight into whether countries predominantly emphasise positive goals and principles (strengths-based framing) or highlight existing problems and gaps (deficit-based framing), thereby illustrating differences in policy orientation, priorities, and approaches to conceptualising equity across Plans.

Germany and Japan report no mentions of equity-related keywords in their NCCPs. This may reflect language or translation factors rather than a true absence of equity considerations in the respective plans. Interpretation of these findings should consider this limitation.

Table 14 - Equity Keywords

Equity Dimension (Key Term)	Related terms	Total mentions	Countries Mentioned (with frequency)	Countries with zero mentions	Comment
Equity	Equities, equitable, equitably	141	Australia (42), Wales (25), Scotland (21), England (17), Canada (16), USA (10), Northern Ireland (8), France (2)	Germany, Japan	
Inequity	Inequities, inequitable, inequitably	22	Canada (7), USA (5), Scotland (3), Wales (3), Australia (2), Northern Ireland (2)	England, France, Germany, Japan	
Equality	Equal, equally, equalise, equalisation, equalising	35	England (12), Japan (9), Scotland (5), Australia (5), Germany (2), Northern Ireland (1), USA (1)	Canada, France, Wales	Terms related to *Equalization* are used 9 times by Japan, but *equity* or *equality* is not used.
Inequality	Inequalities, unequal, unequally, disparity, disparities	148	Scotland (49), England (25), Northern Ireland (19), France (13), Wales (6), Canada (7), Australia (5), Japan (1)	England, France, Germany, Japan, Wales, USA	
Fair/Fairness	Just, justly, fairly, fairer	23	England (13), Australia (2), Scotland (2), Germany (5), Japan (1)	Canada, France, Northern Ireland, USA, Wales	
Unfair/Unfairness	Unjust, unjustly	3	Canada (1), England (1), Scotland (1)	Australia, France, Japan, Northern Ireland, Germany, USA, Wales	
Deprivation	Deprive, deprived	72	Northern Ireland (34), Scotland (24), England (12), France (1), USA (1)	Australia, Canada, Germany, Japan, Wales	

Access	Accessible, accessibility, accessing	645	England (169), France (81), Northern Ireland (75), Scotland (70), Canada (67), Wales (64), Australia (56), Japan (23), Germany (20), USA (20)		
Experience	Experiences, experienced, experiencing	302	England (70), Northern Ireland (55), Scotland (36), Wales (36), Australia (34), Japan (33), Canada (24), Germany (7), France (5), USA (2)		
Priority population group	Vulnerable, vulnerabilities, marginalised, underserved, underserviced, disadvantaged, disadvantages, high-risk populations, high risk populations, at risk populations, minority populations, minority groups, minoritised groups	138	England (20), France (20), Australia (18), Northern Ireland (16), USA (16), Canada (14), Germany (14), Scotland (7), Wales (7), Japan (6)		Australia mentions the term *priority population (groups)* 16 times. Canada uses the term *underserviced* 12 times.
Determinant	Determinants	24	Australia (7), England (7), USA (6), France (2), Northern Ireland (1), Wales (1)	Canada, Germany, Japan, Scotland	

Strengths-based and deficit-based framing

Table 15 summarises the total number of equity-related keywords identified in each country's Plan, categorised as strengths-based and deficit-based. Only keywords associated with the predefined equity dimensions are included: strengths-based ('equity', 'equality', 'fair/fairness') and deficit-based ('inequity', 'inequality', 'unfair/unfairness', 'deprivation').

Australia - and to a lesser extent Wales - prioritise strengths-based equity language. Australia, England, and Wales used more strengths-based keywords and their Plans lean towards strengths-based framing. Canada balances between strengths-based and deficits-based keywords. Northern Ireland, Scotland, and the USA lean towards deficit-based framing. France, Germany, and Japan make minimal reference to equity dimensions overall, and where present, framing is exclusively strengths-based.

Table 15 - Frequency of Equity-Related Keywords Across G7 Cancer Plans

Country	Total Keywords	Strengths-based keywords	Deficit-based keywords	Comment
Australia	56	49	7	High use of equity (42); deficit terms minimal
Canada	31	16	15	Equity was the only strengths-based keyword; relatively even split between strengths and deficit-based keywords
France	2	2	0	Equity is the only keyword and used only twice
Germany	7	7	0	Equity not used; no deficit-based keywords used
Japan	10	10	0	Equity not used; no deficit-based keywords used
England	80	42	38	High use of inequality (25); consistent use of deprivation (12), inequity not used
Northern Ireland	64	9	55	Fairness/unfairness not used; high use of deprivation (34); considerably more deficit-based keywords used than strengths-based
Scotland	105	28	77	High use of equity (21); high use of inequality (49); more deficit-based keywords used than strengths-based
Wales	28	25	3	Equity/inequity were the only keywords used
USA	40	11	29	Fair/unfair not used; high use of inequality (23); more deficit-based keywords used than strengths-based

3.2.4 Expressions of Equity

Table 16 summarises how equity is expressed across the G7 Cancer NCCPs, using five key dimensions: access, societal value, human rights, exposure and vulnerability to risk, and outcomes [66]. The most consistently articulated and detailed dimension is access to services,

resources, and opportunities. All Plans include commitments to improving access, typically framed around reducing geographical, financial, cultural, or systemic barriers to cancer care.

Beyond access, equity is expressed in more varied ways. All Plans apart from Germany's discuss exposure and vulnerability to risk. Several Plans, notably those from France, Japan, and parts of the United Kingdom, frame equity as a societal value and as a root cause or driver of wider public health and social benefits, linking cancer control to broader wellbeing. France adopts a rights-based framing, presenting equity as the enjoyment of individuals' rights and patients' rights to services. Equity is also expressed through commitments to equitable outcomes, such as achieving comparable survival rates and quality of life regardless of social position – an approach made explicit in Canada, Germany, the USA, and all UK nations, though the level of operational detail varies.

While all G7 Cancer Plans share a strong rhetorical commitment to equity, they differ in scope and emphasis from narrow, access-focused approaches to more expansive societal and rights-based frameworks.

Table 16 - How Equity is Expressed in G7 Cancer Plans

How equity is expressed	Australia	Canada	France	Germany	Japan	United Kingdom				USA
						England	Northern Ireland	Scotland	Wales	
Access to services, resources and opportunities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Value of society, and a root cause contributing to other societal benefits	-	-	✓	-	✓	✓	-	✓	✓	✓
Enjoyment of human rights	-	-	✓	-	✓	-	-	-	-	-
Exposure and vulnerability to risk	✓	✓	✓	-	✓	✓	✓	✓	✓	✓
Outcomes	✓	✓		✓		✓	✓	✓	✓	✓

3.2.5 Equity-Specific Commitments

Table 17 explores the presence of equity-specific commitments across G7 Cancer Plans, focusing on explicit statements, overall plan goals, and high-level objectives. The analysis does not extend to detailed actions or initiatives. Detailed data extracted from each Plan are provided in Appendix 4.

A consistent commitment to equity is evident across the NCCPs. All G7 Cancer countries except England include an explicit statement or goal on the importance of cancer-related health equity. The absence of a cancer-specific equity statement in England's Plan likely reflects the nature of the document itself, given the cancer strategy is embedded within a broader health strategy, rather than articulated through a standalone, dedicated cancer plan. England, however, along

with Canada, Wales, and the United States, includes a statement or goal related to the broader concept of health equity. Notably, Canada, Wales, and the United States include statements addressing both health equity and cancer-related equity, signalling a dual emphasis.

These cancer-related and health equity goals are expressed as qualitative statements of intent (e.g., improving access, reducing inequities) across all Plans. While some refer to concepts that could, in principle, be quantified (such as earlier diagnosis or improved survival), none of the Plans include specific numerical targets or quantifiable indicators.

Three NCCPs - France, Germany, and Scotland - specify how success of the cancer equity goal will be assessed and monitored. For France and Germany, these are stated as intended outcomes, though no detail is provided on how progress will be measured. Scotland goes further by outlining mechanisms to assess progress. In contrast, the majority of Plans (Australia, Canada, Japan, England, Northern Ireland, Wales, and the United States) do not define how equity-related goals will be measured. The absence of consensual definitions to measure equity-related commitments highlights variation in how equity commitments are operationalised across countries.

Table 17 - Equity-Specific Commitment in G7 Cancer NCCPs

Equity Commitment	Number of Frameworks	Relevant G7 Cancer Member Countries
Does the NCCP/Plan include an explicit statement or overall goal related to health equity?	Yes, plan includes an explicit statement about the importance of cancer-related health equity: 9/10 (90%)	Australia, Canada, France, Germany, Japan, Northern Ireland, Scotland, Wales, USA
	Yes, plan includes a goal related to health equity: 4/10 (40%)	Canada, England, Wales, USA
	No: 0	-
Is the explicit statement or overall cancer-related or health equity goal qualitative, quantitative, or both?	Qualitative: 10/10 (100%)	All member countries
	Quantitative: 0	-
	Both: 0	All member countries
Does the NCCP/Plan specify how success of the cancer-related or health equity goal is designed and monitored?	Yes: 3/10 (30%)	France, Germany, Scotland
	No: 7/10 (70%)	Australia, Canada, Japan, England, Northern Ireland, Wales, USA
Does the NCCP/Plan include any objectives to reduce disparities in any cancer outcomes or address cancer-related inequities?	Yes: 10/10 (100%)	Australia, Canada, France, Germany, Japan, England, Northern Ireland, Scotland, Wales, USA
	Yes, and objectives are measurable: 0	-
	No: 0	-

3.2.6 *Equity Principles*

Equity is framed as an underlying principle across most NCCPs. All G7 Cancer country NCCPs or equivalent policy documents include guiding or overarching principles, and in every case these principles, either explicitly or implicitly, address equity or related principles. The analysis takes a broad interpretation of principles, recognising that equity may be articulated not only in designated "principles" sections but also through the way equity is embedded and described across the Plans. This reflects a universal, formalised commitment to embedding equity as a foundational element across all G7 Cancer NCCPs and related documents.

Canada grounds its plan in equity, adopting the WHO definition and incorporating the First Nations principles of Ownership, Control, Access, and Possession (OCAP®), Inuit research principles and Métis research protocols [67][5]. Australia places equity at the centre of its NCCP, framing it as a fundamental measure of success and embedding Indigenous-specific goals and actions. France and Germany emphasise fair and proportionate access, including targeted support for high-risk groups. Japan draws on broader societal values, highlighting equal access, diversity, inclusion, and the principle of "leave no one behind".

In the UK, all four nations integrate equity within their principles. England acknowledges longstanding inequities in NHS care and commits to addressing them through a devolved operating model. Northern Ireland embeds equity in access to health services and cancer research, including clinical trials. Scotland grounds its aims in ensuring equitably accessible care. Wales highlights equity in screening and clinical trials. The USA ties its strategic goals directly to reducing disparities and improving equity.

3.2.7 *Data Strategies and Equity Metrics*

Table 18 summarises the availability of data strategies and equity metrics within G7 Cancer country Plans. Canada, Scotland, and Wales have Plans that either include or are accompanied by a data strategy, whereas Australia, France, Germany, Japan, England, Northern Ireland, and the United States do not.

Equity-specific metrics are not formally embedded in the Plans of any G7 Cancer country. Northern Ireland has undertaken equity impact assessments [68-71], providing publicly available evaluation and assessment data, but these are not included as formal metrics within its NCCP. Analysis of supporting data strategies outside the NCCPs was not undertaken in this study.

As shown in Table 12, only a small number of G7 Cancer countries have Plans accompanied by supporting documents. Australia and Scotland are the only countries with both an implementation or action plan and a monitoring and evaluation (M&E) framework, suggesting there are limited mechanisms across G7 Cancer countries available to translate cancer control policy commitments into measurable action and outcomes.

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[5] It is important to note that equity and reconciliation are distinct, but aligned concepts in the Canadian context. Reconciliation specifically aims to acknowledge the colonial practices and policies that continue to impact the well-being of generations of First Nations, Inuit and Métis. The Government of Canada has committed to advancing reconciliation with Indigenous Peoples by implementing the Truth and Reconciliation Commission (TRC)'s 94 Calls to Action

Table 18 - Data Strategies and Equity Metrics in G7 Cancer Plans

Equity Dimension	Number of Frameworks	Relevant G7 Cancer Member Countries
Data strategy: Does the NCCP/Plan include, or is it accompanied by, a data strategy?	Yes: 3/10 (30%)	Canada [72], Scotland [64], Wales [73]
	No: 7/10 (70%)	Japan, Germany, England, France, Northern Ireland, Australia, USA
Equity metrics: Does the NCCP/Plan include explicit measures or indicators to monitor progress on equity?	Yes: 0	-
	No: 10/10 (100%)	Australia, Canada, France, Germany, Japan, England, Northern Ireland, Scotland, Wales, USA

3.2.8 Strategic Approach to Equity

Equity in NCCPs can be pursued through three main strategic approaches:

- *Universal* approaches aim to benefit the entire population equally, regardless of social or economic differences
- *Targeted* approaches focus resources and interventions on groups experiencing vulnerability or disadvantage.
- *Blended* approaches, including targeted universalism and proportionate universalism, combine the strengths of both models. Targeted universalism sets shared population-wide goals but tailors the pathways for different groups to achieve them, while proportionate universalism delivers universal interventions at an intensity and scale proportional to the level of disadvantage [66, 74].

An assessment of the strategic approaches to equity was undertaken. All G7 Cancer countries adopt a blended approach to equity in their Plans, combining universal goals with targeted actions to address varying levels of need. This pattern suggests that while equity is a shared priority across NCCPs, the G7 Cancer countries recognise the importance of combining population-wide strategies with tailored measures to address inequities effectively.

3.2.9 Policy Areas Prioritised

Health equity goals can be advanced through action across five interconnected policy domains:

- *Health and health services* encompass measures to ensure prevention, treatment, and care are available, accessible, affordable, and high quality for all.
- *Income security and social protection* include policies that provide a basic level of income and mitigate the health and social impacts of poverty across the life course.
- *Living conditions* refer to efforts that reduce unequal access to safe housing, healthy environments, and other physical and social determinants of wellbeing.
- *Social and human capital* policies aim to strengthen skills, education, and literacy, while fostering social networks and community connections that safeguard and promote health.

- *Employment and working conditions* cover strategies to enhance the health impacts of work, including secure employment, fair wages, safe workplaces, and support for both physical and mental wellbeing [75].

Table 19 shows that health and health services are consistently prioritised across all G7 Cancer Plans. Living conditions receive the least attention, appearing only in France, Japan, Northern Ireland, and Wales. Income security and social protection are addressed variably: France includes both income security and social protection, while Canada, England, Northern Ireland, and Scotland focus on social protection measures. Social and human capital policies are prioritised in all four UK nations, the USA, and Australia (as human capital). Employment and working conditions appear in Australia and all four UK nations but are less commonly addressed elsewhere.

Overall, the results indicate that while all Plans prioritise core health services, attention to broader determinants of health and workforce-related policies is more variable.

Table 19 - NCCP Policy Areas Prioritised

Policy Areas Prioritised	Australia	Canada	France	Germany	Japan	United Kingdom				USA
						England	Northern Ireland	Scotland	Wales	
Health and health services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Income security (IS) and/or social protection (SP)	-	✓	✓	-	-	✓	✓	✓	-	-
Living conditions	-	-	✓	-	✓	-	✓	-	✓	-
Social and/or human capital	✓	-	-	-	-	✓	✓	✓	✓	✓
Employment and working conditions	✓	-	-	-	-	✓	✓	✓	✓	-

3.2.10 Cancer Continuum Stage Focus

Table 20 shows that prevention and early detection, and treatment stages in the cancer care continuum are universally prioritised across all G7 Cancer member countries' NCCPs whereas later stages (survivorship and palliative care) and system-level monitoring of cancer burden and outcomes receive comparatively less attention across G7 Cancer countries' Plans.

Table 20 - NCCP Cancer Continuum Stage Focus

Cancer Continuum Stage	Australia	Canada	France	Germany	Japan	United Kingdom				USA
						England	Northern Ireland	Scotland	Wales	
Prevention and early detection	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Diagnosis	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Survivorship	✓	✓	✓	-	-	✓	✓	✓	✓	✓

Cancer Continuum Stage	Australia	Canada	France	Germany	Japan	United Kingdom				USA
						England	Northern Ireland	Scotland	Wales	
Palliative and end-of-life care	✓	✓	✓	-	-	-	✓	✓	✓	-
Overall cancer burden and outcomes	✓	✓	✓	-	-	✓	✓	✓	✓	✓

3.2.11 Identification of Priority Population Groups

NCCPs were assessed for their attention to priority population groups, based on a list of twelve groups defined by the G7 Cancer Working Group 3. As shown in **Table 21**, the extent to which Plans prioritise these groups varies considerably across countries.

Some groups, such as people from culturally and linguistically diverse (CALD) backgrounds, people living in geographically remote areas, and children – are included in nearly all G7 Cancer member countries plans, with each absent from only one plan: France, Wales, and Germany, respectively.

Immigrants and refugees are addressed only in Canada's NCCP, while Indigenous Peoples are explicitly included in the NCCPs of Australia, Canada, and the USA. Additionally, Australia has a dedicated supporting plan for Indigenous peoples: the Aboriginal and Torres Strait Islander Cancer Plan [77], and Canada has distinct Peoples-specific[6] cancer priorities and cancer strategic plans [78].

No Plan covers all population groups, but Canada's NCCP includes 11 of the 12 priority population groups identified in this review, with people living with disability not specifically referenced. Overall, the variation in prioritised groups reflects differing national contexts and equity priorities.

Table 21 - NCCP Priority Population Groups

Priority Population Groups	Australia	Canada	France	Germany	Japan	United Kingdom				USA
						England	Northern Ireland	Scotland	Wales	
People in lower socio-economic groups	✓	✓	✓	-	-	✓	✓	✓	-	✓
Adolescents and young adults	✓	✓	✓	-	-	✓	✓	✓	✓	✓
People from CALD backgrounds	✓	✓	-	✓	✓	✓	✓	✓	✓	✓
People living in geographically remote areas	✓	✓	✓	✓	✓	✓	✓	✓	-	✓
Children	✓	✓	✓	-	✓	✓	✓	✓	✓	✓
People living with mental illness	✓	✓	-	✓	-	✓	✓	✓	-	-
People living with disability	✓	-	✓	-	✓	✓	✓	✓	-	✓
Racialised people	-	✓	-	-	-	-	✓	✓	✓	✓

[6] Canada has three groups of Indigenous peoples: First Nations, Inuit and Métis.

Priority Population Groups	Australia	Canada	France	Germany	Japan	United Kingdom				USA
						England	Northern Ireland	Scotland	Wales	
LGBTIQA+ people	✓	✓	-	-	-	✓	✓	✓	-	✓
Older people	✓	✓	-	-	✓	✓	✓	✓	✓	✓
Immigrants and refugees	-	✓	-	-	-	-	-	-	-	-
Indigenous peoples	✓	✓	-	-	-	-	-	-	-	✓

3.2.12 Determinants of Health

Table 22 shows that social determinants of health are addressed in the NCCPs of all G7 Cancer member countries, reflecting universal recognition of their importance.. USA is the only country to address all six determinants of health in its NCCP.

Table 22 - NCCP Determinants of Health

Determinants of Health	Australia	Canada	France	Germany	Japan	United Kingdom				USA
						England	Northern Ireland	Scotland	Wales	
Social	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cultural	✓	✓	✓	-	✓	-	✓	-	-	✓
Economic	-	✓	✓	-	✓	✓	✓	-	-	✓
Structural	-	✓	-	-	✓	✓	✓	-	✓	✓
Environmental	-	✓	-	-	-	✓	✓	-	-	✓
Commercial	-	-	-	-	-	✓	-	-	-	✓

3.2.13 Key Actors

Across the G7 Cancer countries, cross-sector collaboration is a consistent theme, though the scale, diversity, and clarity of roles differ. Cross-sector collaboration is consistently framed as both a guiding principle and a practical mechanism for delivering cancer control. The number of actors identified in NCCPs ranges from a small group of health system and government partners (e.g., Northern Ireland) to very broad, multi-level and sector networks spanning public, private, academic, civil society, and community organisations (e.g., Japan, Wales, and the USA). Most Plans highlight partnerships between government, healthcare providers, research institutes, charities, with some explicitly including Indigenous peoples (e.g., Australia and Canada) or linking collaboration to EU or international frameworks (e.g., France and Japan). The breadth of actors therefore varies from primarily health sector bodies to dozens of organisations across education, local government, workplaces, industry and patient advocacy.

In terms of roles and responsibilities, most countries stress shared ownership and collective effort, but few plans provide detailed or systematic assignment of responsibilities for delivering equity. This represents a critical implementation gap: even strong commitments to equitable outcomes are unlikely to be realised if organisational roles and accountability are unclear. Australia acknowledges Aboriginal and Torres Strait Islander leadership, while France and

Germany embed structural mechanisms for multisectoral governance, though explicit equity accountability remains limited. The USA and UK reference equity strongly but stop short of designating clear organisational responsibilities. Taken together, while cross-sector collaboration is broadly promoted and ranges from narrow to very expansive, the insufficient clarity around who is responsible for achieving equity outcomes may undermine the effectiveness of these plans. Strengthening the link between actor responsibilities and equity goals in NCCPs is therefore essential to ensure commitments translate into action.

3.3 Phase 3 Findings - Qualitative interviews

This section presents findings of the qualitative semi-structured interviews with representatives from each G7 Cancer member country.

3.3.1 Interview Participants

Table 23 summarises the characteristics of the qualitative interview participants by country, interview metrics, primary institutional affiliation, and whether participants represented the lead agency responsible for NCCP oversight. Twenty participants from government agencies, NGOs, and academic institutions across all G7 Cancer member countries were included. Twelve semi-structured interviews, conducted both individually and in groups, were undertaken. All countries contributed at least two participants. Government-affiliated participants were present in all countries, while NGO and academic participants were represented in only a subset, reflecting the study's focus on institutional roles most directly involved in national cancer control and equity policy. Participants from lead agencies responsible for NCCP oversight were included in all G7 Cancer countries except for Germany and the United Kingdom. Interviews averaged 49 minutes in duration, ranging from 34 to 65 minutes, with variation likely reflecting participants' seniority, availability, level of engagement, and the range of topics covered.

Diversity of views represented

In addition to their primary affiliation, some participants reported additional roles or affiliations, lived experience of cancer, or identification with priority population groups. While these aspects were not systematically collected, they provide valuable context for the diversity of views represented.

Participants held professional roles, affiliations, expertise, and recognised leadership relevant to cancer control and equity policy within their respective countries. They worked across policy, research, and practice, bringing expertise in areas such as policy design, programme implementation, cancer and health statistics, psycho-oncology, and sociology. Several described long careers in cancer control with a sustained focus on inequity, underscoring the depth of expertise within the sample

Table 23 - Characteristics of qualitative interview participants by country, interview metrics, and primary institutional affiliation

Country	Participants (n)	Interviews (n)	Total interview hours	Interview duration (mean; range, min)*	Primary affiliation**	Lead agency for NCCP ***
Australia	3	3	2.5	49 (43-52)	Government (3)	Yes (3)
Canada	6	2	5.1	51 (48-57)	Government (4), NGO (2)	Yes (4), No (2)

France	2	2	1.6	48 (46-50)	Government (2)	Yes (1), No (1)
Germany	2	1	1.6	49	Government (1), Academia (1)	No (2)
Japan	3	1	3.3	65	Government (2), Academia (1)	Yes (2), No (1)
UK	2	2	1.5	45 (34-57)	NGO (2)	No (2)
USA	2	1	1.3	39	Government (1), NGO (1)	Yes (1), No (1)
Total	**20**	**12**	**16.9**	**49 (34-65)**	**Government (12), NGO (5), Academia (3)**	**Yes (11), No (9)**

* Interview duration presented as mean; range shown where multiple interviews were conducted. Overall duration is the weighted average across all interviews; range reflects the minimum and maximum durations.
** Primary affiliation denotes each participant's main institutional role. Government institutions were defined as those established by government, publicly funded, or operating under ministerial or federal authority.
*** Lead agency for NCCP indicates whether the participant's primary affiliation is responsible for overseeing the national cancer control plan (NCCP), or equivalent policy document in their country.

3.3.2 Analysis of semi-structured interviews

Conceptualising cancer equity: No shared definition of cancer equity exists across G7 Cancer countries. Most participants emphasised access to care, with fewer addressing outcomes, patient experience, or health literacy. Equity was often framed as a secondary goal of broader health improvement rather than an explicit objective: "Addressing inequity is a tactic to a strategic game, and the strategic game is better health outcomes" and tensions between equity and equality were noted. In France and Germany, a focus on equality of opportunity and access to services rather than actively addressing inequities was perceived as limiting. Terminology such as "inequality," "disparity," and "equity-deserving" was used inconsistently across and within countries, complicating shared understanding.

Drivers of inequities: Participants consistently identified systemic, social, cultural, and structural determinants - including education, socioeconomic status, geography, and racism - as key drivers. Cultural norms shaped perceptions of responsibility in Japan, while widening gaps for Indigenous Australians and disparities across US and Canadian jurisdictions were noted. Factors beyond cancer care, such as housing, employment, and commercial influences, were viewed as major contributors but largely beyond the direct control of cancer agencies, requiring cross-sectoral and cross-government coordination.

NCCP implementation and policy action: NCCPs provide formal coordination structures, but their maturity and equity emphasis vary. Participants described early-stage implementation constrained by political cycles, fiscal pressures, cultural norms and sensitivities, and system capacity, with formal equity-targeted policy remaining limited despite numerous initiatives. Canada's plan was described as having a "strong and explicit focus on reconciliation and reducing inequities," Australia's 10-year plan provides a coordinated framework, the US plan remains nascent, Germany explicitly addresses inequalities but faces delivery challenges, and in the UK, "the national narrative has shifted a little away from health inequalities being absolutely front and centre." Early-stage action was shaped by systemic capacity and political constraints: "We're in this kind of storming phase of how to address inequalities."

Data, monitoring, and evaluation: Equity-focused data systems were widely described as fragmented and underdeveloped, with limited social variables and poor linkage: "We are far away from very comprehensive, all-encompassing evaluation data collection for cancer inequity." Participants emphasised the need for actionable, disaggregated clinical and social indicators, secure data linkage, and actionable outputs, particularly for Indigenous Peoples, implemented

in culturally safe ways that uphold data sovereignty. Measuring and monitoring inequities is essential, yet structured data frameworks, comprehensive cancer registries, and effective linkage remain limited across G7 Cancer countries.

Stakeholder engagement and cross-sector collaboration: Meaningful engagement with a broad range of stakeholders, particularly communities and people with lived experience, was viewed as essential: "Many patient advocates agreed...that's why the main target included no one left behind in cancer control activities."

Priority population groups and intersectionality: Participants identified priority populations including refugees, prisoners, rural and remote communities, and Indigenous Peoples. Recognition of intersectionality—how overlapping vulnerabilities amplify inequities - is emerging. Tailored approaches were widely supported, though some cautioned that overly specific strategies may be less effective if broader systemic challenges remain.

Critical levers for addressing inequities: Prevention, screening, and early detection were identified as high-impact levers to improve cancer outcomes and address inequities. Persistent inequities in access to cancer treatment and clinical trials, research prioritisation, and translation of innovation into practice were noted as ongoing challenges. Participants emphasised the importance of enabling social and policy environments, horizon scanning, measurable targets, and explicit program logic or theories of change.

3.3.3 Detailed findings by theme

How inequities in cancer outcomes are defined

- There is **no shared definition** of cancer equity across the G7 Cancer countries, and national conceptualisations vary considerably. Most definitions emphasise access to care as a central component, with some also incorporating outcomes and patient experiences, and, in one case, health literacy. In several countries, the emphasis is on creating equal opportunities and services rather than explicitly addressing and reducing cancer inequities.

In **Australia**, participants described equity as encompassing access, outcomes, and patient experience, emphasising that it is not just about access to services, but also the experiences and outcomes people have once they receive care. They also noted that the definition remains ambiguous and that "*different individuals would have different perspectives of it.*"

In contrast, **Canada** was reported to lack a consistent definition, though efforts were underway to harmonise how equity is conceptualised and measured. Definitions tended to reference the social determinants of health, with a particular focus on access to care for communities facing systemic barriers.

> *"There isn't really one core definition in Canada of how we define or measure cancer inequalities."*
>
> *"Generally, it's around the social determinants of health, and it's talked about in ways around access to care and thinking about different communities who often face systemic barriers or disadvantages to accessing care."*

Similarly, **Japan** was described as striving for a common definition, with the absence of one creating significant challenges.

> *"We are trying to use the same definition. It's [a] very big problem."*

In the **United Kingdom**, participants defined equity as avoidable differences in outcomes, adopting a modified version of the NHS England definition.

> *"The definition that we have adopted, but slightly modified is the NHS England definition, which is essentially avoidable differences in outcomes. And based on social or cultural factors, we have modified that slightly to talk about the interplay between biological and social and cultural factors."*

By comparison, in the **United States**, equity was characterised as targeted action for groups with differential access to healthcare, with access prioritised over outcomes. Participants emphasised that inequities were often addressed as a by-product of efforts to improve overall outcomes, rather than as an explicit policy goal.

> *"The disparities relate primarily to definable demographic groups that have differential access, which I think is probably the primary issue. And, to a somewhat lesser degree in the United States, a focus on outcomes, as opposed to access, I think is a distinction. And I think access gets a little greater precedence than outcomes, although there are lots of groups that will focus on the latter."*

> *"But the value proposition in the US isn't that equity versus inequity is the goal, or that inequity is the bad thing. The bad thing is the health care, or the outcome, or the suffering, or the economic cost, or whatever else. So the solutions are addressing inequities, but that's not their primary stated purpose. It's not as if we value equity versus inequities, what I'm trying to say, we value not dying of colon cancer."*

> *"Addressing inequity is a tactic to a strategic game, and the strategic game is better health outcomes. And that's not the same as a country that says inequity is a bad thing and we want to fix inequity ... the most fundamental point to me is that it's not about elevating inequity as a problem, it's about addressing inequity sometimes because it's the road to the solution. Yeah, as a byproduct, almost."*

In **France** and **Germany**, a lack of explicit commitment to equity was also observed. Participants reported a prevailing emphasis on equality of opportunity and access, rather than explicitly naming or addressing inequities. This framing was seen to complicate efforts to meet differential needs and, in some cases, risk reinforcing health inequalities.

> *"In France, we talk more about, or more concerned by equality. And this is a problem because you know, it's a very important word in France. And it's also a problem because when we talk about inequality, we assume that needs are different according to populations, and maybe we have to treat or to manage population in a different way. And it's complicated when you assume everywhere equality, which means for many, many person here, that you give the same thing to anybody. And we know that this attitude is increasing health inequalities."*

- Terminology used to describe inequities in cancer is context- and time-dependent, reflecting evolving perspectives, policy environments, and local preferences.

As shared by a **German** participant:

> *"You will not find the word inequality in that document. It's named nowhere. I looked it up once again...So, everyone should have access, and at a different point they say, okay, independent of age, sex, origin, region, you should have access to services. But it's not in*

> *the sense that they say, okay, we want to reduce inequalities. It's just everyone should have that. So it's in the sense of equal opportunity. But not as proactively saying, okay, there is a problem, and we should address that."*

It was also noted that empowerment and health literacy were considered key components of equity in **Germany**.

Participants noted that terms such as 'inequality,' 'disparity,' 'inequity,' 'underserved,' and 'equity-deserving' are applied differently both across countries and within countries over time. In **Canada**, for example, 'underserved' was introduced around seven years ago to emphasise systemic responsibility rather than individual or community deficit, but participants noted that the terminology is currently under review and continues to evolve

Current context

- Cancer inequities are observed across G7 Cancer countries, **shaped by social, cultural, and systemic contexts**. While disparities are recognised, participants reported variation in awareness, perceived drivers, and the urgency to act.

In **Japan**, inequities such as differences in cervical cancer incidence and vaccination rates across socioeconomic groups were described, but participants noted that cultural norms around personal responsibility reduce recognition of systemic drivers:

> *"...many people are not thinking that there is a serious health disparity in Japan, although data clearly indicates that there is health disparity in smoking prevalence or many other fields. This may be a result of those homogeneous atmospheres in Japan. People tend to think that inappropriate lifestyles is self-responsibility. People in lower health status are likely to smoke, but people tend to think that they chose it."*

In **Canada** and **Australia**, widening inequities for Indigenous populations were emphasised, as noted by an Australian participant:

> *"We really want to see the gap closing in terms of outcomes for people, for Aboriginal and Torres Strait Islander people, in particular, where the gaps are widening."*

In **Canada** and the **United States**, disparities were described across jurisdictions and socioeconomic groups. As one USA participant reflected:

> *"There's wide disparities in education, in resources, in both financial and otherwise. And they, at a minimum, I think, amplify some of the other challenges that exist in the United States."*

In **France**, education was identified as a key driver, while in the **United Kingdom**, smoking was highlighted as a major contributor to inequitable cancer outcomes.

Perceptions of equity and equality

- **Tensions between advancing equity and treating people equally** were evident, shaped by cultural norms, political sensitivities, and fiscal constraints. Across countries, participants noted that directing additional resources to specific populations was often politically contested and socially sensitive.

In **Japan**, policies were described as aiming to treat all citizens equally, with targeted action perceived as sensitive and likely to generate resistance.

> *"They don't like to differentiate their policies according to the statuses of citizens, and they tend to give equal opportunity to every citizen."*

In **France**, a strong cultural emphasis on equality makes equity approaches challenging. As one participant reflected:

> *"And when I talk about proportionate universalism, developed by Michael Marmot, and you know that, of course, it's very complicated here to talk about that and to imagine action using this approach, because it sounds like stigmatisation or inequality. Some groups say, oh, it's not fair to develop more action for them, because I pay the same taxes, so I have the same rights."*

Resource constraints and political sensitivities were also reported as major barriers to equity action in the **UK**. One participant linked this to broader social debates:

> *"Because we have a problem in this country, like many, many countries around the world, where there's this increasing disquiet about immigration. And so some of the perception of over focusing on minorities is something that I think people are sensitive to, and also it's hard to justify when funds are just so strapped, you know?"*

In **Germany**, concerns about fiscal pressures and setting precedents were prominent:

> *"What do we offer one group of people more than the others? And of course, they had in mind, you know, we don't want to spend much money, or it's a kind of opening the Pandora's box, if we pay this, then we also have to pay it for other patient groups."*

In **Canada**, participants similarly noted that resource constraints, competing priorities, and political sensitivities can create complexities when prioritising equity-focused action:

> *"Like most countries, we are undergoing some fiscal constraints right now...we have capacity pressures, we have competing overall priorities. So, for example, our health workforce crisis, ageing population, and all of these things are adding to the challenges in being able to prioritise addressing inequities within the country."*

Early-stage action on cancer inequities

- Countries are at **an early stage of translating awareness and commitment** to cancer inequities **into actionable strategies**. Readiness, capacity, and systemic constraints shape whether and how equity initiatives can be implemented.

In the **United Kingdom**, participants described the sector as being "*in this kind of storming phase of how to address inequalities*," reflecting a heightened awareness of inequities but limited capacity and translation into action.

> *"We're still at quite an immature state, I think, in some of our understanding of these things."*

> *"So for example, there was a lot of data put out about, including by ourselves, about how on the waiting list that we have in this country, the people from more disadvantaged backgrounds or minority groups are more highly represented, and there's quite a lot of*

hand wringing about that, and isn't that bad, but there aren't really any strategies to sort that out."

In **Australia**, participants acknowledged limited clarity across policy areas:

"I don't think we've got much of a sense of it at all across those policy focuses."

In **Japan**, participants described an early-stage focus on creating the authorising environment and building capacity to use relevant data:

"We are still at an early stage of tackling health disparities."

"We need to create an atmosphere where health disparity statistics is always there... we are not accustomed to health statistics according to income or educational history or racial or ethnicities, but we need to create a world where those statistics are always there, and it is quite usual to utilise those statistics to make a policy."

Early-stage efforts were shaped by political and systemic constraints. In **Germany**, participants noted that strong support at the federal level was lacking, while **Canada** exhibited varied readiness and capacity across jurisdictions.

In **France**, discourse around social inequalities was emerging, but operationalisation remained nascent.

In the **United States**, participants noted that, although inequities are recognised in the NCCP, measuring and explicitly addressing them is not yet a formal policy priority.

"But first they have to say that inequities, measuring them, is important in their goals. This is the whole point from the beginning of the conversation; that's not the goal in the United States by policy."

Variability and integration of NCCPs across G7 Cancer countries

- Across countries, participants indicated that while NCCPs provide a formal structure for cancer control, their **maturity and emphasis on equity vary**. NCCPs were described as central but evolving tools for guiding cancer control and equity action.

In **Canada**, the NCCP has a strong and explicit focus on reducing inequities within the cancer system across the country.

In **Australia**, the NCCP was described as a comprehensive framework coordinating sector-wide action.

"The Australian Cancer Plan is the first national cancer plan that's a strategic overview of what we're going to do in cancer control in Australia for the next 10 years. It recognises that Australia has some of the best outcomes from cancer in the world, in many pockets and in many cancers, but also similarly, it has very important inequities that we need to do something about."

In the **United States**, comments reflected early-stage implementation within a shifting political context.

"That's one of our elements of the national plan is addressing inequities or eliminating inequities. It's a tool that we use to talk about. It's a good question if it's operative or not.

You know, in other countries, the national cancer plans are very formalised documents. And here, this is the first time we've ever had one. I think it was really just getting socialised in the last year or so."

In **Germany**, the NCCP has explicitly addressed inequalities, though participants noted ongoing implementation challenges.

In the **United Kingdom**, participants observed that attention to inequalities had recently declined.

"National narrative has shifted a little away from health inequalities being absolutely front and centre"

- NCCPs **operate within broader policy landscapes**, with alignment and integration varying across countries.

In **Australia**, the NCCP complements state and territory cancer plans and broader national health strategies, though differences across government departments and other concurrent plans, can complicate coordination.

In **Japan**, regional cancer plans largely mirror the national plan, while *Health Japan 21* focuses on primary prevention and monitors disparities mainly at the prefecture level.

These examples illustrate that, while NCCPs provide a central framework for cancer control, their integration with other policies and emphasis on equity differ across contexts.

- Implementation of NCCPs is uneven across G7 Cancer countries, with **tensions between high-level commitment and practical operationalisation** at scale.

In **Australia**, implementation was described as variable, influenced by factors including sector dynamics. It was noted that efforts are underway to map activities across jurisdictions and partners to NCCP objectives, to better understand how the NCCP is being implemented within local contexts.

In **Canada**, implementation emphasises co-developed initiatives to test and refine models of care, promoting alignment with the NCCP.

In the **United Kingdom**, participants noted the absence of a dedicated implementation chapter in the 10-year plan, raising questions about whether planned actions will achieve intended outcomes.

"It's really noticeable with our overarching 10-year plan, that there's not even a chapter on implementation...what we haven't been so good at is, 'is the implementation that we're setting out going to get us there?'"

In **France**, successes were reported in localised areas, but scaling interventions nationally remains challenging. Interventional research was identified as a potential pathway to broader impact.

"It's working in a very small specific area in France, and now the challenge is to develop that in other areas or at the national level. And we need to develop interventional research to do that."

Current approaches to cancer equity

Determinants of health

Factors beyond cancer care - such as education, poverty, housing, employment, and other social, economic, and commercial forces - play a central role in driving inequities in cancer outcomes.

Yet, despite this widespread recognition, the complexity, scale, and cross-sectoral nature of these determinants often places them beyond the direct control of cancer organisations and policymakers, limiting the translation of awareness into tangible action.

In **Japan**, a participant noted the breadth of upstream influences:

> *"It is true that there are many upstream areas unrestricted to cancer control."*

In **Germany**, the role of education and related health literacy was emphasised:

> *"Education is a major thing that contributes to inequality, and that's associated with, as you know, health literacy."*

Despite this awareness, participants highlighted the difficulty of acting on these determinants. Cancer organisations often focus on disease-specific priorities and may view upstream factors as 'outside my lane', given that structural determinants typically require societal-level change rather than direct interventions.

In **Canada**, participants described partnership work as a strategy to navigate this tension while remaining within organisational mandates:

> *"We do our best to make sure that we are engaged in all of these different parts of the conversations, but we have to just be mindful of our mandate.... anytime it's not cancer specific...that's where we would work in partnership with other organisations, right. So our priorities often are cancer specific, just as a cancer organisation."*

In **France**, participants highlighted the challenge of translating recognition of upstream determinants into actionable policy, noting the difficulty of integrating health into broader societal policies:

> *"So when policymakers try to do something, they try to develop access to services, okay, because they have the power to do something."*
>
> *"It's never happened in France that, you know, if you want to decrease cancer incidence, you increase level of education of the population. You know, this association is impossible. You're talking about education. This is not related to health. Why are you talking about education? This is not health. So, the main problem is to think of health as a very global concept. We try to develop the idea that in each, in other policy, we need to think in terms of health as well to see the impact on health, so health in all policies. And we try to work on that, but it's not so easy, because when you talk about structural determinants, you are talking about changing society. And you know you talk with National Institute of Cancer, how, how they can change society?"*

Similarly, in the **United Kingdom**, participants noted the gap between recognising societal-level determinants and implementing policy to address them:

"It doesn't feel as though there's a kind of societal approach of the order and magnitude needed towards these risk factors, plus, on housing, on employment, on a whole range of other broader determinants. It's tough, yeah, and public policy isn't quite where we'd want it to be."

Legislation and constitutional frameworks

Legislative and constitutional provisions act as foundational, society-wide levers that can shape determinants of health and in health systems by influencing how resources are allocated, and populations are served. Participants highlighted that these provisions play a varied role across G7 Cancer countries.

In **Germany**, principles of equal treatment are embedded in both the Constitution and the statutory health insurance system, ensuring access to high-quality services for all, although not explicitly targeting specific population groups.

In **Canada**, the *Canada Health Act* establishes overarching guidance and principles related to publicly funded health care across the country, playing a foundational role in supporting equitable access to medically necessary services.

In the **United Kingdom**, participants highlighted that the *Equalities Act* mandates collection of data on protected characteristics.

In the **United States**, participants observed that while policies exist - such as through Medicare and Medicaid - there has been no explicit legislative intent to prioritise health equity.

Prevention

Prevention was discussed by some participants, primarily in relation to smoking cessation efforts. Several participants emphasised the need to shift focus from treatment to prevention, highlighting both support for preventive approaches and gaps in current practice.

In the **United Kingdom**, participants highlighted broad support for prevention and its potential to reduce inequities:

"There's so much support around the need to reorientate the health service more towards prevention and more towards community from hospital, and that absolutely should deliver, if done well, around health inequality."

In **France**, participants contrasted the strengths of the curative system with the need for preventive action, noting structural limitations:

"We don't invest in prevention...we have a very good curative system, really, but now it's impossible to manage to fix the number of sick people we have, and we need to change the system so we need to shift from a curative system to preventive system."

Screening and early detection

Screening and early detection are critical levers for improving cancer outcomes and addressing inequities.

In **Australia**, equitable access and screening participation were central:

"We've got to be thinking about equity whenever we're thinking about population screening, because it's not just for the worried well or the people who actually can afford to seek treatment, but for everybody."

Opportunities to strengthen equity within the implementation of new and existing screening programs were shared.

In **Germany**, early detection was linked to quality outcomes, while in **France**, screening was framed as a cost-effective way to improve survival:

> *"The main focus is on screening. Why? Because it's probably one of the main factors for increasing survival... They really want to increase screening because it's a very good prognosis factor, probably the main prognosis factor, and it's cheap, yeah, to act on a very small cancer, it's very cheap."*

Treatment

There are persistent inequities in access to cancer treatment across G7 Cancer countries.

In **Australia**, inequities were noted across various domains, including cancer types, population groups, geography, and public and private healthcare sectors. Inequities also extend beyond availability to difficulties in navigating the system, accessing information, and understanding treatment options.

> *"There's a big inequity in terms of how much people, unfortunately, need to suffer in terms of access, in terms of financial disparity, time off work, access to medications, access to tests, access to surgeries, amount of out-of-pocket costs, all of that stuff just adds to the experience."*

In the **United States**, participants highlighted the transformative potential of universal access to screening and care, noting evidence that equitable access to care and support reduces disparities:

> *"We've proven that access to care and support for treatment eliminates the inequities."*

> *"If you had universal access to screening and care, you would eliminate most of the inequities that we currently see."*

Structural drivers of inequity were also emphasised:

> *"The challenges arise from the very fundamental approach to healthcare...linkage to employment...and the lack of universal access...It's a patchwork without a shared singular goal."*

Participants in the **United Kingdom** and **Australia** stressed the need for national signals, systemic prioritisation, and targeted research for cancers with poor outcomes, including investment in innovative treatments:

> *"...there are cancers you...really don't want to get, on account of not many treatment options...a national signal...to bring forward...feasible treatment pathways for those with really poor outcomes would be welcome."*

Research and clinical trials

Inequities in research prioritisation, access to clinical trials, and translation of innovation into practice may perpetuate disparities in cancer outcomes.

In **Australia**, participants highlighted the importance of investing in research for cancers with poorer outcomes and raised concerns about inequities in access to clinical trials - inequities which risk compounding disparities in the future.

"And one of the things we heard when we did the genomics framework [National Framework for Genomics in Cancer Control], our consultations, is how much inequity there is in access to clinical trials. And some of that is around age, some of it is around comorbidities, some of it is around health literacy, some of it is just the fact that you need to be able to go to a certain number of appointments at a certain time, and that can be quite inflexible. So there's lots of issues in relation to clinical trials. But we also know that clinical trials improve outcomes, so if we're not actually having equity of access to clinical trials, then that's actually another thing that will contribute to poorer outcomes in the future."

In the **United Kingdom**, participants highlighted concerns about translating advances in research and innovation into practice, asking how this could be done fairly.

Key enablers and barriers of effective equity action

- The success of efforts to advance cancer equity - within NCCPs and more broadly - is influenced by **multiple interacting factors**.

Participants identified key enablers that supported progress within their countries, as well as barriers that constrain it, summarised in **Table 24**. A selected number of factors (bolded) are explored further below; these examples are illustrative rather than exhaustive.

Table 24 - Key enablers and barriers to advancing cancer equity identified by interview participants

Category	Enablers	Barriers
Political and leadership context	High-level political commitment; **lead agency with clear remit**; influential equity champions and leadership continuity.	Insufficient political will; shifting priorities; competing policy demands; short political cycles.
Social and demographic context	Social cohesion; trust in government; high literacy and health literacy; societal support for equity.	Low literacy and health literacy; socioeconomic disparities; geographic challenges (large or remote populations); demographic pressures such as ageing populations; systemic racism and enduring impacts of colonial practices.
Health care system	Universal health insurance, national health service models; affordable and high-quality care; broad access via primary care and screening programs; equitable access to clinical trials; change management capacity.	Funding and service delivery constraints; system fragmentation and inefficiencies (particularly evident in federated systems but can occur across all health system types); inequitable access to services; long waiting times; public-private misalignment; employment-linked insurance; structural racism; institutional mandates focused solely on cancer that may limit action on the broader determinants of health that lie outside the health system.
Policy and planning frameworks	Presence of NCCP; long-term policy-horizon; policy coherence; **explicit commitment to equity**; inclusion of equity objectives and indicators; **clear program logic and theory of change**; structured operational guidance; **robust accountability mechanisms**.	Lack of definitional clarity on equity; fragmented policies; absence of logic models/theories of change; insufficient operational guidance.
Funding and resources	Dedicated, long-term financing; integration of equity into budget processes; resourcing targeted to disadvantaged populations; adequate capacity (people, funding, resources); transparency.	Short-term or inconsistent funding; no dedicated streams; misalignment between equity objectives and budget allocations.
Data systems and evidence	Harmonised data standards and definitions; data infrastructure (e.g. cancer registry, screening programs); standardised disaggregated data; equity indicators; linked datasets; international evidence around what works.	Incomplete or inconsistent data; fragmented or siloed data systems; limited capacity for social data.
Workforce and capacity	Skilled workforce; interdisciplinary collaboration; strong research-to-practice ecosystem.	Health workforce shortages; limited expertise; systemic and structural racism within health professions.

Stakeholder engagement and governance	Patient and community engagement; participatory decision-making; co-designed strategies.	Tokenistic consultation; limited accountability; limited NGO or community involvement.
Partnerships and collaboration	**Sector-wide shared responsibility**; **inclusive and consultative processes**; multisectoral partnerships addressing upstream determinants (e.g. poverty, education); cross-country knowledge sharing.	Limited partnerships and collaboration; siloed sectors; gaps in interagency coordination; limited international collaboration.
Communication and advocacy	Framing equity as fairness and efficiency; evidence-informed public narratives; advocacy resources and case studies.	Poorly communicated equity rationale; conflation of equity with equality; low awareness among public or policymakers; misperceptions of unfair advantage.

Enablers of effective equity action

These factors support G7 Cancer countries, and other countries like them, to take action to advance cancer equity:

- Explicit commitment to equity
- Clear program logic and theory of change
- Lead agency with clear remit
- Inclusive and consultative processes
- Sector-wide shared responsibility
- Robust accountability mechanisms.

Explicit commitment to equity

The way equity is framed within NCCPs influences how it is operationalised. Explicit commitments to equity are more likely to drive action and accountability, whereas implicit commitments may signal intent but often risk failing to translate into measurable outcomes.

In **Japan**, participants described a high-level rhetorical commitment and broad consensus, but noted the absence of concrete goals or targets:

> *"The national cancer control program has two overall goals, one of which is no one left behind. So there is a slogan on the national cancer control plan regarding health disparities, but there are no specific goals or objectives in it."*

> *"There's a general agreement that we need to tackle health disparities. But when we go into details, we don't have any specific methodology or perspective."*

In **Australia**, equity priorities - such as a focus on Aboriginal and Torres Strait Islander people - signal intent, though participants noted discussions remained at a broad level:

> *"I think we're at that high level really. We haven't really dug deep into thinking about what this is going to take to unpack it."*

Canada's NCCP positions equity and reconciliation as central.

> *"The focus on equity, the focus on reconciliation, are key. They are front and centre throughout the strategy."*

Similarly, in the **United Kingdom**, participants observed high-level pledges but noted limited translation into concrete initiatives.

> *"There was this high-level pledge around healthy life expectancy that doesn't feel as though it's materialising into much."*

Clear program logic and theory of change

The use of program logic or change models varies across countries, limiting the ability to clearly link NCCP activities to outcomes.

Participants in the **United Kingdom** noted the absence of a clear change model, raising uncertainties about whether the NCCP's vision can be realised.

> *"There's a lot of heroic dependence on innovation, on technology, and fundamentally, there isn't actually a change model described there, as in, how are we going to get to this?"*

> *"I'm quite excited about the vision that's been set, the million-dollar question is around implementation and how."*

In **Japan**, efforts are underway to strengthen the connection between activities and results:

> *"We are trying to find which type of strategy is effective to reduce the cancer mortality and incidence to examine the relationship between the activities and outcomes."*

In contrast, **Canada** has developed logic models that align projects to the NCCP, explicitly connecting outputs and intermediate outcomes to ultimate goals such as fewer cancer diagnoses, improved survival, and more equitable care. Equity and reconciliation are embedded within evaluation plans to ensure all activities contribute to these aims. In addition, the design of evaluation plans and indicators are co-developed with First Nations, Inuit and Métis partners.

> *"We have a logic model at CPAC [Canadian Partnership Against Cancer] that aligns to the Canadian Strategy for Cancer Control, so it has those ultimate outcomes at the top, fewer people diagnosed with cancer, more people survive, better quality of life and more equitable cancer care. And then we've got the intermediate outcomes, immediate outcomes and outputs that all relate to the work that the Partnership does in collaboration with our partners.... each of those projects often have their own logic model that we build in collaboration with our partners who we're funding and working with to make sure that that theory of change does exist and everything is laddering up again to those ultimate outcomes anchored in the strategy, the Canadian Strategy for Cancer Control."*

Lead agency with clear remit

Participants noted that having a central organisation with authority and mandate facilitates progress.

In **Australia**, Cancer Australia's leadership in setting priorities and promoting a sector-wide approach was noted as critical:

> *"One of the key challenges, I think, is, again, who's holding this sort of space of information inside of the countries and so, you know, if Cancer Australia hadn't put inequity inside of the Australian Cancer Plan, where would we be in this discussion in Australia?"*

> *"They [Cancer Australia] are setting that broad agenda in a way that allows the whole Australian community to start to come along this cancer journey in a different type of way."*

In contrast, participants from **Japan**, the US, and **Germany** highlighted the absence of a singular responsible agency, with fragmented responsibilities and limited strategic leadership seen as barriers to coordinated action.

Japan:

> *"There is no official organisation in charge of tackling health disparity."*

United States:

> *"There's nobody directly responsible for it. When you talk about addressing inequity, you're immediately introducing everything from the largest insurer on earth, Medicare, Medicaid, to the local initiatives that will get people out to get their PSA checked or to get them in a van to a treatment appointment or whatever else. It's this patchwork of solutions. It's not unified."*

Germany:

> *"There's quite some evidence, but we need to align, and make a good initiative, and really have someone leading that one. I really see this issue of leadership here."*

Inclusive and consultative processes

Participants emphasised that the development and delivery of NCCPs is strengthened from targeted engagement, co-design, and broad stakeholder consultation.

In **Australia**, for example, the NCCP development incorporated a 'targeted engagement period'. As one participant explained:

> *"The consultative nature of working out what's important to the community is very important...we tried so hard with the consultation to know that by the time the thing landed, everybody who wanted to have a say, will have had a say and be heard."*

Across several G7 Cancer countries, stakeholder consultation and co-design with diverse actors, including the groups most affected by cancer, were described as critical to effective cancer control and equity action.

In **Canada**:

> *"We bring different partners together and support that collaborative partnership."*

In **Germany**:

> *"Together with the German Cancer Society and the Psycho-Oncology Group and the social workers and we were sitting together for like two or three years, writing down what we think should be the measures and in constant contact with the ministry. It's a long process, but they took care that many people are involved from stakeholders."*

Sector-wide shared responsibility

Participants emphasised that addressing inequities often relies on distributed, sector-wide engagement and responsibility.

In **Australia**:

> *"Implementation of the Australian Cancer Plan is a shared responsibility across the entire sector and community."*
>
> *"They [Cancer Australia] are setting that broad agenda in a way that allows the whole Australian community to start to come along this cancer journey in a different type of way."*

Similarly, in the **United States**, efforts were described as a "*distributed, shared responsibility*".

Robust accountability mechanisms

There are gaps in monitoring and accountability, which present challenges for ensuring that equity goals translate into tangible outcomes and that NCCPs deliver on their intentions.

In **Germany**, participants observed limited government oversight:

> *"Nobody would say, okay, let's report on how are we doing in terms of reducing inequality, or is our access really universal? It's not that kind of thing."*

In the **United Kingdom**, a participant questioned whether sufficient attention and resources were devoted to evaluation, noting a lack of system-level appraisal:

> *"I do wonder if enough time, effort, resource is spent on evaluating some of the policy changes that are made and some of the structural arrangements that are made... I don't know that we take a step back and evaluate some of that change, or really try to understand in detail what difference it's making. And the same could be said, you know, national cancer plans as a whole.... And I just think that is really interesting for health systems to be constantly trying to evaluate and appraise, not just at the level of the individual intervention, but taking a couple of steps back, is this national plan achieving as much as we wanted to, at the pace we want it to."*

By contrast, Australian and Canadian participants pointed to **Australia** and **Canada** as positive examples, where NCCP monitoring and evaluation mechanisms are in place, though discussions of these mechanisms tended to remain at a high-level.

In **Australia**, the 10-year coverage period for the NCCP was seen as a strength in providing a foundation for sustained action:

> *"And also the fact that it's a 10-year plan, so this isn't just about something that in three years' time is going to get rewritten, it is something that we've got to have a bit of a longer view of."*

Policy in development

Widespread activity, limited policy

Across multiple G7 Cancer countries, participants noted that while numerous initiatives and examples of action exist, formal **policies to address health inequities remain limited** or absent.

In the **United States**, participants highlighted that although many institutional initiatives exist, there is no specific policy:

> *"There are a lot of examples within institutions, for sure, that's different than policy."*

> *"There's no central, singular, charged agency or policy that I know of that is meant to do that."*

In **France**, participants emphasised the absence of national policies addressing social gradients in health:

> *"We don't have any policy focusing on social gradients....We have targeted policies for poor population, but we don't have any national policy focusing on social gradient in health, and that's a problem, and that's the main problem for us."*

In **Japan**, there is no policy structure to monitor disparities across socio-economic groups, limiting the focus on equity:

> *"In terms of socio-economic statuses, we don't have any policy structure or framework to monitor health statistics according to those indexes."*

In **Canada**, participants noted attention to the social determinants of health:

> *"The social determinants of health are really things that people are looking at, whether people can afford their groceries, the cost of housing is a huge challenge across the country right now... And so I'd say in terms of federal policies that are looking at inequities, those are really the top of mind areas of focus...."*

In the **United Kingdom**, participants reflected on recent attention to inequities but a lack of coherent strategies or actionable policy:

> *"There's quite a lot of hand wringing about that, and isn't that bad, but there aren't really any strategies to sort that out."*

> *"In terms of policy responses, honestly, I don't think we've really made any progress, apart from, I think, in terms of focus on the issue, really, we've only been focusing on it properly for five years... So I hope over the next five years, as things settle down, we will start to develop strategies that go beyond small pots of money for pilot projects, which is essentially where we're at at the moment."*

Many opportunities, persistent uncertainties

Participants highlighted both opportunities and uncertainties in addressing inequities across the cancer continuum.

In **Australia**, participants emphasised the wide range of potential action:

> *"There's a lot, all the way across, there's opportunities for doing something about inequity."*

In the **United Kingdom**, participants acknowledged that evidence-based actions exist throughout the pathway, while inequalities remain:

> *"At every point in the pathway, it's doing what we know works."*

> *"There are clearly inequalities throughout the cancer pathway."*

However, uncertainty persists about where interventions may have the greatest impact:

> *"We don't know even at what point in the pathway is the most relevant bit to focus on."*

Practical policy approaches

Table 25 presents examples of **practical policy approaches** identified as supporting commitments to address cancer inequities in G7 Cancer countries. These initiatives highlight **real-world efforts to address inequity**, noting that some may not yet have been formally evaluated.

Table 25 - Examples of practical policy approaches to address cancer inequities in G7 Cancer countries

Country	Policy initiative	Description	Approach to addressing cancer inequity	Link for further information
Australia	Our Mob and Cancer	*Our Mob and Cancer* is a national website designed to provide a central hub of culturally appropriate, evidence- and strengths-based cancer information. By serving as a central hub of information, this initiative, developed by and for Aboriginal and Torres Strait Islander people, provides information about cancer that is relevant to, and resonates with, Aboriginal and Torres Strait Islander people with cancer and their health professionals.	The *Our Mob and Cancer* website features the artwork 'Hope and Healing', which fosters a sense of cultural safety, belonging and hope, and enables users to feel connected throughout their experience. Continuous updates and community involvement in the website's development help to advance cancer equity by ensuring information is accessible, respectful, and tailored to user needs.	Our Mob and Cancer
	Australian Comprehensive Cancer Network (ACCN)	The ACCN is a virtual national network that connects cancer services across Australia to enable collaboration, share expertise, and support access to comprehensive cancer care for all people affected by cancer.	Anchored by Comprehensive Cancer Centres, the ACCN aims to strengthen connections between metropolitan, regional, rural, and remote services to improve equity of access to optimal cancer care as close to home as safely possible. Through a networked approach, the ACCN enables services to collaborate with other entities and colleagues to tailor successful models of care to meet the needs of their patients (lift, shift and tailor).	Australian Comprehensive Cancer Network

Canada	Elimination of cervical cancer	The *Action Plan for the Elimination of Cervical Cancer in Canada, 2020–2030* is Canada's response to the call by the World Health Organization to eliminate cervical cancer worldwide within the century. Canada's Action Plan focuses on addressing the inequities and barriers in accessing prevention and care that are experienced by rural and remote communities, people with low income, recent immigrants, First Nations, Inuit and Métis and other populations, such as LGBTQ2S+ individuals.	Canada is making progress toward eliminating cervical cancer through enhanced immunization, screening, follow-up care and action on Peoples-specific, self-determined priorities by implementing: • innovative, community-based human papillomavirus (HPV) immunization strategies to increase coverage among under-immunised communities • HPV primary screening programs, including self-screening, to support culturally safer care and enable access for people who may not have a primary care provider	Eliminating cervical cancer in Canada
	Models of care	Through a multi-year Models of Care Initiative, the Canadian Partnership Against Cancer is supporting 43 projects across 11 provinces and territories that test and scale innovative models across the cancer care continuum. Projects are co-designed with the communities they serve, including First Nations, Inuit and Métis, newcomers and people who are vulnerably housed to ensure approaches are culturally appropriate and equity focused.	All phases of models of care projects are centred around relationship building, engagement and collaboration with equity denied communities and/or First Nations, Inuit, and Métis. Projects include providing nurse-based virtual education about endoscopy to rural and remote patients, remodelling lung cancer diagnostic pathways for patients without a primary care provider, optimising cancer diagnosis pathways for people who are unhoused, among others.	Rethinking how we deliver care across Canada – 2024-25 Annual report
France	Institut National du Cancer (French National Cancer Institute)	The **Ten-Year Cancer Control Strategy 2021–2030** sets a collective ambition: to reduce the burden of cancer in society by acting across the entire continuum—from prevention to quality of life after illness. Built around research, it brings together	It includes a cross-cutting pillar: **'Ensuring that progress benefits everyone.'** This axis aims to reduce inequalities in access to prevention, care, research, and innovation.	Stratégie décennale de lutte contre les cancers 2021-2030 - Institut

		health policies, innovation, and social support through four main pillars: preventing, treating, improving life after cancer, and ensuring that everyone benefits from progress.	It is structured around seven components, two of which are central to addressing inequalities: • **IV-3:** Combating inequalities through a pragmatic approach tailored to different populations. • **IV-4:** Enabling isolated territories to provide accessible and high-quality healthcare. The approach departs from overly general policies, favouring targeted action toward the most vulnerable populations (people with disabilities, those in precarious situations, prisoners, non-French speakers, the elderly, etc.). It emphasises: • better identification of vulnerabilities, • training professionals for brief and adapted interventions, • personalised support (case coordinators, teleconsultations), • and fairness in access to prevention, screening, and care across all regions, notably through telehealth and intervention research.	national du cancer
		The **National Tobacco Control Program (PNLT)** is France's comprehensive public health policy to reduce tobacco use and its health burden. It combines prevention, regulation, cessation support, and protection from second-hand smoke exposure. Tobacco use disproportionately	To reduce these inequalities, the program implements **targeted and localised measures**. These include free or reimbursed nicotine replacement therapies, reinforced cessation support through healthcare professionals and social services in underserved areas, awareness campaigns adapted to low-literacy audiences,	Lutte contre le tabagisme

		affects people in precarious situations and those with lower educational attainment, deepening social inequalities in morbidity and mortality. The PNLT aims to reverse this trend and to achieve France's overarching goal of creating the **first tobacco-free generation by 2032**.	and the expansion of *smoke-free zones* in public spaces. The PNLT also promotes better training for health and social workers to identify and support vulnerable smokers, ensuring that tobacco control efforts benefit the entire population, not only the most advantaged groups.	
Germany	National Decade Against Cancer (NKD)	The National Decade Against Cancer is a joint initiative of the German Federal Ministries of Education and Research and of Health. It promotes collaboration between research, healthcare, and patient communities to strengthen cancer research and ensure faster translation of scientific advances into better care for people affected by cancer.	The National Decade Against Cancer aims to ensure that all patients have access to high-quality cancer prevention, treatment, and research across Germany. By fostering collaboration between research institutions and healthcare providers, establishing model regions, and strengthening patient participation, the Decade seeks to reduce regional disparities and ensure that all individuals benefit equally from advances in cancer research and care. The initiative is closely linked to the establishment of nationwide clinical cancer registries, which provide a comprehensive data foundation for evaluating treatment quality and outcomes across regions. Together, these instruments aim to strengthen evidence-based improvements in cancer care and ensure equal access and quality for all patients in Germany. While the initiative aims to ensure equal access for all patients, it does not explicitly address the broader issue of inequity. This presents a valuable opportunity for future policy development to more clearly acknowledge and target inequity.	Homepage - Die Nationale Dekade gegen Krebs

	HPV School Vaccination Program in Bremen	The HPV School Vaccination Program is a state-wide initiative providing HPV vaccinations directly in schools to increase uptake among adolescents and simplify access.	By targeting schools in socially disadvantaged areas and monitoring uptake via the school social index, the program achieved substantial increases in vaccination rates where they had been lowest, contributing to more equitable cancer prevention.	HPV-Schulimpfprogramm
Japan	Basic Plan to Promote Cancer Control Programs (national comprehensive cancer control plan)	The 4th-term plan sets up the overall goal: Promote cancer care that **leaves no one behind**, and work to overcome cancer with all citizens.	The 4th-term plan sets three target fields: Cancer prevention, Cancer care, and Coexistence with cancer. In the field of Cancer care, a sub-goal is to equalise and consolidate systems for providing care. Through this, the national and prefectural governments will promote equitable and sustainable cancer care by coordinating roles among core hospitals and regions, while the national government supports this through data sharing and best-practice exchange. In the area of Coexistence with cancer, to ensure equal access to care, the Designated Cancer Care Hospitals will raise awareness of cancer support services and expand online access. The government will maintain training, build a sustainable high-quality support system, and strengthen links among hospitals, organizations, and peer supporters so every patient can receive timely, appropriate support.	https://ganjoho.jp/public/qa_links/report/statistics/2025_en.html https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000183313.html (in Japanese)
	National research funding activities	Extensive research aimed at reducing health disparities is being conducted under various national research funding frameworks, including the Health and Labour Sciences Research Grants, the Japan Agency for Medical Research and Development (AMED), and the Ministry of	These research initiatives monitor disparities across each phase of the cancer continuum by utilising and linking public statistics and healthcare data, such as cancer registries and claims records, and identify underlying factors. Research findings are shared with stakeholders to inform national and regional cancer control	Cancer GeoHub (https://ncc-geo-hub-ncc-csi.hub.arcgis.com/), in Japanese

		Education, Culture, Sports, Science and Technology (MEXT) Grants-in-Aid for Scientific Research. The National Cancer Center also publishes area deprivation indices and related resources that can be used to advance these research initiatives.	strategies aimed at reducing cancer-related inequities.	
United Kingdom	CORE20PLUS5	Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The fourth of the clinical areas is about early cancer diagnosis and sets an ambition for 75% of cases to be diagnosed at Stage 1 or 2 by 2028.	The 'CORE20' is the most deprived 20% of the national population. The 'PLUS' parts of the population are locally defined, and might include, for example ethnic minority populations, including traveller communities, vulnerable migrants and those in contact with the justice system.	CORE20PLUS5
	Mobile lung cancer screening vans	Lung cancer is the biggest cause of cancer mortality in the UK. Cancer mortality is 60% higher in the most deprived parts of the country compared to the least. Higher incidence and mortality is driven by smoking rates which are around 3.5% higher in the most versus least deprived groups. Targeted lung health checks started as a pilot in some parts of England in 2019. In June 2023, the Westminster government announced the rollout of a national targeted lung cancer screening programme following a recommendation from the UK National Screening Committee (UK NSC)	Rollout of the national screening has been prioritised first in the most deprived areas of England and it will continue to expand to the rest of the country to provide full coverage of the eligible population by 2029. A core feature of the programme rollout has been the use of mobile units which are deployed to locations within local communities, like supermarket car parks, with the aim of improving access for people who face barriers to accessing healthcare. Experts in Northern Ireland, Scotland and Wales are still looking into the best way to introduce lung cancer screening in these nations.	Mobile lung cancer screening vans (a local example)

		for people aged 55–74 with a smoking history and high lung cancer risk.	So far, more than 1 million people have taken up their lung cancer screening invitations and screening has diagnosed more than 5,500 people with lung cancer. Over 75% of these lung cancers were found at an early stage (1 or 2), compared to less than 30% of lung cancers detected outside of screening.	
United States of America	The National Cancer Plan	The **National Cancer Plan**, released by the National Cancer Institute in 2023, serves as a comprehensive framework to unify efforts across government, academia, health systems, advocacy organizations, and the private sector toward ending cancer as we know it. It outlines **eight interconnected goals**—ranging from preventing cancer and detecting it early to eliminating inequities, engaging every person, delivering optimal care, and maximising data sharing to advance research and outcomes.	Central to the National Cancer Plan is the recognition that progress against cancer requires a coordinated, multisectoral approach that extends beyond biomedical innovation. The plan emphasises health equity, community engagement, and data-driven collaboration as essential drivers of sustainable change. It calls on all stakeholders—researchers, clinicians, policymakers, patients, and the public—to align their efforts and resources to translate discoveries into tangible benefits for every community. By integrating prevention, care delivery, research, and policy, the National Cancer Plan provides a shared roadmap for transforming the cancer landscape and achieving longer, healthier lives for all.	https://nationalcancerplan.cancer.gov/
	Medicaid expansion under the Affordable Care Act (ACA)	The United States does not offer universal healthcare to its citizens. Medicaid is a government program, managed at the state level, that provides health insurance for adults and children with limited income and resources. Medicaid expansion is a policy under the ACA that allows states to extend health insurance coverage to all low-income adults earning up to 138% of	Medicaid expansion under the ACA has been one of the most significant policy levers for improving cancer equity in the United States. By extending coverage to millions of low-income adults, expansion states saw measurable gains in cancer prevention, early detection, and access to timely treatment. Studies show that individuals in expansion states are more likely to receive recommended cancer screenings—such as	https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/ Schafer, et al. Cancer Discov

		the federal poverty level, improving access to affordable care and reducing health disparities.	mammograms, colonoscopies, and cervical cancer tests—and to be diagnosed at earlier, more treatable stages of disease. Expanded coverage has also reduced racial and socioeconomic disparities in treatment initiation and survival, particularly among Black and Hispanic patients who historically faced the greatest barriers to care. In addition, to improve access to cancer care, Medicaid expansion has lessened the financial burden of cancer.	2025 https://doi.org/10.1158/2159-8290.CD-25-1244

Priority population groups

- **Specific populations** are frequently identified as priorities for cancer equity, with recognition of **intersectionality** emerging as an increasingly important consideration. Interviewees across G7 Cancer countries highlighted particular groups - refugees, prisoners, rural and remote populations, and Indigenous peoples - as facing distinct cancer inequities.

Intersectionality

In several countries, participants noted that these groups often experience overlapping vulnerabilities, such as socioeconomic disadvantage, geographic isolation, and cultural or linguistic barriers. Recognition of intersectionality - how multiple risk factors combine to amplify inequities - was frequently mentioned, particularly in **Australia** and the **United Kingdom**, indicating a growing recognition that populations are not homogeneous but affected by layered, interacting factors.

Tailored approaches

While many participants supported tailored approaches to advance equity, others cautioned that overly specific strategies may not always be the most effective, especially when broader systemic challenges remain.

In **Canada**:

> *"We do not have a kind of one-size-fits-all for advancing equity. We're really looking at more tailored approaches."*

In the **United Kingdom**:

> *"We shouldn't jump to the conclusion that only tailored strategies, like only kind of hyper tailored strategies, are the right answer....we have universal access problems in the NHS, and my take, honestly, is that we should start there. It is, like, making services accessible to people who are most disadvantaged is the same challenge as making services accessible to people who are advantaged."*

Data, monitoring, and evaluation

Data gaps and system limitations

Countries remain at an early stage in building comprehensive, equity-focused cancer data systems, with no comprehensive national system identified that fully measures inequities in cancer. Major barriers included missing data, inconsistent collection practices, fragmented systems, and limited capacity to capture key social variables.

As one **Australian** participant reflected:

> *"We are far away from very comprehensive, all-encompassing evaluation data collection for cancer inequity in Australia."*

In **Japan**, the absence of personal identifiers prevents linkage across surveys, and race or ethnicity data is not collected in national statistics. **German** participants highlighted the lack of unified datasets to "*make a good case for evidence-based policy making*."

Similar challenges were reported in **France** and in the **United Kingdom**, where data collection is largely shaped by the Equalities Act but remains limited in scope.

Canada offered an example of promising practice, with initiatives to collect race and ethnicity identifiers and strengthen First Nation, Inuit, and Métis data sovereignty in alignment with data sharing principles. Participants emphasised that data are collected in collaboration with Indigenous organisations, analysed in culturally safe ways, and reported back to communities before governments can access them, ensuring trust and meaningful use.

> *"With respect to First Nation, Inuit, and Métis governments and organisations, there's work underway to ensure there's data sovereignty and to ensure that the data goes back to community if it is collected within the healthcare settings. And so there are linkage projects underway to link citizen registries with health care data, but then that data is collected in a very safe and culturally appropriate way, it's analysed in collaboration with First Nation, Inuit, and Métis organisations and partners, presented first back to First Nation, Inuit, Métis communities before governments will be able to access it and what not, and then action plans are developed through that information."*

Indicators and Targets

It is important to measure and monitor cancer inequities. There are a range of clinical and social indicators essential for understanding and addressing cancer inequities, but gaps in equity-relevant measures remain.

Clinical indicators such as stage at diagnosis and access to treatment were emphasised, alongside patient-focused measures including PREMs, PROMs, and out-of-pocket costs. As one **Australian** participant reflected:

> *"We can't assume that anybody has the sort of experience that we think they're having. And so the input of patient experience data, PREMs and PROMs, is actually critical for addressing disparity and inequity. So we really need that information, and we don't have that information for a lot of cancers, for a lot of people."*

Socioeconomic and demographic factors - such as geography, rural or remote residence, Indigenous or minority status, and education or income level - were also identified as essential for monitoring disparities.

Highlighting the importance of social variables, a **French** participant noted:

> *"We should have this social variable at individual level if we want to do some good work on social inequalities in health."*

Participants also highlighted the need for comprehensive data on program implementation and population characteristics to ensure interventions effectively reach those most in need.

Data frameworks, cancer registries, and data linkage

Structured data frameworks, comprehensive cancer registries, and effective data linkage are essential enablers of cancer control generally and equity specifically.

Participants described new frameworks in **Australia** and **Canada**, designed to "*use data to drive equity*" and address gaps in data. They stressed the importance of harmonised standards and definitions to enable comparison and monitoring across contexts.

Cancer registries were widely regarded as critical infrastructure for screening, service improvement, and research. In the **UK**, participants emphasised the ability to "*watch people from first presentation all the way through to either recovery or death*,"

Data linkage was identified as a key factor for continuous, systematic monitoring, though regulatory and privacy barriers remain. In **France**, participants pointed to the need for legal change to enable data integration, while in the **UK**, developments in "*secure data environments*" and efforts to link primary care with other datasets were viewed as transformative.

> *"We're moving into this era of secure data environments, and a new organisation actually being formed which is meant to do much more end-to-end linking of all health and care data."*

Privacy, consent, and trust were seen as critical across all contexts, particularly in relation to Indigenous populations.

Evidence into policy

Engaging policymakers is essential to ensure equity-relevant data informs decision-making. However, fragmented systems, limited interoperability, and data gaps are major barriers to translating evidence into action.

In **France**, participants noted the ongoing challenge of explaining the role of social determinants to politicians, describing this as "*not a classic way to see health and to develop actions*." In **Germany**, the absence of unified datasets was seen to hinder policymaking:

> *"We don't have this unified number and can combine all the data sources and see, and make a good case for evidence-based policy making."*

Similar challenges were reported elsewhere. **Canadian** participants highlighted interoperability gaps that make it "*hard to really understand equity-denied populations*," while in **Australia**, the federated system produces variable and incomplete data across states and territories. **Japanese** participants emphasised the need for dialogue with government officials to determine which statistics should be monitored and made public.

Across contexts, participants agreed that without robust, harmonised data, it is impossible to assess inequities and act on them.

Key actors and collaborative mechanisms

- **Engaging a broad range of stakeholders**, particularly patients and consumer advocates, is crucial to advancing equity in cancer control.

Participants described the value of including patients, carers, clinicians, researchers, policymakers, and community members, with broad consultation viewed as a key mechanism for enabling cross-sector collaboration. Patient advocates were seen as especially influential in shaping policy and raising awareness of disparities, with formal involvement in national committees in **Japan** cited as ensuring equity goals are embedded in NCCPs.

As one **Japanese** participant explained:

> *"In the committee of the fourth national cancer control plan, many patient advocates agreed and put this target to reduce the inequalities and monitor inequalities. That's why the main target included no one left behind in cancer control activities."*

NGOs and philanthropic organisations were also identified as important actors in strengthening collaboration by providing resources and amplifying patient voices. However, structural

constraints - such as severe funding cuts to local authorities in the **UK** - were noted to limit the capacity of non-health sectors to engage, leaving health systems as the primary driver of equity efforts.

Participants also noted the value of learning from international plans and aligning with global frameworks, such as WHO resolutions and UICC checklists, to guide priorities and implementation considerations for each population group.

In **Australia**, engagement across the broader cancer community was identified as a challenge:

> *"I don't think you know that we've got a huge focus outside of the Cancer Australia team on some of these issues, and that's part of the challenge... How do we start to support the Australian cancer community to get more engaged in thinking about some of these equity issues beyond what they're being pushed to do through their state and territory government agency?"*

Leveraging collaboration and evidence to advance cancer equity

- G7 Cancer countries value **international collaboration** to exchange practical solutions and evidence-based strategies for addressing cancer inequities.

Participants highlighted the importance of sharing concrete examples of what works to highlight actionable approaches, alongside supporting this study and its efforts to showcase initiatives that advance cancer equity.

In **Japan**, participants noted the need for evidence on actionable strategies that can be implemented locally, and that international peer engagement can help raise awareness and accelerate action.

Australian participants described learning from other countries, such as Japan's approach to liver cancer, to inform domestic action.

German and **French** participants highlighted the importance of practical, implementable solutions to reduce inequalities, underscoring the need for a "*science of solutions*" to complement recognition of disparities.

- Creating **enabling social and policy environments**, along with horizon scanning and measurable targets, is essential for translating awareness of inequities into actionable outcomes.

Participants reflected that long-term planning and coordination are critical to effective cancer control.

Australian participants highlighted the need for horizon scanning to anticipate emerging issues and to ensure future iterations of the cancer plan are informed by evolving evidence. International frameworks, such as those from the UN or WHO, were suggested as tools to simplify and align collective action.

Japanese participants noted that building a supportive social climate, including engaging patient advocates, is key for generating momentum in policy implementation.

4. Discussion

This study provides the first comparative analysis of cancer equity policy across G7 Cancer countries, extending a nascent evidence base on how equity is addressed within NCCPs [30, 31].

The analysis draws on three complementary phases:

1. Review of cancer and health equity frameworks (Phase 1)
2. Analysis of NCCPs (Phase 2)
3. Expert qualitative interviews (Phase 3).

Together, these phases integrate diverse sources of evidence to identify opportunities for advancing equity in cancer control. From Phase 1, an evidence-informed model was developed to examine equity in cancer control and guide policy action, which is elaborated below.

Key insights from each phase are summarised in turn. Taken together, the findings reveal persistent inequities, marked variation in policy approaches, and consistent gaps between rhetorical commitment and operational delivery. These gaps highlight the need to move beyond aspirational statements of intent and to strengthen cancer control policy, practice and governance through both country-specific and shared opportunities.

These insights directly inform the policy recommendations that follow, which offer a roadmap to support national and international efforts toward more equitable cancer outcomes.

4.1 Policy Framework for Equity in Cancer Control

From Phase 1, an evidence-informed model was developed to examine equity in cancer control and guide policy action. The *Policy Framework for Equity in Cancer Control* (**Table 26**) is a global policy framework designed to support G7 Cancer member countries, and others, in advancing equitable cancer policy. This evidence-informed model aligns with the study's aims to illuminate drivers of cancer inequities, identify actionable policy imperatives, and establish measurable outcomes. The framework is structured around three core functions:

1. **Identify what impacts equity** - outline the drivers of cancer inequities across the cancer continuum, providing a foundation for action.

2. **Describe what to do** - present evidence-informed, equity-oriented policy imperatives spanning prevention, care delivery, and system infrastructure. These are designed to support practical action and are adaptable across national contexts.

3. **Guide what to measure** - highlight equity indicators and accountability tools to support monitoring, evaluation, and policy accountability.

The framework synthesises insights from 14 global, European, and multi-regional cancer and health equity frameworks [39, 75, 79-90], selected from 53 identified in Phase 1 for their broad applicability. This includes eight global frameworks, four European frameworks, one multi-regional framework, and one European data tool (the ECIR data tool, included alongside the ECIR Framework). Frameworks with a single-country or narrow regional focus were excluded to ensure broad applicability across diverse contexts.

Spanning the entire cancer care continuum - from prevention and early detection through treatment, survivorship, and end-of-life care - the framework integrates upstream, midstream, and downstream determinants of health across societal, community, and healthcare settings.

Analysis highlighted common drivers of inequities, including unequal access to screening, socio-economic disadvantage, and cultural or geographic barriers to access. Corresponding policy imperatives ranged from targeted programs for underserved populations to system-level reforms such as equity-informed funding models and culturally safe care. The '*what to measure'* component was shaped by evaluation guidance within the source frameworks, which provided examples of relevant metrics and monitoring systems. This ensures that equity is positioned not only as an aspirational goal but as a measurable and accountable objective within cancer control.

Cross-framework analysis revealed foundational principles, including routine use of disaggregated data, culturally safe and responsive care, and community-led governance in policy and service design. While there is convergence on these principles, variations in how equity is defined, operationalised, and resourced underscore the need for context-specific application. Taken together, these insights informed a holistic, action-oriented framework linking drivers of inequity to policy imperatives and measurable outcomes, supporting equity-focused policy development and performance monitoring at global, regional, and national levels, and offering practical utility across G7 Cancer member countries, and other countries striving to apply an equity lens to cancer control.

Table 26 - Policy Framework for Equity in Cancer Control

Determinants	**Upstream**		**Midstream**		**Downstream**		
Cancer continuum		**Prevention**		**Detection, Diagnosis, Treatment**		**Survivorship End-of-life care**	
Setting		**Society**	**Community**	**Healthcare system** (primary, secondary, tertiary, community)			
Cancer equity levers and outcomes	**Policies and program settings**	**Determinants of health**	**Risk & protective factors**	**Access**	**Experiences**	**Clinical outcomes of cancer care**	**Broader outcomes**
Drivers of cancer inequities	• Limited equity leadership and governance[13,14] • Limited equity-explicit policy goals[13,14] • Limited accountability for equity across the system[13] • Policy inertia and insufficient political will[13,14] • Limited community involvement in governance, planning, and evaluation[13,14] • Funding and resource allocation challenges[1,10,14] • Underinvestment in prevention and early detection[13] • Short-termism in funding and program cycles[13]	• Socioeconomic disadvantage • Poverty, income inequality, and unemployment[1,2,3,4,5,7,9,10,11,13,14] • Income insecurity[1,2,3,7,9,10,11,13,14] • Educational attainment[1,2,3,4,7,8,19,11,13,14] • Low literacy[7,10,13] • Low health literacy[1,9,10,13] • Housing instability and homelessness[5,7,10,12,13] • Food security[4,7,10,11,13] • Social connectedness and support networks[1,5,7,10,12,13]	• Tobacco use[1,7,8,9,10,11,12,13,14] • Alcohol consumption[1,7,8,9,10,11,12,13,14] • Overweight and obesity[1,7,8,11,13,14] • Physical inactivity[1,7,8,9,10,11,12,13,14] • Unhealthy diets[1,8,9,10,11,12,13,14] • Lower uptake of protective behaviours (e.g. HPV vaccination, cancer screening)[1,8,9,11,12,13] • Environmental and occupational exposure to carcinogens and hazards[1,7,8,9,10,11,12,13,14] • Air pollution[1,7,8,9,10,11,13]	Lack of access to: • Preventive services[1,8,9,11,12,13] • Screening and early detection[1,8,9,11,12,13] • Timely and accurate diagnosis (e.g. diagnostic imaging, pathology, specialist referrals)[9,12,13] • Treatment options[1,9,12,13] • Clinical trials and innovative therapies[1,11,12,13] • Supportive care and health information[1,12,13] Barriers to access: • Affordability and out-of-pocket costs[1,7,10,11,13] • Geographic maldistribution of services[1,7,9,10,11,12,13]	• Discrimination, stigma and bias in care[1,7,13] • Lack of person-centred and culturally safe care[1] • Lack of trauma-informed care approaches[13] • Limited health system literacy and trust[1,9,13] • Language barriers and insufficient access to translated materials[13] • Navigation challenges[1,13] • Limited involvement of patients and families in decision-making[1,12,13]		

Determinants	Upstream		Midstream		Downstream		
Cancer continuum		Prevention		Detection, Diagnosis, Treatment		Survivorship End-of-life care	
Setting		Society	Community	Healthcare system (primary, secondary, tertiary, community)			
Cancer equity levers and outcomes	**Policies and program settings**	**Determinants of health**	**Risk & protective factors**	**Access**	**Experiences**	**Clinical outcomes of cancer care**	**Broader outcomes**
	• Insufficient resourcing and poor targeting of efforts to priority populations[13,14] • Gaps in program and service design[1,13,14] • Program design that does not accommodate diverse populations[1,10,13,14] • Fragmented and siloed program delivery[1,13,14] • Lack of coordination across levels of government and sectors[13] • Limitations in data, evidence and accountability[1,10,13] • Limited use of disaggregated data and equity monitoring[10,13] • Limited integration of equity in cancer research agendas[13]	• Access to digital infrastructure[7,13] • Structural inequities and discrimination • Racism, colonisation, and discrimination[1,4,5,7,10,12,13,14] • Gender inequality and rigid gender roles[1,2,3,4,5,7,9,10,11,13,14] • Legal status and entitlements to care (e.g. visa, citizenship status)[7,13] • Incarceration or involvement with the justice system[7,13]	• Genetic or hereditary cancer risk[12,13] • Sun exposure[8,13] • Underlying contributors to unequal exposure or uptake • Disproportionate exposure to risk factors[8,11,13,14] • Commercial determinants of health (e.g. targeted marketing of tobacco, alcohol and foods high in fat, salt, sugar)[1,10,13,14] • Limited access to prevention information and services[1,8,9,11,12,13] • Low awareness of cancer symptoms and risk[1,9,12,13]	• Travel distance and transport burden[13] • Availability and system capacity constraints[7,9,13] • Waiting times and service delays[1,10,13] • Health insurance limitations or exclusions[1,12,13] • Appropriateness and acceptability of services[10,12,13]	• Poor management of co-morbidities[12,13] • Lack of continuity of care and relationships with providers[13]		

Determinants	Upstream		Midstream		Downstream		
Cancer continuum		Prevention		Detection, Diagnosis, Treatment		Survivorship End-of-life care	
Setting		Society	Community	Healthcare system (primary, secondary, tertiary, community)			
Cancer equity levers and outcomes	Policies and program settings	Determinants of health	Risk & protective factors	Access	Experiences	Clinical outcomes of cancer care	Broader outcomes
Policy levers (What to do)	• Establish an NCCP[1,13] • Include equity goals in the NCCP[1,13] • Ensure policy coherence.[7,13] • Allocate resource / expenditure[7,10,13] • Monitor progress and embed accountability mechanisms[2,3,7,9,10,13,14] • Ensure data systems and linkages in place[7,10,13] • Engage with community[1,7,10,13, 14] • Apply equity-weighted funding models[7,13] • Conduct equity impact assessments of new cancer policies[13,14]	• Develop income and welfare policy[2,3,7,9,10,13] • Create housing policy[5,7,10] • Advance education policy[1,2,3,4,5,7,9,10,12,13] • Implement urban planning and transport[7,9,10,13,14] • Enforce anti-racism and equity legislation[2,3,5,10] • Implement environmental regulation[1,7,13,14] • Allocate community development funding[1,10,13] • Promote school and workplace health policy[7,10,12,13,14]	• Cancer –specific prevention and early detection • Regulate tobacco, alcohol, and food[1,8,9,11,12,13,14] • Implement vaccination and screening policy[1,8,9,11,12,13] • Promote health and education policy[1,4,5,8,11,12,13,14]	• Expand universal health/insurance coverage[1,7,10,13] • Implement targeted funding models (e.g. equity-weighted funding)[1,10,13,14] • Guide workforce distribution policies[1,7,13] • Adopt telehealth policy[1,12,13] • Integrate service delivery policies[1,12,13,14] • Invest in infrastructure (e.g. mobile services)[1,7,10,13]	• Establish cultural safety and responsiveness standards[13] • Adopt patient-centred frameworks[1,12,13] • Ensure interpreter and communication access[13] • Implement care navigation and coordination policies[1,13] • Embed lived experience and community governance[13] • Provide complaint and redress mechanisms[5] • Set standards for equity in health service accreditation[13]	• Develop national cancer survivorship frameworks and plans[1,9,12,13] • Implement return-to-work reintegration policies[12]	

Determinants	Upstream		Midstream		Downstream		
Cancer continuum		**Prevention**		**Detection, Diagnosis, Treatment**		**Survivorship End-of-life care**	
Setting		**Society**	**Community**	**Healthcare system** (primary, secondary, tertiary, community)			
Cancer equity levers and outcomes	**Policies and program settings**	**Determinants of health**	**Risk & protective factors**	**Access**	**Experiences**	**Clinical outcomes of cancer care**	**Broader outcomes**
		• Strengthen product labelling and consumer protection[1,13]					
Equity indicators (What to measure)	• Proportion of research funding directed to equity-focused projects[10,13] • Inclusion of intersectional data in surveillance and evaluation frameworks[12,13] • Investment in capacity-building for underserved communities[7,12,13] • Support for Indigenous- or community-led cancer initiatives[1,13,14] • Monitoring of implementation fidelity and equity outcomes[2,3,7,9,10,13] • Public reporting of disaggregated data and equity indicators[7,9,10,13]	• Household income[7,10,11,13] • Poverty rate[2,3,4,7,9,10,11] • Employment and unemployment rates[2,3,4,5,7,9,10,11,13] • Job security and working conditions[7,9,10,13] • Access to employment benefits[7,10] • Education and literacy[2,3,4,5,6,7,9,10,11,13] • Housing stability, quality, geographic remoteness, proximity to healthcare and transport[5,7,10]	• Distribution of risk factors • Smoking/tobacco use[1,7,8,9,10,11,12,13,14] • Alcohol consumption[1,7,8,9,10,11,12,13,14] • Overweight and obesity[1,7,8,11,13,14] • Physical inactivity[1,7,8,9,10,11,12,13,14] • Unhealthy diets[1,7,8,9,10,11,12,13,14]	• Service availability (number and location)[1,7,9,10,11,13] • Cancer screening programs and participation/screening rates (breast, cervical, colorectal, lung)[1,8,9,11,12,13] • Access rates (e.g. clinical trials, palliative care, follow-up care)[1,9,11,13] • Health workforce numbers and distribution (e.g. shortages of doctors/nurses)[1,7,11,13] • Infrastructure gaps (e.g. CT scanners, MRI units, reimbursed cancer medicines)[1,11,13] • Affordability of care (out-of-pocket costs	• Healthcare utilisation rates and acceptability[10,11,13] • Cancer screening participation[1,8,9,11,13] • Timeliness and continuity of care[1,9,10,13] • Cancer care pathway navigation and coordination[1,9,12,13] • Quality of care[1,7,9,10,12,13] • Availability of culturally safe and linguistically appropriate services[12,13] • Use of interpreters or translated health materials[13]	• Stage at diagnosis[1,9,11,12,13] • Survival rates (short and long-term)[1,2,3,9,12,13] • Mortality[1,2,3,7,9,11,12,13] • Morbidity[7,11,12,13] • Potential years of life lost (PYLL)[1,11,13] • Percentage reduction between population groups (e.g. income groups)[1,2,3,6,7,9,10,13] • Patient-reported outcome	• Disaggregated cancer outcomes and service data (by socioeconomic status, Indigeneity, geographic location, ethnicity and cultural background, gender, age, disability, migration status[1,9,11,13] • Incidence[1,8,9,11,12,13] • Prevalence[9,11,13] • Survivorship, including health-related quality of life (HRQoL) after treatment[9,11,12,13] • Caregiving burden[12] • Percentage reduction in disparity between population groups

Determinants	Upstream		Midstream		Downstream		
Cancer continuum		Prevention		Detection, Diagnosis, Treatment		Survivorship End-of-life care	
Setting		Society	Community	Healthcare system (primary, secondary, tertiary, community)			
Cancer equity levers and outcomes	Policies and program settings	Determinants of health	Risk & protective factors	Access	Experiences	Clinical outcomes of cancer care	Broader outcomes
		• Environmental exposures[7,9,10,11,12,13] • Food security and nutrition[4,7,10,11,13,14] • Social inclusion[4,5,7,10,13] • Legal status and health entitlements[13] • Digital access and literacy[1,7,13]		for appointments, diagnostics, and medications; health insurance coverage / entitlements)[1,7,13] • Digital access to care (telehealth availability and use by marginalised groups)[1,7,12,13] • Wait times[1,13]	• Type of treatment[1,2,3,7,9,11,12,13] • Patient-reported experience measures (PREMs) (e.g. satisfaction, trust, perceived discrimination)[13]	measures (PROMs)[13] • Cancer recurrence and progression rates[12,13] • Access to and outcomes from palliative, hospice, or end-of-life care[12,13]	(e.g. income quintiles)[1,2,3,6,7,9,11,13] • Complication and readmission rates[13] • Financial burden of cancer or related health conditions[1,13] • Mental health outcomes[2,3,4,13] • Employment outcomes post-treatment[12] • Health system efficiency[1,13] • Population-level improvements in wellbeing and equity[7,13]

Reference Key for Table 26:

1. UICC – World Cancer Day 2024 Equity Report
2. UN – Global Indicator Framework for the Sustainable Development Goals and Targets of the 2030 agenda for Sustainable Development
3. UN – Sustainable Development Goals
4. UN - Transforming our world: the 2030 Agenda for Sustainable Development
5. UN - United Nations Declaration On The Rights Of Indigenous Peoples
6. WHO - Health Equity Assessment Toolkit (HEAT and HEAT Plus)
7. WHO - Operational Framework for monitoring social determinants of health equity (SDHE)
8. IARC – World Code Against Cancer Framework
9. European Commission – European Cancer Inequalities Registry (ECIR) Framework
10. WHO Europe – Health Equity Policy Tool
11. European Commission – ECIR Data Tool
12. ICRP – Common Scientific Outline (CSO)
13. OECD – Beating Cancer Inequalities in the EU
14. WCRF – Policy Blueprint for Cancer Prevention

4.2 Overarching themes

This section synthesises key insights from all three phases, integrating findings from frameworks, NCCPs, and stakeholder interviews. These insights directly inform the policy recommendations, highlighting opportunities to advance equity in cancer control policy, practice, and governance.

Conceptual clarity and shared definitions

> *"Health inequalities are the measurable differences in health across population subgroups, and health inequities are those differences that are avoidable and unjust. They are the result of political, cultural, social and economic systems that shape daily living conditions: the social determinants of health equity." [91]*

A recurring theme is the absence of a shared understanding of cancer equity. Frameworks frequently offer aspirational definitions, focusing on access to care, while NCCPs vary in scope and explicitness. Stakeholders noted differences in understanding inequities' drivers, with some equating equity with equal opportunity rather than actively reducing disparities. Establishing national definitions alongside shared, context-sensitive definitions across G7 Cancer members will provide a foundation for coordinated action, accountability, and comparability, supporting the operationalisation of equity across policy, monitoring, and reporting [92].

From frameworks to actionable strategies

Although numerous frameworks exist, most lack implementation mechanisms, measurable targets, and structured guidance. NCCPs articulate broad goals, yet operationalisation remains limited, and stakeholder interviews highlighted early-stage translation of commitments into actionable strategies. Expanding shared frameworks, embedding equity in NCCPs with specific targets, and using program logic and theories of change provide practical pathways to move from aspiration to measurable outcomes.

Priority populations and intersectionality

Frameworks and NCCPs commonly prioritise geographically remote and culturally diverse populations, while groups such as refugees, immigrants, and LGBTIQA+ populations are less consistently recognised. Interviews underscored that intersecting social vulnerabilities amplify inequities. Explicitly identifying priority populations and integrating their needs into planning, monitoring, and interventions ensures resources are targeted effectively and policies are responsive to diverse contexts.

Social determinants and upstream factors

Inequities in cancer outcomes are shaped by structural, economic, environmental, and social determinants beyond healthcare. Effective equity strategies require action across sectors, as upstream determinants—such as education, poverty, housing, employment, and commercial influences—drive health disparities more than healthcare access or genetics [91]. While some NCCPs acknowledge these factors, implementation is often limited due to their complexity and cross-sectoral nature. Strengthening multisectoral partnerships, formal agreements between government departments, coordinated policies, and dedicated funding streams can align national action with broader determinants, reduce population-level inequities, and facilitate cross-country learning from successful multisectoral approaches.

Equity across the cancer continuum

Inequities persist across the cancer continuum including research. NCCPs prioritise prevention, early detection, screening and treatment, but variation in access and outcomes remains. Embedding equity explicitly into NCCPs with measurable targets and strengthening data infrastructure ensures actions are evidence-informed, enabling tailored interventions across the cancer continuum.

Evidence, data, and monitoring

Many countries remain at an early stage of developing comprehensive equity-focused datasets, with fragmented systems, limited interoperability, and gaps in equity-relevant measures constraining the translation of evidence into policy. Robust, harmonised datasets with shared indicators aligned to national definitions of equity are needed to monitor disparities, inform resource allocation, and evaluate interventions.

Stakeholder engagement and participatory governance

Engaging patients, communities, and civil society is important for culturally appropriate and locally relevant equity strategies. Permanent structures for, and approaches to, meaningful participation, combined with sharing best-practice models, can work to support accountability, legitimacy, and sustainable implementation of equity initiatives.

Building institutional and policy capacity

Strong institutional capacity enables effective and positive advocacy to advance equity. Leveraging national successes and cross-country knowledge exchange can strengthen policy influence and accelerate adoption and adaptation of equity-focused interventions to local contexts.

Communication and advocacy

Strategic communication helps to build an authorising environment, which is fostered when equity is framed clearly, distinct from equality, and positioned in terms of fairness, efficiency, and societal benefit. Framing equity effectively can increase political and public support, enabling sustainable implementation of policies.

International collaboration and shared learning

Cross-country learning accelerates adoption of effective strategies. Shared frameworks, indicators, case studies, and workshops promote alignment, facilitate adaptation of successful interventions, and reinforce G7 Cancer's leadership role in advancing global cancer equity.

Enabling environments and sustainability

Sustained equity action relies on structured governance, measurable targets, and long-term investment. Embedding equity in governance, financing, and cross-sector collaboration ensures that policy commitments translate into tangible, enduring outcomes.

4.3 Policy Recommendations

Evidence from this study, supported by the wider literature, highlights both country-specific and shared opportunities to advance equity in cancer control.

To capitalise on these opportunities, we set out policy recommendations that translate equity commitments into coherent, actionable, and measurable steps. These policy recommendations are designed to build on the diversity of initiatives across and within G7 Cancer member countries that are already working towards improving cancer equity for their populations.

Advancing equity requires a combination of enabling conditions that span the entire policy cycle and sequenced actions that build cumulatively over time. Some recommendations are ongoing and must be embedded at every stage (e.g. sustained engagement and consultation), while others are more sequential (e.g. establishing shared definitions before embedding equity in NCCPs).

To capture this dual character, the recommendations are organised into two complementary categories:

1. **Cross-cutting enablers** – foundational conditions that underpin policy recommendations outlined in the phased roadmap.
2. **Phased roadmap** – three stages: Foundations, Integration, and Consolidation.

Together, they offer a practical approach towards moving from recognition to implementation.

The recommendations provide guidance for all policy makers seeking to advance equitable cancer control, with a focus on individual G7 Cancer member countries as well as suggested collective actions for G7 Cancer Working Group 3 (WG3). They are intended to inform and support policymakers, governments, and other decision-makers in advancing equitable cancer control. While not all G7 Cancer members are policy-setting bodies or hold authority to enact these recommendations, there is broad support for their intent and a shared commitment to working collaboratively with policymakers and governments to progress them.

Organisations represented within G7 Cancer are well placed to lead, catalyse and support these efforts in collaboration with others. By acting in concert at both national and collective levels, G7 Cancer members can help reduce inequities across the cancer continuum and generate transferable models with global relevance.

We recognise that aspects of some recommendations, particularly those targeting country-specific actions, may already be underway. This existing momentum provides a platform for accelerated progress, creating opportunities to scale, harmonise, and exchange learning across G7 Cancer countries and beyond.

4.3.1 Cross-cutting enablers

These recommendations underpin **all actions** and must be embedded **continuously**, rather than following a sequential order:

Enabler 1: *Promote participatory governance through engagement of patients, communities and citizens*

Engaging patients, communities, and citizens in defining and prioritising equity actions ensures policies are relevant, culturally appropriate, and responsive to local needs.

- *Country*: Establish and embed mechanisms for patient, community and citizen input into cancer policy and planning.
- *G7 Cancer:* Share exemplary models of participatory governance and collate best-practice approaches for meaningful engagement.

Enabler 2: *Build and strengthen authorising environments through sustained communication and advocacy*

Clear, evidence-informed messaging fosters support for equity initiatives.

- *Country:* Develop communication strategies and narratives that distinguish equity from equality, framing equity in terms of fairness, efficiency, and societal benefit. Support research, constructive advocacy and implementation projects that test effective ways to positively convey equity to decision-makers and the public.
- *G7 Cancer:* Share tested framing approaches, advocacy resources, and case studies to facilitate cross-country adaptation and learning.

Enabler 3: *Ensure long-term resourcing for sustainable equity initiatives*

Long-term investment beyond political cycles will support structural reforms and sustain equity-focused action.

- *Country:* Where feasible, integrate cancer equity considerations into core health and public service budgetary processes and establish dedicated national funding streams. This includes mechanisms to fund the piloting of new interventions, generate evidence on their value, and support full-scale implementation where effective.
- *G7 Cancer:* Share evidence on the cost-effectiveness of equity-focused interventions and models for financing pilots and scaling proven approaches, supporting countries to make informed investment decisions.

Enabler 4: *Build understanding and evidence on what works to advance cancer equity*

Generating robust evidence is essential to guide policy and practice in reducing cancer inequities.

- *Country:* Fund interdisciplinary research, notably interventional research, embed equity-focused evaluation within programs, and integrate patient and community perspectives to generate robust evidence on the effectiveness, feasibility and equity impact of interventions – including those using digital health, AI, and genomic technologies - across the cancer care continuum.
- *G7 Cancer:* Support cross-country studies, harmonise metrics and methodologies, and disseminate findings through shared platforms and peer-reviewed publications, with

particular attention to emerging technologies and other intervention modalities, including their equity implications.

Enabler 5: Foster multisectoral partnerships to address upstream determinants

Achieving cancer equity requires coordinated action beyond the health system. Collaboration across sectors - such as education, employment, housing, and environment - is critical to addressing the multiple determinants that drive inequitable cancer outcomes.

- *Country:* Establish coordination and collaboration mechanisms across government departments and sectors (e.g., housing, education, environment, tobacco and alcohol control) to align policies and target upstream determinants of health.
- *G7 Cancer:* Support knowledge sharing on transferable partnership models by documenting and disseminating effective approaches to addressing upstream determinants, facilitating cross-country learning.

4.3.2 Phased roadmap

Stage 1: Foundations – Establishing clarity and commitment

Adopt clear and shared definitions of equity

Conceptual clarity is critical for establishing robust equity goals and developing sustainable, measurable actions to advance equity across the cancer control continuum [92].

A shared conceptual foundation – both within countries and across G7 Cancer members - is important for coordinated action, accountability, and comparability. Clear, explicit, and shared definitions align policy, planning, measurement, and reporting, providing a common language for monitoring progress and sharing best practice.

- *Country:* Endorse and operationalise a national definition of cancer equity through formal adoption in NCCPs or equivalent strategies, and disseminate it via policy guidance, reporting frameworks, and monitoring systems to ensure consistent application across the cancer care continuum.
- *G7 Cancer:* Establish shared, context-appropriate definitions of equity and related terms through G7 Cancer Working Group 3 agreements or communiqués. Although collective reporting mechanisms are not yet widely established, these definitions can support alignment across member countries and foster cross-country learning, while allowing local adaptation.

Build a shared framework for cancer equity

A common operational and conceptual foundation is supportive of effective policy implementation. Evidence-informed frameworks ensure policy decisions are grounded in best practice.

- *G7 Cancer:* Consider the *Policy Framework for Equity in Cancer Control* (Table 26) as a practical tool for countries to explore and adapt within their own contexts. Integrate evidence reviews, operational guidance, and practical tools (e.g. checklists, metrics,

policy prompts) to support harmonised action while allowing flexibility for country- and context-specific implementation.

Establish a consensus statement on equity in cancer control

Consensus statements provide authoritative guidance, signal priority, mobilise resources and support aligned, evidence-informed action across diverse stakeholders [93-96] .

- *G7 Cancer:* Develop a consensus statement to define equity, outline key principles, and guide NCCPs. Such a statement would signal commitment, leadership and accountability, while supporting the integration of equity into cancer control policies and practice and enabling coordinated, evidence-informed action across countries. Consider convening a consensus conference to bring together experts, policymakers, and stakeholders to inform the statement and foster shared understanding and commitment.

Stage 2: Integration – Embedding equity into systems

Embed equity explicitly in NCCPs and related strategies

Explicit equity objectives in planning documents ensure commitments translate into measurable action. Equity should be operationalised through specific targets (e.g., stage at diagnosis, treatment timeliness, survivorship outcomes) and systematically monitored across relevant social variables (e.g. age, education, gender, geographic location, income, Indigenous identity, racialised group, sex at birth [97]) to track and reduce disparities over time.

- *Country:* Integrate equity objectives, indicators, and monitoring requirements into NCCPs, with regular reporting and accountability mechanisms. Embed equity criteria into policy and program decisions to ensure resources are directed according to differential needs.
- *G7 Cancer:* Share guidance, templates, and best-practice examples to support the systematic embedding of equity into cancer control policies and programs.

Integrate program logic models and theories of change into equity initiatives

Robust planning frameworks are important for implementing, monitoring, and evaluating equity-focused interventions.

- *Country:* Where appropriate, embed both a program logic model, linking inputs and activities to outcomes, and a theory of change, outlining how activities are expected to achieve long-term impact, into equity-related policies, initiatives, and NCCPs.
- *G7 Cancer:* Provide templates, exemplars, and guidance to support national implementation, enhance comparability, and promote within- and cross-country learning.

Strengthen data infrastructure for equity monitoring and accountability

Robust, harmonised data systems are needed for monitoring cancer inequities and providing the evidence base to inform resource allocation, guide targeted interventions, monitor progress and drive equitable action. Data collection should align with nationally endorsed definitions of cancer

equity, be consistently implemented at the national level, and include a common minimum set of equity-specific indicators to enable cross-country comparisons.

- *Country:* Develop and maintain national cancer datasets that capture equity-relevant variables in line with a shared definition of cancer equity.
- *G7 Cancer:* Establish a shared, equity-specific minimum dataset with harmonised standards, definitions, and indicators to enable cross-country comparison, and monitoring.

Reorient health systems towards prevention and equity

Strengthening primary care, increasing access to general practitioners, reducing access barriers, and expanding community-based prevention and health promotion programmes – especially for priority populations – are vital steps in reducing social inequalities in health.

- *Country and G7 Cancer*: Support and expand access to evidence-based, cost-effective and culturally safe primary care programs and platforms, particularly those targeting priority population groups to increase primary prevention, early detection, cancer screening, and care navigation.

Stage 3: Consolidation – Shared learning and sustained progress

Document and scale effective equity interventions to facilitate adaptation to local contexts

Learning from proven interventions accelerates adoption and improves impact across contexts.

- *Country:* Evaluate and disseminate national equity initiatives; adapt and scale those with demonstrated impact.
- *G7 Cancer:* Document and disseminate case studies and toolkits for sharing and adaptation.

Leverage international collaboration for shared learning and strengthen capacity for evidence-informed policy

Cross-country cooperation facilitates shared learning and accelerates progress.

- *Country:* Contribute data, case studies, and lessons learned to international platforms.
- *G7 Cancer:* Establish shared indicator dashboards, joint workshops, and alignment with WHO and OECD initiatives; capture and share lessons from specific policy measures, interventions and partnerships, highlight successes, and promote strategies that advance cancer equity and foster effective, positive change.

4.4 Limitations of the research

4.4.1 Scope limitations

The following scope-related factors should be considered when interpreting the findings of this study.

- **Absence of a comprehensive literature review:** This study did not include a systematic or comprehensive review of the academic or grey literature. As such, it may not capture the full range of evidence, frameworks, or international policy approaches relevant to cancer equity across G7 Cancer nations.
- **Evaluation of impact:** The study was not designed to assess the impact of NCCPs or cancer and health equity frameworks on cancer outcomes. The analysis focused on the scope, content, and equity-related features of NCCPs, equivalent policy documents, and cancer and health equity frameworks, but does not assess their quality, implementation, or impact. No conclusions can therefore be drawn about causal links between specific policies and population-level cancer outcomes.
- **Primary focus on NCCPs:** This study focused on NCCPs as the primary policy document for each country. While some related policies were included where available, the analysis was not exhaustive. Broader national strategies, sub-national initiatives, or non-governmental programs are not fully represented.
- **Limited coverage of broader determinants:** While cancer-specific policy imperatives were the focus, the analysis did not fully address broader health system factors or determinants of health that significantly influence cancer outcomes and equity.

4.4.2 Methodological and contextual considerations

Variability and cross-sectional nature of data: Differences in the availability, transparency, and detail of policy documents across G7 Cancer countries may have affected the comparability and completeness of the analysis. Additionally, this study provides a cross-sectional snapshot based on documents and perspectives available at the time of data collection and does not reflect temporal changes in policy or implementation.

Language and translation constraints: This report draws exclusively on materials available in English. Two NCCPs (Germany and Japan) were translated from their original languages using AI-based tools without human verification, which may have led to the loss of nuanced or culturally specific meanings. Other relevant documents not available in English may have been excluded from review, potentially limiting the comprehensiveness and contextual depth of the analysis.

Selection bias in interview participants and document sources: The report relied on purposive sampling of nominated participants and publicly available documents. As a result, it may not fully reflect the diversity of stakeholder perspectives - particularly those of marginalised or priority populations. The study did not include direct recruitment of cancer patients or community members, limiting insights into lived experiences of inequity.

Potential reporting bias: Participants may have presented their countries or programs in a more favourable light, either consciously or unconsciously, which could have influenced qualitative findings and interpretations.

Resource and time constraints: The scope of interviews and depth of analysis were constrained by the project's timelines and resources, which limited the breadth of perspectives included from each country.

Generalisability and transferability: While the findings offer policy-relevant insights for G7 Cancer member countries, they may not be fully generalisable to all national contexts. Caution is advised when applying these findings beyond the study setting, as health systems, policy environments, and population needs may vary.

5. Conclusion

The three-phase study demonstrates that G7 Cancer countries share common opportunities and challenges in advancing equity across the cancer continuum. While strategic frameworks and NCCPs establish an important policy foundation, critical gaps remain in the operational definition of equity, its implementation, monitoring, and translation into practice. Without explicit targets and indicators, there is a risk that equity commitments remain rhetorical rather than demonstrably effective. Persistent inequities across populations, social determinants, and access to care highlight the need for co-ordinated, evidence-informed action.

The phased policy recommendations provide a structured roadmap, moving from conceptual clarity (Foundations), through integration into systems and data infrastructure (Integration), to shared learning and sustained progress (Consolidation). By combining national action with collective G7 Cancer collaboration, these recommendations support measurable reductions in cancer inequities, provide transferable models for other countries, and strengthen the evidence base for global equity-focused cancer control.

Contributors

This study was conceptualised by members of the G7 Working Group 3, co-led by Dr Ambreen Sayani and David Meredyth. The study questions were jointly developed by working group members and Prof Adam Elshaug. Thereafter, data collection and analysis were conducted independently by the research team, led by Adam Elshaug and Rebecca Zosel, who also drafted the manuscript with the support of a core writing team, including Ambreen Sayani, Daniel Chaji, Merilyn Penn and David Meredyth. Ambreen Sayani drafted the Introduction, and, together with Daniel Chaji, Merilyn Penn and David Meredyth, contributed as co-authors for study design, interpretation of results, and the editorial process. All authors provided project guidance and oversight, reviewed, and contributed to the content. Members of Working Group 3 approved the final manuscript. The analysis of cancer and health equity frameworks and G7 Cancer National Cancer Control Plans was informed by equity-related questions developed by the International Cancer Control Partnership.

Declaration of interests

This study was commissioned and funded by Cancer Australia on behalf of G7 Cancer Working Group 3. Adam Elshaug has served as an economic and policy Advisor to Cancer Australia since 2014 and is an elected member (Australia) of the Scientific Council of the International Agency for Research on Cancer, WHO. Ambreen Sayani is Health Equity Advisor and Policy Advisor to the Canadian Partnership Against Cancer. All other authors declare no competing interests. This work is academic in nature, and all statements, interpretations, and conclusions reflect the authors' perspectives and should not be interpreted as representing the views of any government of the G7 Cancer member countries, nor as endorsing any particular policy position. Where authors are identified as personnel of the International Agency for Research on Cancer or WHO, the authors alone are responsible for the views expressed in this Policy Review and they do not necessarily represent the decisions, policy, or views of the International Agency for Research on Cancer or WHO.

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Acronyms

AI	Artificial Intelligence
CALD	Culturally and linguistically diverse
COREQ	Consolidated Criteria for Reporting Qualitative Research
DKFZ	Deutsches Krebsforschungszentrum (German Cancer Research Center)
ECIR	European Cancer Inequalities Registry
IARC	International Agency for Research on Cancer
ICRP	International Cancer Research Partnership
INCa	Institut National du Cancer (French National Cancer Institute)
LGBTIQA+	Lesbian, gay, bisexual, trans and gender diverse, intersex, queer, questioning, and asexual
M&E	Monitoring and Evaluation
NCCP	National Cancer Control Plan
NCD	Noncommunicable Disease
NGO	Non-Governmental Organisation
NHS	National Health Service
OCAP®	Ownership, Control, Access, and Possession
OECD	Organisation for Economic Co-operation and Development
SDG	Sustainable Development Goal
SRQR	Standards for Reporting Qualitative Research
UICC	Union for International Cancer Control
UK	United Kingdom
UN	United Nations
USA	United States of America
WCRF	World Cancer Research Fund
WG3	(G7 Cancer) Working Group 3
WHO	World Health Organization

Appendices

Appendix 1a: Phase 1 Cancer and Health Equity Frameworks Full Dataset (Excel)

Appendix 1b: Phase 1 Cancer and Health Equity Frameworks Supplementary Results

Appendix 2: Phase 2 Documentary analysis key variables

Appendix 3: Phase 2 Equity Dimensions

Appendix 4. Phase 2 Equity-related commitments in G7 Cancer NCCPs

All appendices are available on the Working Group 3 page of the G7 Cancer website at the following address: https://g7cancer-events.com/

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G7 Cancer is an international cooperation mechanism that brings together the most advanced countries in the fight against cancer. It provides a unique forum for participating organizations to share expertise, improve knowledge of cancer mechanisms, accelerate the transfer of scientific discoveries and their clinical application, and stimulate innovation on an international scale.

At the initiative of the French National Cancer Institute (INCa), G7 Cancer officially launched on May 9, 2023, bringing together these organizations:

International Agency for Research on Cancer