

MACMILLAN CANCER SUPPORT

# Compounded:

## Living with cancer and other long-term conditions

November 2026

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# Foreword



Anna, 42, diagnosed with breast cancer in 2018

At 33, with a two-year-old son by my side, I was diagnosed with stage 3, grade 3 breast cancer. Chemotherapy, surgery, radiotherapy and hormone therapy saved my life, but left their mark: immunosuppression, arthritis, fatigue, permanent neuropathy and disability, alongside early menopause, infertility, mental health challenges, financial hardship, family heartbreak and grief for the future – and the parenting – I had imagined.

My life has changed but has also been saved and supported by the NHS and Macmillan Cancer Support more than once; I remain profoundly grateful, while concerned by the pressure and fragmentation facing patients, carers and professionals.

I survived. But survival tells us that someone is alive; it tells us extraordinarily little about how well they are living.

So, the path I walk is not one I would ask you to join me on. But I will ask you to bear witness and walk beside me, and the cancer community.

Not to experience the cancer, disability, fear, or exhaustion, but to see the path more clearly. To notice where it becomes unnecessarily steep, where it fragments, and where, together, we might make the journey easier for those already walking it and those who will follow.

Cancer does not happen in isolation. It enters a life already being lived. Treatment may end, but appointments continue, new conditions emerge and disability changes what is possible. Meanwhile, work, parenting, relationships and finances continue. Different specialists hold different pieces of the picture, while the person at the centre is often left trying to connect them.

This is how things become compounded.

I understood this through my own body and life. Then cancer entered my family again.

Having come so close to losing my own life, it is difficult to describe watching someone you love to face that same uncertainty. My mum was diagnosed with

stage 3 breast cancer, underwent a double mastectomy and is now living with stage 4 disease alongside fibromyalgia, chronic migraine and arthritis. I now walk beside her while experiencing my own complex care as a patient, daughter and carer.

And yet, through all of this, I have found a possible place – in my mind, my life and my work – where I continue to believe deeply in what we can create together.

For me, that is the potential of this report, *Compounded*: bringing evidence and analysis together with conversation, policy and lived experience to drive change from the heart of experience.

I write this for the millions quietly carrying the daily weight of illness and disability, including my mum, and for everyone walking beside them.

Our challenges may be compounded. But so too can our knowledge, compassion and collective power to create change.

# Introduction

Macmillan Cancer Support was established over 100 years ago and has been a long-standing champion for holistic, person-centred care and support that focuses on the whole person. We know that living with cancer isn't a single, linear event – it is often one part of a much bigger health story.

For many individuals, cancer is an added layer of complexity on top of ongoing physical, mental, and practical challenges. Living with cancer and one or more other long-term conditions has an impact on people's cancer diagnosis, treatment options, experiences of care, and on their outcomes, and it makes coordination, daily life and emotional wellbeing that much harder to manage.

This report provides a breakdown of the data on prevalence of cancer and other long-term conditions, summarises a Macmillan-commissioned review of the literature and other evidence on cancer and other-long-term conditions, and draws on lived experience insight to shed light on the challenges, complexity and day-to-day load that arise for people navigating complex health journeys. We're particularly grateful to Andy, Anna, Lee, Lynda, Mohammad and Pamela for agreeing to share their stories for this report, and to Anna for also reviewing a draft version and helping us make the content as good as it could be.

At Macmillan, we hope this data, evidence and insight helps intensify efforts by health and care professionals and decision-makers to ensure people living with cancer have their cancer and other conditions managed well. Our vision is a future where people with cancer and other long-term conditions feel supported, healthcare professionals have the skills and the confidence to support people living with cancer and other conditions, and where health and care systems work in sync to treat the whole person, not just their parts.

We know this will be an ambitious endeavour and we cannot go it alone. This is why we invite others to join us in our mission to spark a revolution in cancer care. Together, we can transform cancer care – for those with other long-term conditions, and for everyone.



Heather McLean
Director – Communities and System Partnerships
Macmillan Cancer Support

# Executive summary

Living with cancer alongside one or more long-term conditions (LTCs) is the norm for people with cancer, rather than the exception. This report shows that the majority of people with cancer have at least one additional long-term condition, with many experiencing multiple conditions over time. These individuals often face greater clinical complexity, poorer outcomes, and reduced quality of life, yet health and care systems, including many cancer services, remain predominantly designed to treat single diseases in isolation.

## Scale and nature of the challenge

Four in five people living with cancer in the UK (80%) have one or more other long-term conditions, such as hypertension, osteoarthritis or diabetes. The risk of having cancer and another long-term condition increases with age, with 93% of people aged 75+ with cancer living with another condition. However, significant inequities persist – among those of a similar age, the prevalence of long-term conditions among people living with cancer is higher among people living in the most deprived areas of the country and is higher among some ethnically diverse groups.

## Impact on diagnosis and outcomes

People with cancer and other long-term conditions often experience delays in diagnosis, which is driven by a variety of factors, including symptom misattribution ("diagnostic overshadowing"), communication barriers, and pressures on clinicians and the health system. In some cases, however, cancer is potentially identified earlier than it would have been otherwise because of the care and monitoring in place for other conditions. People with cancer and other long-term conditions are more likely to be diagnosed through emergency routes, which is associated with poorer outcomes, and are also less likely to have complete staging information for their cancer, which makes it harder for healthcare professionals to advise on the right treatment. There is also evidence to suggest that co-existing conditions such as cardiovascular disease or diabetes is associated with a significantly higher mortality risk compared to having cancer alone.

## Impact on treatment and care

People with cancer and one or more other long-term conditions are less likely to receive guideline-recommended cancer treatment and more likely to experience delays or be offered less-intensive options compared to those who don't have another long-term condition. At the same time, care remains fragmented across specialties, with poor coordination between cancer services, primary care, and other health and care services.

## Experience and quality of life

Living with cancer and other long-term conditions has a compounding effect on wellbeing. People often report greater pain, fatigue, emotional distress, alongside the burden of managing multiple appointments, medications and systems. Many feel no single professional is responsible for their overall care, leaving them to act as their own care coordinators. Experiences are particularly poor for those with mental health conditions, learning disabilities, autism, and neurological conditions.

## Conclusion

Living with one or more long-term conditions in addition to cancer is the norm. Without systemic change, people living with cancer and other long-term conditions will continue to experience poorer outcomes and fragmented care. A coordinated, person-centred approach – spanning policy, practice, and research – is essential to deliver care that treats the whole person, not just cancer.

# Cancer and other long-term conditions

## Four in five

people living with cancer (80%) have one or more other long-term conditions.

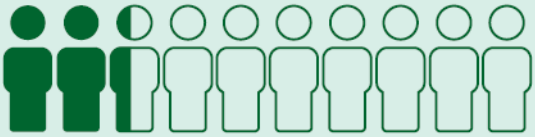


The three most common other conditions for people with cancer are:

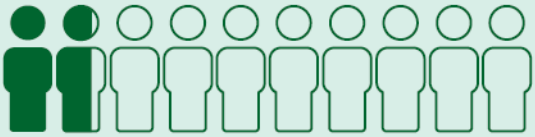
**1. High blood pressure: 50%**



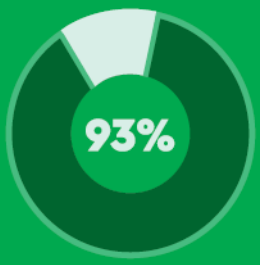
**2. Osteoarthritis: 23%**



**3. Diabetes: 18%**



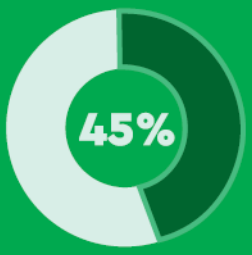
**Older people with cancer have the highest rates of other long-term conditions**



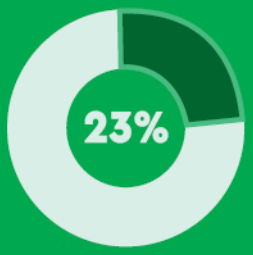

Among over-75s

However

**Younger people with cancer show the biggest difference compared with their wider age group**




Among those aged 25–34 with cancer




Among those aged 25–34 overall

**Diabetes is substantially more common among Asian and Black people with cancer** and the gap generally increases with age and deprivation.




**60%** of Asian people with cancer aged **65–74** in the most deprived areas have **diabetes**

Compared to




**15%** of White people aged **65–74** in the least deprived areas.

**Having another long-term condition as well as cancer can lead to:**

- ✖ Delays to cancer diagnosis (but sometimes quicker diagnosis)
- ✖ Being less likely to receive certain types of cancer treatment
- ✖ Less involvement in decisions about cancer care
- ✖ Higher risk of death from cancer

**People with cancer and other long-term conditions need:**

- ✔ Shared decision-making
- ✔ Support to self-manage their cancer and other conditions
- ✔ Personalised care and treatment

# 1: Prevalence of long-term conditions among people living with cancer

## How are we defining long-term conditions?

Living with multiple long-term conditions is often referred to as 'multi-morbidity', which England's National Institute for Health and Care Excellence (NICE) defines as 'the presence of two or more long-term health conditions'[1]. This includes:

- Defined physical or mental health conditions of long duration, such as cancer, diabetes, schizophrenia, or an infectious disease
- Ongoing conditions, such as learning disability
- Symptom complexes, such as frailty or chronic pain
- Sensory impairment, such as sight or hearing loss
- Alcohol or substance misuse

Our definition of long-term conditions includes people with cancer who had pre-existing long-term conditions before their cancer diagnosis, as well as people who have conditions that developed after their cancer, either as a consequence of their cancer or its treatment or because of other factors.

## How many people are living with cancer and other long-term conditions?

It is challenging to produce a definitive number for how many people are living with cancer and other long-term conditions because of variation in the definitions and the datasets used in research.

To produce the estimates in this report, we have used hospital data for patients in England compiled by Outcomes Based Healthcare in the National Bridges to Health Segmentation dataset[2]. Because these data are based on patients in England, we applied the resulting rates to the age structure of the cancer population in each UK nation to produce a UK figure[3]. As we are relying primarily on hospital data, our figures represent a conservative estimate. More detail on the dataset selection, our methodology, and its limitations can be found in the appendices.

We estimate that approximately four in five people living with cancer (80%) are also living with one or more other long-term conditions. This is equivalent to around 2.8 million people in the UK[4], and estimated to rise to 4 million people by 2040[5]. Over half (59%) of those living

with cancer currently have two or more long-term conditions.

Across every age group, people living with cancer have higher rates of long-term conditions than the general population. This is largely because cancer shares the same risk factors with many other long-term conditions, such as smoking and obesity, and because cancer and its treatment can increase the risk of developing additional long-term conditions.

## What are the most common other conditions that people with cancer are living with?

The most common other long-term conditions recorded in the hospital records of people with cancer in England are high blood pressure (hypertension), osteoarthritis and diabetes (figure 1).

These conditions are common among people with cancer because they:

- are also common conditions in the general population
- have shared risk factors with cancer, including increasing age[6]
- can be caused by cancer treatment

For example, some chemotherapy and immunotherapy treatments can damage blood vessels or affect kidney function, leading to hypertension. One common type of drug used to treat some types of breast cancer (aromatase inhibitors) can lower oestrogen levels, potentially causing onset of osteoarthritis, while immunotherapy and steroid treatment can spike blood sugar levels and lead to immunotherapy-induced[7] and steroid-induced[8] diabetes.

It should be noted that there are other common long-term conditions, which

**"I had chemotherapy first, and I dealt with that not too badly, although I am a type two diabetic, and it knocked my blood sugars like crazy. I had to go back to the hospital one night for them to sort that out and change my treatment. Then I started the radiotherapy, and it was really quite severe.**

**"I've been left with serious bowel issues and nerve damage in my legs. My life has completely changed as a result of my cancer treatment, and I am now classed as disabled because I am dealing with so many issues. I have always been able to advocate for myself and I will fight till I get what I need, but I shouldn't have to do that."**



Lynda, 63, from County Armagh in Northern Ireland, diagnosed with vulval cancer in 2021

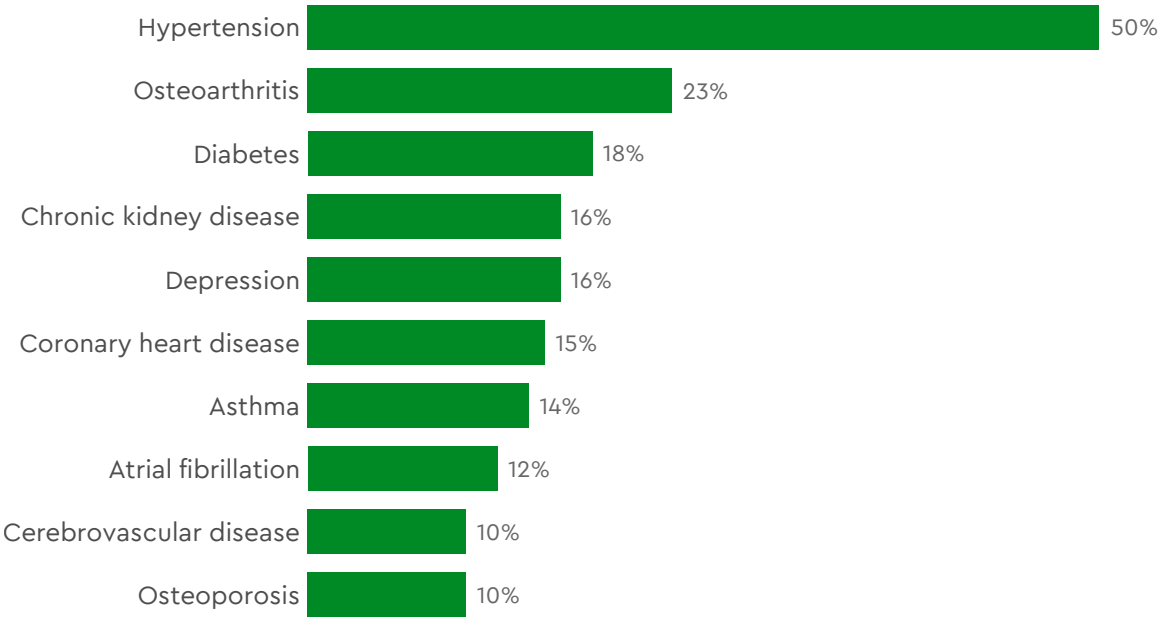
have a significant impact on people with cancer, which aren't routinely captured in hospital records, such as frailty[9]. Frailty is a condition where people lose their in-built reserves and become increasingly susceptible to illness.

The size of the cancer population living with frailty is difficult to measure for a number of reasons. It is not routinely and consistently measured in routine healthcare datasets or research. It is also a multidimensional condition, in which physical elements, socioeconomic circumstances, and psychological factors all contribute to its development. Frailty also exists along a continuum ranging from mild to severe frailty[10].

A Macmillan/YouGov online survey of over 2,100 people living with cancer in the UK estimated that more than one in four (27%) respondents over the age of 65 had risk factors that could indicate suspected frailty[11], although this is likely to be an underestimate as people with the highest levels of frailty may be less likely to participate in online research. Another UK study found that 56% of women over 70 with breast cancer were at risk of frailty[12].

Prevalence of most common hospital-recorded long-term conditions among people living with cancer, England, 2024

Top 10 conditions by prevalence




Produced by Macmillan from the Population and Person Insight (PaPI) Dashboard (NHS England); National Bridges to Health Segmentation Dataset v5.0 (Outcomes Based Healthcare) (2024).

Figure 1: Prevalence of the 10 most common other long-term conditions in the England cancer population. This graph shows that high blood pressure (hypertension) is the most common other condition for people with cancer in England, affecting 50% of people, followed by osteoarthritis (23%) and diabetes (18%)

Living with frailty often results in more complex cancer care. Someone living with frailty may be less likely to tolerate cancer treatment and at higher risk of treatment complications[13]. Living with frailty also means cancer care needs to be carefully balanced against a patient's overall function, quality of life and personal preferences. However, assessment of frailty can be subjective and is often not carried out consistently, especially for care home residents, potentially leading to inappropriate under-treatment[14,15]. People living with frailty are also less likely to be included in clinical trials, meaning there is less evidence to guide treatment decisions[16].

## How does the prevalence of cancer and other long-term conditions vary between different population groups?

### Intersectionality in cancer and other long-term conditions

In this section, we explore how the prevalence of living with cancer and other long-term conditions varies between people from different population groups. The likelihood of an individual with cancer having one or more other long-term conditions varies substantially depending on their age, other personal characteristics, and where they live. This variation becomes even more pronounced when examining specific long-term conditions.

However, when looking at differences between different population groups, it is important to note that people's experiences of cancer and other long-term conditions are shaped by more than one aspect of their identity or circumstances. Factors such as age, race and ethnicity, sex and gender, disability, and socioeconomic deprivation, do not act independently. They can overlap and combine in ways that impact someone's likelihood of living with multiple health conditions and how these long-term conditions affect their experiences and outcomes. This is often referred to as intersectionality.

For example, our analysis shows that people from some ethnic groups are more likely to be living with certain long-term conditions, but these differences can become larger or smaller depending on a person's age and the level of deprivation in the area where they live. While these data breakdowns provide a useful starting point to understand differences between different sub-groups, many of these factors need to be considered together to gain a fuller picture of which groups of people are more like to be at risk of experiencing inequities and where support, services and interventions may need to be tailored to meet the needs of different communities.

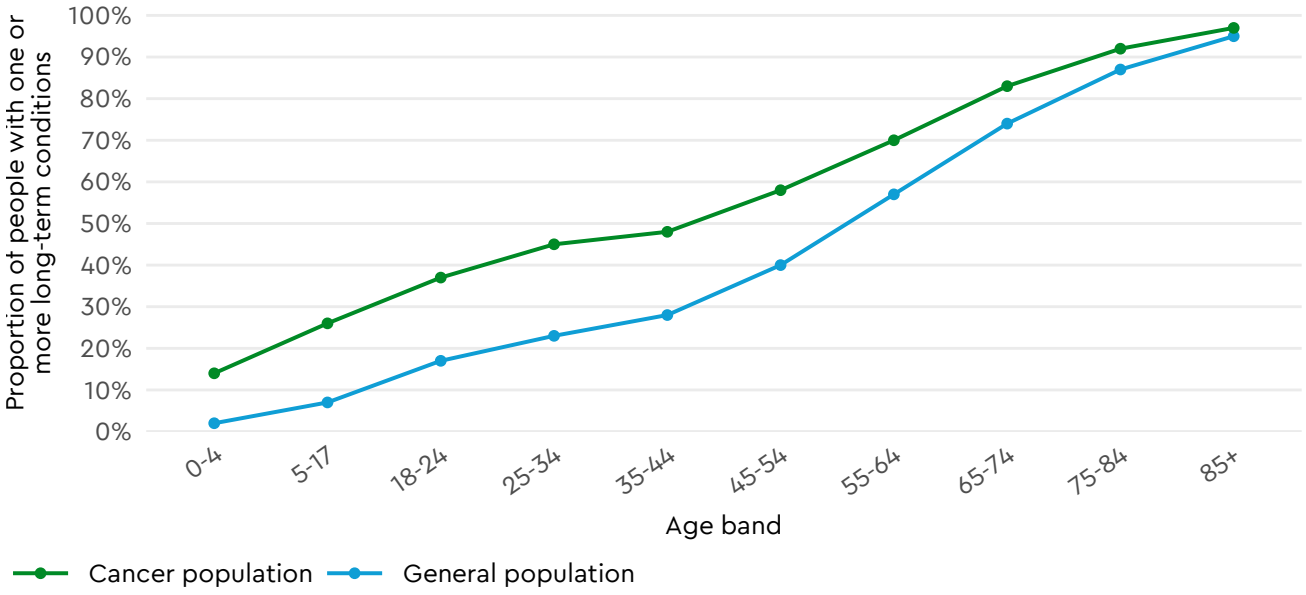
### Differences by age, sex/gender, deprivation and ethnicity

Similar to the general population, age is the strongest determinant of whether someone with cancer has another long-term condition. Our estimates show that 9 in 10 people (93%) with cancer in England over the age of 75 have one or more other long-term conditions.

However, when comparing people with cancer to the general population by age group, the biggest differential between the two populations is seen in younger age groups (see figure 2). According to our analysis, among those aged 25-34, almost one in two people (45%) living with cancer have one or more other long-term conditions compared with almost one in four people (23%) in the same age group in the general population. Some of this difference will be related to their cancer diagnosis, while some may be due to 'surveillance bias'. This is where the regular monitoring and follow-up that is part of someone's routine cancer care can provide more opportunities for other conditions to be diagnosed and for that diagnosis to be recorded in hospital records. Surveillance bias is particularly present in the younger population, who have fewer interactions with the healthcare system, and particularly secondary care. This means younger people without cancer are likely to have fewer interactions with the healthcare system than those with cancer, so may have reduced opportunity for an existing long-term condition to be detected and recorded.

Different demographic groups also have different age profiles. To account for differences in population age structure,

Long-term condition prevalence among people living with cancer compared to the general population, by age, England, 2024




Produced by Macmillan from the Population and Person Insight (PaPI) Dashboard (NHS England); National Bridges to Health Segmentation Dataset v5.0 (Outcomes Based Healthcare) (2024).

Figure 2: Long-term condition prevalence in the England cancer population by age, compared with the general population. This graph shows that the prevalence of other long-term conditions in both people with cancer and the general population increases with age. It also shows that while people with cancer are more likely to have other long-term conditions in every age group, this difference is more pronounced in those below the age of 45

and to ensure we are comparing like with like, we explored how prevalence of long-term conditions in the cancer population varies between different demographic groups, split by age band. The analysis is based on the health records of all people registered with a GP in England rather than a sample, so differences between groups are not subject to sampling error and reflect real differences in the recorded health for this population.

When comparing people of a similar age, the data suggests that people with cancer living in the 20% most deprived areas of England are more likely to be living another long-term condition compared to those living in the 20% least deprived areas (figure 3). This is true for both men and people assigned male at birth, and women and people assigned female at birth.

When comparing people of a similar age, the data also suggests that people with cancer from Black and Asian backgrounds are generally more likely to have one or more other long-term health conditions than White people (figure 4). For example, among those aged 55-64, 79% of Black people with cancer and 79% of Asian people with cancer have one or more other long-term conditions, compared with 70% of White people with cancer in this age group. Other research has shown a similar pattern for Asian people with cancer in particular. For example, a recent analysis of GP records in England showed Asian people with cancer had the highest overall prevalence of comorbidity compared to people from all other broad ethnic groups based on comparisons with the White population after controlling for age, sex, body mass index (BMI), and smoking status[17].

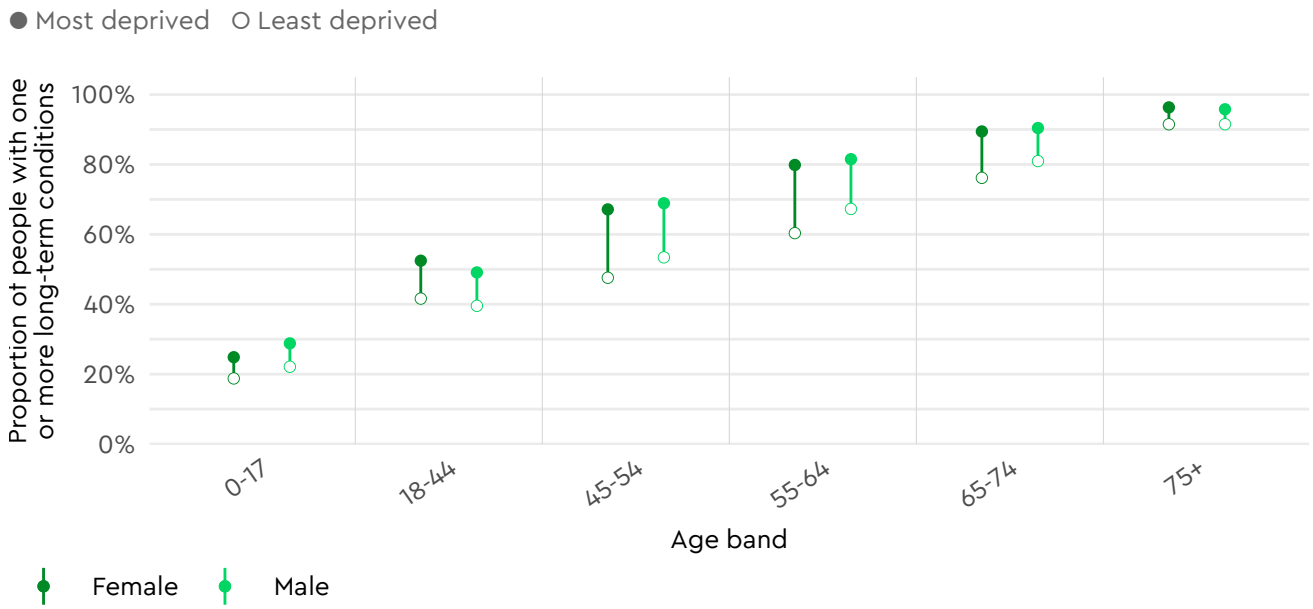
As previously seen, high deprivation is strongly associated with having one or more long-term conditions. By stratifying further by deprivation quintile, the

**"As a result of the cancer, the operation, and the treatment itself, I now have numbness in both of my feet and chronic and severe nerve damage down my right leg. I have to be very careful not to overexert myself. The pain is constantly there. I wear a leg brace wherever I go, and I have a mobility scooter to help me when out and about. I also have a stoma that kind of has a life of its own. That was difficult to come to terms with, but I'm more comfortable with it now. It's all been quite an ordeal for me and my family and a huge learning curve. I just keep trying to find a new normal. By being open and honest, it will hopefully encourage people to get tested and find the support they need."**



Mohammad, 42, from Hertfordshire, England, diagnosed with bowel cancer in 2021

Long-term condition prevalence among people living with cancer, by age, gender, and deprivation, England, 2024




Produced by Macmillan from the Population and Person Insight (PaPI) Dashboard (NHS England); National Bridges to Health Segmentation Dataset v5.0 (Outcomes Based Healthcare) (2024).

Figure 3: Long-term condition prevalence in the England cancer population by age, gender, and deprivation. This graph shows that in each age group, people who live in the 20% most deprived areas are more likely to have other long-term conditions than in the 20% least deprived areas, with the gap largest between the ages of 45-64

differences between people from different ethnic backgrounds narrow and become more varied, particularly among younger adults living in the most deprived areas (figure 4).

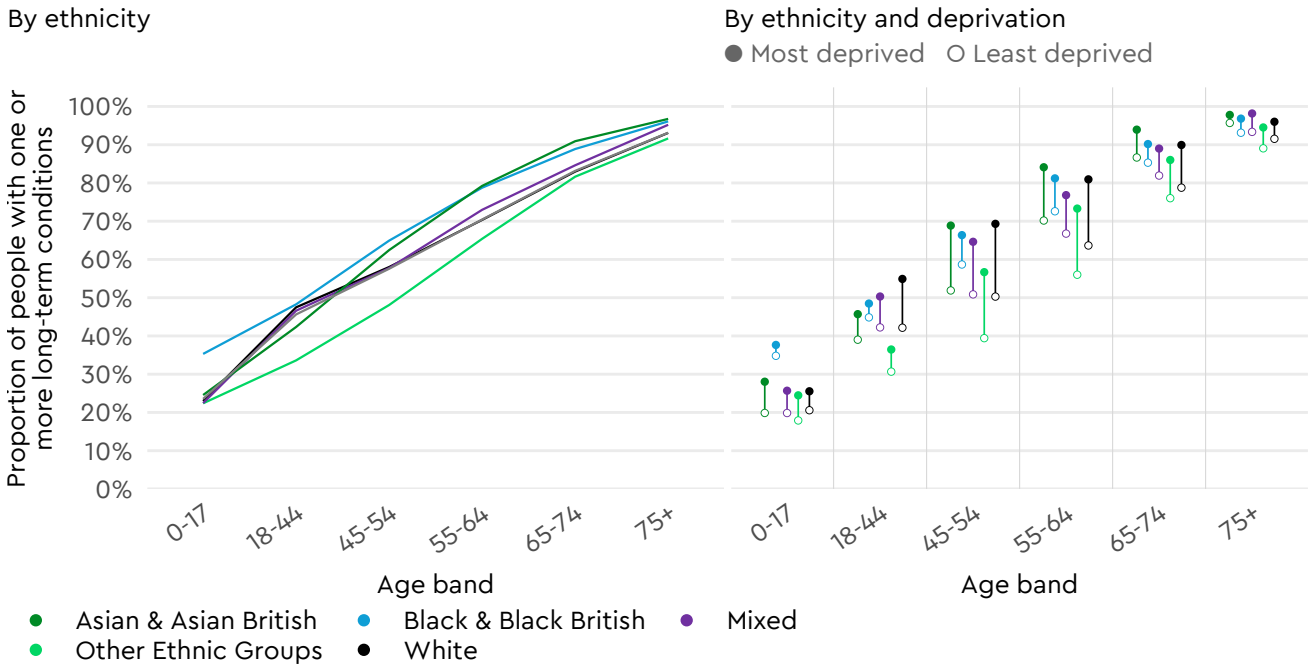
There are also differences by population demographics when looking at the prevalence of specific conditions in the cancer population. Figures 5 and 6 demonstrate the stark difference in prevalence for both hospital-recorded clinical depression[18] and diabetes[19] across demographics, by age, ethnicity, and among the most and least deprived areas.

Depression is the fifth most common additional condition recorded in the hospital records of those living with cancer and the most common additional condition among those living with cancer under 55. Alongside asthma, it is one of two conditions to have a higher prevalence recorded in hospital records in younger age groups than older. Among people of a similar age and level of deprivation, depression is more prevalent among women and people assigned female at birth than men and people assigned male at birth, in the cancer population.

There are stark differences in the prevalence of depression in the cancer population between people from different ethnic groups, when comparing similar age and deprivation. Among

Long-term condition prevalence among people living with cancer, by age, ethnicity, and deprivation, England, 2024

Shared y-axis




Produced by Macmillan from the Population and Person Insight (PaPI) Dashboard (NHS England); National Bridges to Health Segmentation Dataset v5.0 (Outcomes Based Healthcare) (2024).

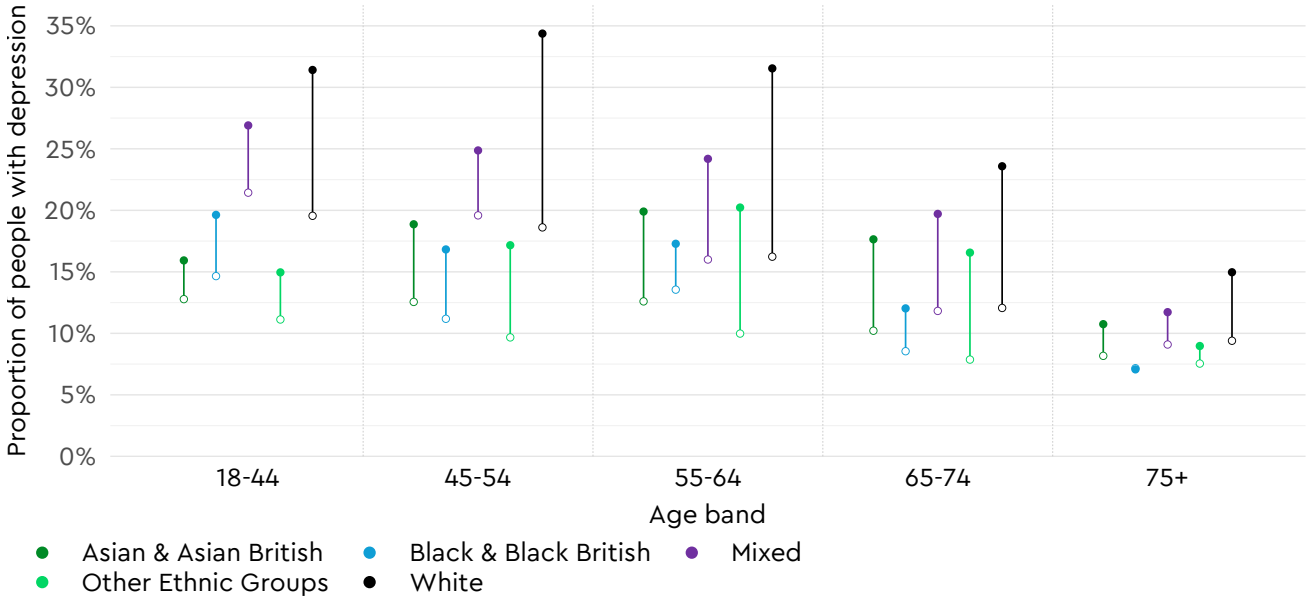
Figure 4: Long-term condition prevalence in the England cancer population by age, ethnicity, and deprivation. This graph shows that over the age of 45, people with cancer who are Asian/Asian British or Black/Black British are more likely to have other long-term conditions than people who are White, with the differences becoming more nuanced when deprivation is taken into account

people of a similar age, depression is considerably more prevalent in the most deprived areas than in the least deprived.

Data in figure 6 show that within the cancer population, diabetes disproportionately affects people from Asian and Black ethnic groups compared to those from all other broad ethnic backgrounds. Research suggests this is true for both the general and cancer populations. The reasons for this are multifaceted and not entirely understood; but include genetic and epigenetic factors such as increased insulin resistance in South Asian adults[20], as well as socioeconomic and structural factors. The data in figure 6 highlight that high deprivation is linked with a disproportionate increase in prevalence of diabetes in those living with cancer from Asian ethnic backgrounds. Three in five (60%) Asian people with cancer aged 65-74 from the 20% most deprived areas have diabetes, compared to just 15% of White people with cancer aged 65-74 from the 20% least deprived areas.

Depression prevalence among people living with cancer, by age, ethnicity and deprivation, England, 2024

● Most deprived ○ Least deprived




Produced by Macmillan from the Population and Person Insight (PaPI) Dashboard (NHS England); National Bridges to Health Segmentation Dataset v5.0 (Outcomes Based Healthcare) (2024).

Figure 5: Variation in prevalence of depression in the England cancer population by patient characteristics. This graph shows that there is considerable variation in the prevalence of depression between people from broad ethnic groups, depending on age and deprivation. For example, in the 20% most deprived areas, depression is more common among White people with cancer in each age group; in the least deprived areas, it is most common among people with cancer of Mixed/Multiple ethnicities in the under-55 age groups.

## How does the prevalence of conditions diagnosed before cancer compare to those diagnosed after?

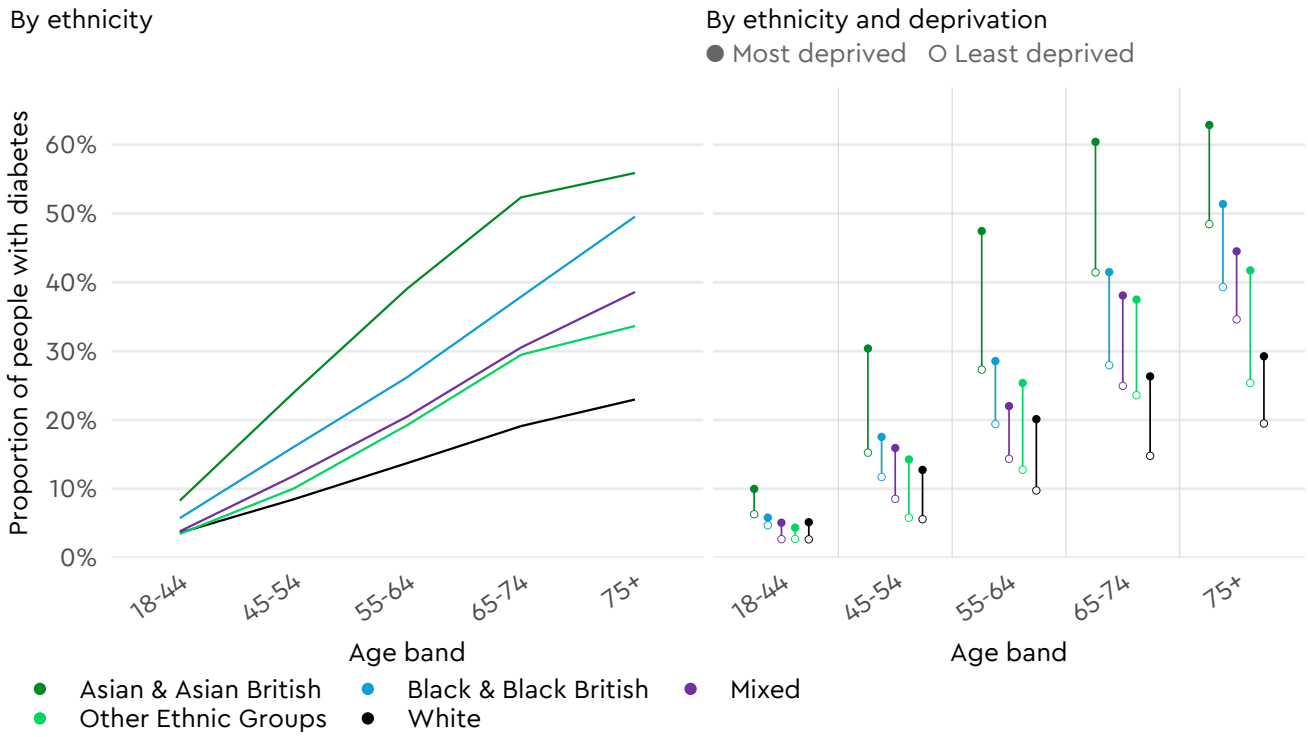
Macmillan's survey data shows that for those living with cancer and one or more other long-term conditions, 58% of additional long-term conditions were diagnosed prior to the individual's cancer diagnosis[21]. For conditions diagnosed post-cancer diagnosis, almost a quarter were reported by the person living with cancer to be caused by their cancer treatment[22]. Among the most prevalent other conditions, those most commonly reported to be as a result of cancer treatment include depression, anxiety and restricted mobility (figure 7).

One study which examined the hospital recorded prevalence of multi-morbidity in those who had received their cancer diagnosis two or more years previously in England found that constipation, anaemia and pain-related conditions saw the greatest increases following cancer diagnosis compared to before

diagnosis[23]. Notably, these conditions fall outside the scope of standard ways of measuring the existence of multiple conditions, meaning their prevalence is frequently undetected and underreported in the wider research literature. Taken together, survey and study results demonstrate that while most people living with cancer and other long-term conditions developed their conditions prior to their cancer diagnosis, there is a significant increase in long-term condition prevalence following diagnosis, driven both by treatment-related effects and other factors associated with living with cancer. Because many of the conditions that develop post-treatment are unlikely to be captured by conventional multi-morbidity measurement tools, the health burden of these conditions is likely being systematically underestimated.

Diabetes prevalence among people living with cancer, by age, ethnicity, and deprivation, England, 2024

Shared y-axis

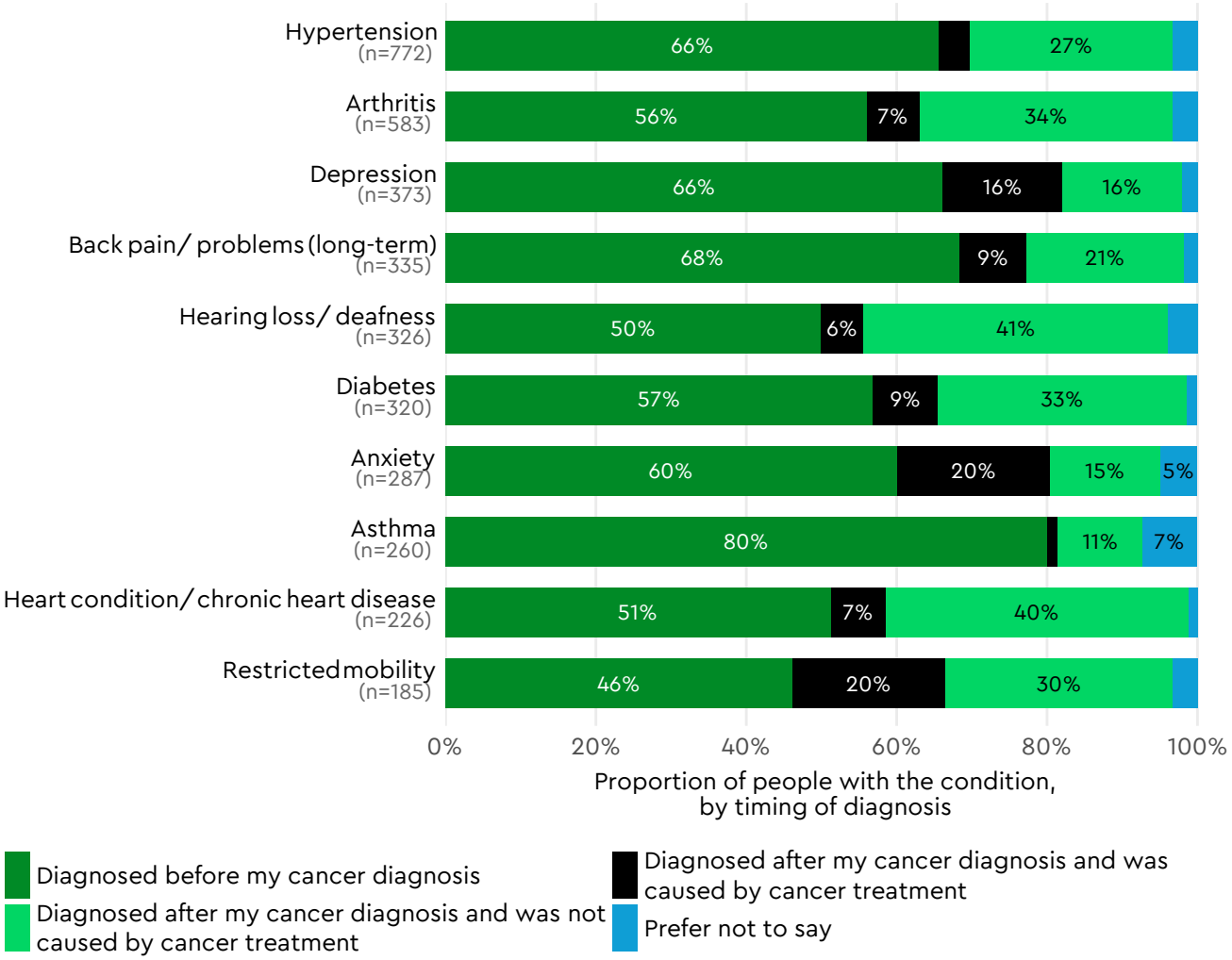



Produced by Macmillan from the Population and Person Insight (PaPI) Dashboard (NHS England); National Bridges to Health Segmentation Dataset v5.0 (Outcomes Based Healthcare) (2024).

Figure 6: Variation in prevalence of diabetes in the England cancer population by patient characteristics. This graph shows that diabetes is substantially more common among Asian/Asian British and Black/Black British people with cancer and the gap generally increases with age and deprivation.

Self-reported point at which long-term conditions were diagnosed, relative to cancer diagnosis, UK-wide survey, 2026

n = number of people reporting each condition




Macmillan Cancer Support/YouGov – The lived experiences of people with cancer (2026). The figures have been weighted and are representative of people living with cancer in the UK (aged 18+).

Figure 7: Results from a 2026 Macmillan Cancer Support/ YouGov survey. This graph shows 10 of the most common other long-term conditions and when these conditions were reported to be diagnosed in relation to cancer diagnosis and treatment. Survey question: "You said that you have cancer and other long-term conditions: Was this other health condition(s):" [options shown in graph]. Base: All people living with cancer: Jan 26 (2,107) (bases vary by group; minimum = 185).

# 2: Impact on people's experiences, wellbeing and outcomes

The 2025 England Cancer Patient Experience Survey (CPES) reports 21% of respondents with a minimum of one long-term condition in addition to their cancer experience "a lot" of impact on their day-to-day activities from their long-term condition(s)[24]. Having multiple long-term conditions can also have a considerable impact on people's experience of care.

A study carried out by the Richmond Group's Taskforce on Multiple Conditions highlighted several strong, cross-cutting themes[25], including:

- **Fragmented, condition-focused healthcare**: People described a system organised around single diseases, with poor coordination between healthcare professionals and having to repeat information multiple times.
- **Burden of self-management and system navigation**: People repeatedly reported the cumulative overwhelm and exhaustion of having to manage multiple appointments, complex medication regimes, and interacting treatments and side effects, where people don't always know who to ask for help or understand what support is available.
- **Lack of personalised or holistic support**: People often reported care that didn't take into account the realities of their lives, such as living in poverty, unsuitable housing and insecure or low-paid work.
- **Cumulative 'losses across life':** People described experiencing a compounding impact of losses over time, such loss of mobility, independence, work and identity, relationships and social life and their previous 'healthy self'. This progression of losses affects overall quality of life more than any single diagnosis.

Participants in the study from the Taskforce on Multiple Conditions also described having to make difficult

> **"And now I have to explain my whole medical history to every new doctor or nurse. You see, it's really exhausting, repeating myself, and sometimes I worry that they won't see the whole picture. Diabetes doesn't just stop because you have cancer."**
>
> Participant in Macmillan-commissioned research project

decisions, such as needing to prioritise which symptoms to address and which would have to go without treatment or support. For example, one study participant with HIV, diabetes, a heart condition and stage 4 prostate cancer explained that diabetes was the least significant of his conditions and that he rarely attends his diabetes check-ups and reviews. He reported that it would be too difficult, practically, financially but also emotionally, to attend them all. Similar coping strategies have been documented in other studies[26].

These experiences largely resonated with research commissioned by Macmillan that included workshops and in-depth interviews with people with lived experience. This research, carried out by research agency Soda in partnership with grassroots charity Cysters, used justice and accessibility principles and a culturally competent approach to focus on seldom-heard voices through community centred-recruitment. It aimed to understand their experience of managing cancer and other long-term conditions and the impact on daily life[27].

Experiences across population groups were resoundingly similar, with people with lived experience reporting:

- **No one taking responsibility for the "whole person":** People with cancer and other long-term conditions often felt their conditions were treated separately and not considered holistically. This included a lack of understanding of how cancer treatment may interact with medication for other long-term conditions. People felt there was little coordination between cancer specialists and GPs, pharmacists, nurses, and community teams, which meant that no one holds the full picture.
- **Individuals becoming their own default 'care coordinators':** As a result of fragmented and siloed care, many reported the mental exhaustion of managing multiple appointments, medications and competing medical advice across specialities, and needing to

**"I've gone from being fit and healthy to a blood cancer diagnosis, then clots and other blood disorders, followed by an asthma diagnosis and damaged lungs. It's been a wild ride to now. I used to do 300-mile cycle rides for charity, but now I've had to sell my bikes. On some days, I can walk a mile or two, other days I'll walk over the road or round the corner and I'm out of breath! The physical, mental and financial support I've had from Macmillan has been a huge help, and the volunteering I now do gives me a real boost."**



Lee, 52, from Yorkshire in England, diagnosed with blood cancer in 2020

**"[A question] I get asked a lot, is the pain scale, and I have to say, I don't know. And you get treated like that means you are stupid. But the pain scale is – sorry, I was gonna swear – it's rubbish. I hurt all the time. I cannot tell you if it's a seven or a one, like it doesn't mean anything to me. I just hurt."**

Participant in Macmillan-commissioned research project

constantly re-explain histories and justify symptoms. People with cancer and other conditions said they themselves became the default care coordinators, without being fully trusted or believed.

- **Compounded burden on daily life:** Living with cancer and another long-term condition was described as overwhelming, exhausting and often isolating. Cancer and its treatment often amplifies existing symptoms, adds new ones and pushes people beyond coping thresholds.
- **Cancer treatment prioritised over other conditions:** Individuals reported that their cancer treatment was frequently considered the dominant priority – often sidelining care for any other existing long-term condition or disabilities.
- **Not enough support for secondary symptoms or conditions developed as a result of cancer treatment:** Cancer and its treatment can create new long-term conditions or disabilities, yet after cancer treatment completion, people often felt pushed out of the

**"I'm very grateful that my cancer has gone and I'm still here, but the tricky bit is dealing with all the side effects. I had 12 rounds of chemotherapy and 21 sessions of radiotherapy. That was tough. The dosage was really strong. The skin on my hands was peeling and my nails were badly damaged. Then there was neuropathy, which I still have today. I have no sensation at the tips of my fingers and toes. It's a great party trick, but I still can't open any tins. I also had immunotherapy, which gave me heart failure. So I had to deal with medication for heart failure and I have thyroid issues too. It's a lot, and all while being a parent to two very active boys!"**



Pamela, 43, from Surrey in England, diagnosed with an aggressive form of breast cancer in 2021

system with no route back in to address secondary conditions.

- **Quality of life plays a more central role:** For people living with existing long-term conditions, cancer adds to an already complex and reduced baseline of quality of life. Many felt that decisions about their cancer care and treatment did not focus enough on quality of life, with cancer treatment decisions framed primarily around clinical outcomes rather than how treatments might affect daily living or impact on their other conditions.

Macmillan's survey data found that one in six (17%) people with cancer and one or more other health conditions said they felt overwhelmed from having more things to manage when it comes to my health. However, one in eight (12%) said that their experience of managing their other condition(s) helped them cope with going through cancer[28].

**Having cancer and another long-term condition has a compounded impact on someone's overall wellbeing**

People with cancer and other long-term conditions often experience more severe common side effects, such heightened pain and fatigue, reduced physical function and higher levels of emotional distress, anxiety and depression compared to those without another condition[29,30]. They are also more likely to report overall worst health status, particularly if they are living with a mental health condition.

Their experience is often exacerbated by poorly coordinated healthcare that adds to their 'workload' of managing their health rather than alleviating it. Despite the increased burden of symptoms, many people with cancer and other conditions receive little coordinated help to manage their multiple conditions[31]. Fragmented care often leads to missed opportunities for proactive symptom management and holistic support.

**The differences in experience of care are particularly stark for certain conditions**

The impact of living with cancer and another condition is even more pronounced for certain conditions such as autism, learning disabilities, neurological conditions, blindness or partial sight and mental health conditions.

The qualitative research commissioned by Macmillan into people's lived experience found that people with learning disabilities can face unique challenges when navigating cancer care, from processing complex medical information to understanding treatment options and managing appointments. For people living with dementia, memory loss, confusion and difficulty processing information added significant complexity to their cancer care, creating a 'complex dual situation' with conflicting care needs[32].

People living with these conditions consistently report the worst experiences in the England Cancer Patient Experience Survey (CPES)[33]. For

example, in the 2025 survey, among people with cancer without another long-term condition approximately four in ten (37%) reported that they were able to receive enough emotional support from community or voluntary services, but this drops to only around one in four (27%) people with cancer and autism reporting the same[34].

When asked to rate their overall cancer care experience on a scale from 0 to 10, people without another long-term condition gave an average score of 9.01. In contrast, people with autism reported a lower overall experience with an average score of 8.17 whilst people with dementia or Alzheimer's reported 8.55[35].

Similar results have been seen in Scotland's national CPES, where analysis of the 2015/2016 survey showed that people with cancer and one or more other long-term conditions reported a worse experience of their care in 19 of the 47 questions in the survey[36].

## How does having a long-term conditions impact cancer diagnosis?

The impact of having one or more long-term conditions on cancer diagnosis varies both by type of cancer and by type of long-term condition. However, overall, people with cancer and other long-term conditions are more likely to face difficulties in diagnosis compared to people without another condition.

### Having a long-term condition is often linked to delays to diagnosis

In Macmillan's survey data, one in 12 respondents with cancer and one or more other long-term conditions (8%) said their cancer diagnosis was delayed because their cancer symptoms were mistaken for something else[37]. A literature review commissioned by Macmillan identified a number of research studies that also show a link between having one or more other long-term conditions and a

**"With cancer, dementia, diabetes and other health issues, there is a lot to think about. I've learned the hard way that medicines can interact with each other. I was put on a sleeping tablet once as part of my cancer treatment because I couldn't sleep. A pharmacist realised I had dementia and told me I shouldn't be on that medication because it could make the problem worse. Because of her, I was taken off it. It made a big difference. That's why it matters that people look at the whole person, not just one condition."**



Andy, 70, from the Vale of Glamorgan in Wales, lives with vascular dementia, blood cancer and prostate cancer

negative impact on cancer diagnosis. One study showed that people with non-Hodgkin lymphoma and other long-term conditions in England were more likely to be diagnosed through an emergency route[38], while another study showed people with cancer and other conditions in England were more likely to have an avoidable delay to their diagnosis compared to those without long-term conditions[39].

Studies from a number of different countries suggest that people with cancer and dementia are more likely to be diagnosed via emergency care[40]. Previous research has shown that in England, being diagnosed through emergency care is associated with advanced disease and poorer survival for several major types of cancer[41].

Delays in diagnosis are driven by a number of factors, including the misattribution of cancer symptoms to existing conditions by both patients and clinicians (diagnostic overshadowing), cognitive and communication barriers, particularly for people with dementia and severe mental illness, and systemic time constraints in primary care that act as a barrier to people with long-term conditions being able to fully communicate their symptoms and concerns.

**Some combinations of cancer type and long-term condition can be associated with earlier diagnosis**

In Macmillan's survey data, one in nine respondents with cancer and one or more other long-term conditions (11%) said their cancer was first detected because of the care they receive for their other condition(s)[42]. Other research by Macmillan and Public Health Scotland has shown that while having a severe long-term condition is linked to later-stage diagnosis in breast cancer, it is linked to earlier-stage diagnosis in lung cancer. There was little difference for some other cancers[43].

The type of long-term condition also matters: pulmonary, cardiovascular, neurological, psychiatric disorders, dementia, and serious mental illness have been associated with later-stage diagnosis, while hypertension and some gastrointestinal or musculoskeletal conditions may be associated with earlier detection[44].

**People with long-term conditions are more likely to have no recorded cancer stage**

Across four common cancer types, data from Scotland shows that people with multiple long-term conditions are less likely to have staging information about their cancer[45], which can make it harder for healthcare professionals to choose the right treatment. This can be because cancer staging requires multiple diagnostic procedures, which some people with other health conditions may be medically unfit to undergo[46], or may decline or not be offered because of the further burden of testing.

## How do long-term conditions impact cancer care and treatment?

### People with long-term conditions have reduced access to cancer treatment and care

Macmillan's research with Public Health Scotland found that people with cancer and other long-term conditions in Scotland vary in their access to cancer treatments. For example, compared to those with no long-term conditions prior to cancer diagnosis, people with lung, breast and colorectal cancer and other long-term conditions diagnosed prior to diagnosis are less likely to receive chemotherapy, people with breast and colorectal cancer are less likely to have surgery, and people with breast, colorectal and prostate are less likely to receive treatment with curative intent[47]. This is partly linked to their age profile and stage at diagnosis.

Other research shows that in England, various combinations of cancer type and co-morbidity are associated with lower odds of receiving chemotherapy and surgery[48]. Research from outside the UK has also shown that women with breast cancer living with severe mental illness in a number of countries are less likely to receive the treatment recommended by their national guidelines[49,50].

These differences also extend to how people with cancer and other long-term conditions are supported. For example, in the 2018 Northen Ireland Cancer Patient Experience Survey, people with a long-term condition reported lower rates of receiving enough care and support during treatment from health or social services such as district nurses, home helps or physiotherapists, compared to those without other long-term conditions (63% compared to 71%)[51].

### There is variation in how clinical decisions are made and knowledge gaps exist among healthcare professionals

The differences people with long-term conditions experience in access to cancer treatment could be influenced by valid clinical concerns about how a patient might tolerate treatment and how effective treatment might be in patients with poor overall health. They can also be a result of patient preferences.

However, although clinical factors such as cognition, frailty, and functional status are regularly taken into account when making treatment decisions, assessments can be made subjectively, leaving room for observer bias. Tools such as a Comprehensive Geriatric Assessment exist to support a more structured assessment, but one international review showed they are not consistently used

> **"I haven't had a choice in what medication I'm on. I've just been told that [this is] the rest of your life... this is my life...just kind of dictated to me."**
>
> Participant in Macmillan-commissioned research project

because of healthcare professionals' unfamiliarity with them or concerns about the time and effort required[52].

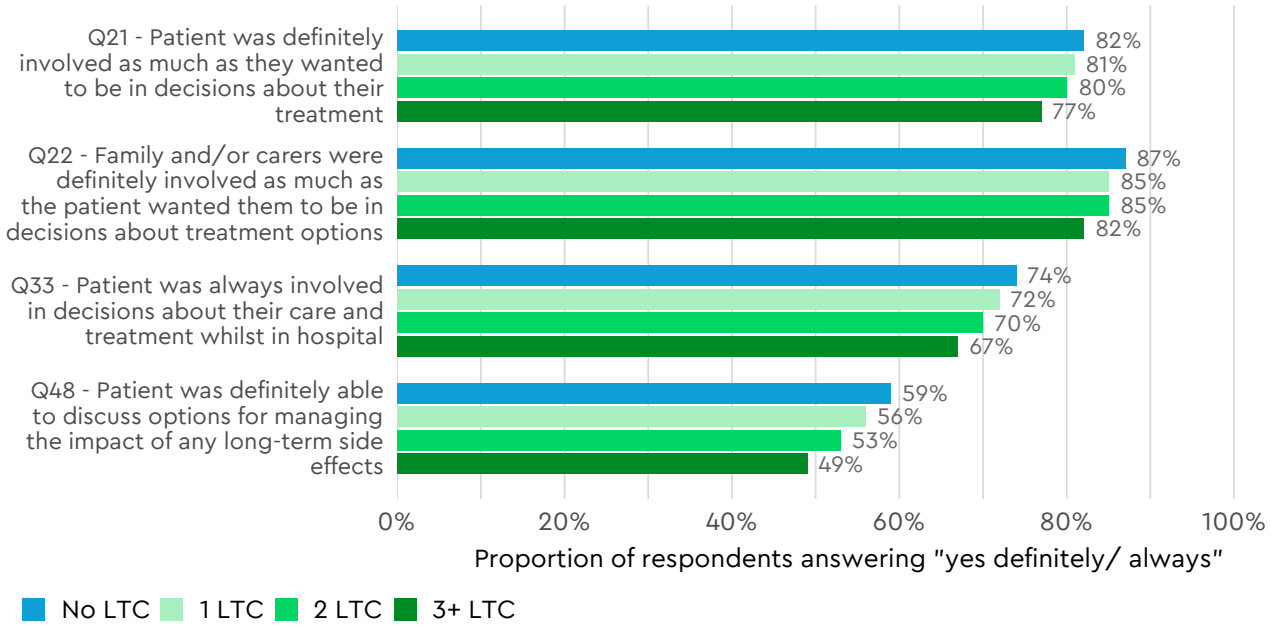
Clinicians can also face complex ethical challenges, particularly for people living with dementia, in balancing treatment benefits, risks, patient autonomy, and quality of life. There are also knowledge gaps among healthcare professionals, with one international review highlighting that cancer specialists may view the management of long-term conditions as outside of their expertise, while GPs may be more likely to take a person-centred, integrated approach but can feel less confident in managing complex cancer-related symptoms[53].

When decisions are made primarily by clinicians, this will not always reflect patients' own values or preferences, leading to a gap in shared decision-making. This is reflected in the 2025 CPES for England, where people with two or more other long-term conditions were less likely to report them or a member of their family being involved as much as they wanted when it came to decisions related to their cancer treatment and options for managing the impact of long-term side effects compared to people without other long-term conditions (figure 8)[54].

This was also reinforced in the Macmillan-commissioned research which found that

Cancer patient involvement in decisions about care and treatment by number of long-term conditions, England, 2025

Selected survey questions, by number of long-term conditions




Produced by Macmillan from the National Cancer Patient Experience Survey (NHS England) (2025)

Figure 8: Selected questions on shared decision making from the NHS England. National Cancer Patient Experience Survey 2025. Graph shows the proportion of people answering "yes definitely" for questions 21, 22, and 48 and "yes always" for question 33. This graph shows that the proportion of people giving a positive score on all four selected questions decreases as their number of other long-term conditions increases.

participants overwhelmingly wanted to be involved in decisions about their care, linking involvement to increased confidence, a sense of control, and reduced anxiety. Yet despite a strong desire to be involved, shared decision making was often described as inconsistent or conceptual rather than practical[55].

**Under-representation in clinical trials and gaps in the evidence may contribute to more conservative treatment approaches**

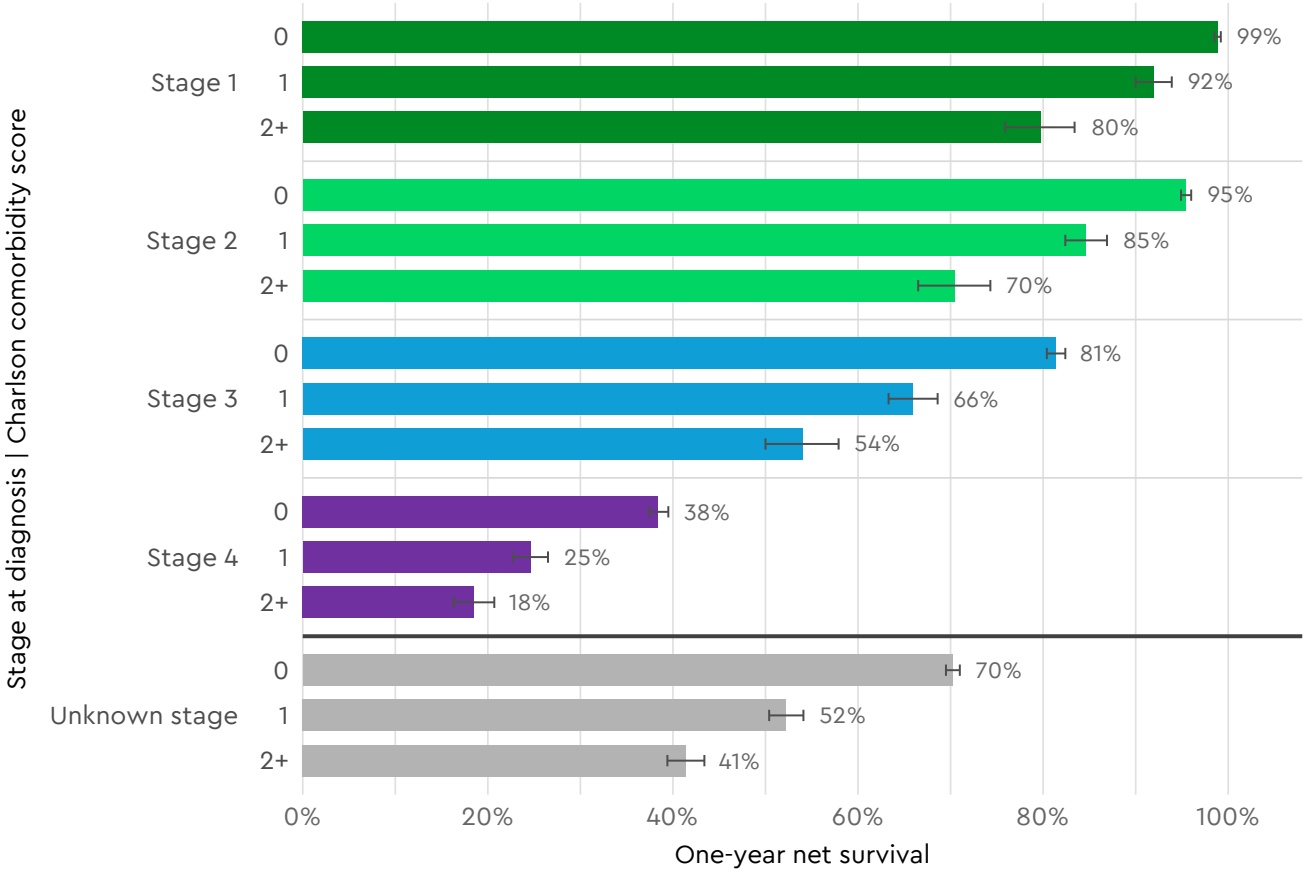
Another factor contributing to the differences people with cancer and other long-term conditions experience in accessing treatment is underrepresentation of older adults, individuals living with frailty and those with multiple conditions in clinical trials. Excluding individuals with multiple conditions from clinical studies results in a lack of robust, evidence-based guidance for making treatment decisions in these complex cases.

## How do long-term conditions impact cancer survival and mortality?

The impact of living with one or more other long-term conditions on survival and mortality is not regularly reported in national statistics in any nation of the UK. However, various studies have demonstrated that living with specific long-term conditions can reduce cancer survival and increase risk of death. For example, one study of seven European countries including the UK suggests people living with cancer and cardiovascular disease or type 2 diabetes have a 25% higher risk of death compared to those without those conditions[56]. An analysis conducted in partnership between Macmillan Cancer Support and Public Health Wales' Welsh Cancer Intelligence and Surveillance Unit examined the impact of specific long-term conditions recorded in hospital records in the year prior to diagnosis on all-cancer net survival. The data showed people with cancer in Wales are less likely to survive for a year following their diagnosis as the severity or number of these existing conditions increases even among those diagnosed at the same stage (figures 9 and 10)[57].

One-year net survival by stage at diagnosis and Charlson comorbidity score, Wales, 2011-2014

All malignancies excluding non-melanoma skin cancer; bars show 95% confidence intervals




Produced by Macmillan from Cancer patients with other chronic health conditions in Wales: GP Cluster Network incidence, prevalence and all Wales survival, Welsh Cancer Intelligence and Surveillance Unit.

Figure 9: One-year net cancer survival in Wales by stage at diagnosis and Charlson score in 2011 to 2014 for all cancer combined excluding non-melanoma skin cancer. Charlson score is based on conditions recorded in the Patient Episode Database for Wales in the year before cancer diagnosis. This graph shows that at all stages of cancer diagnosis, one-year net survival decreases as the Charlson comorbidity score increases.

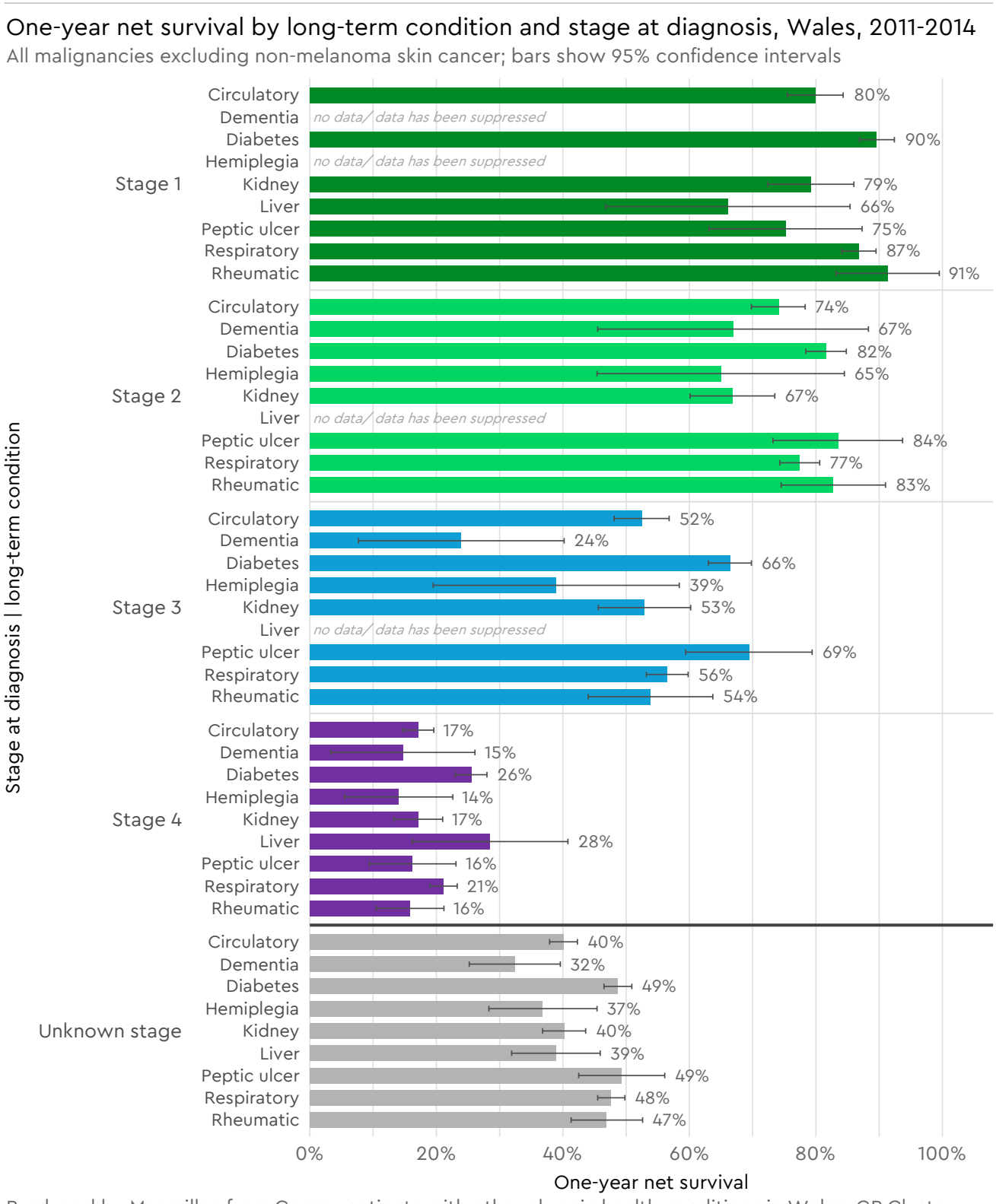



Figure 10: One-year net cancer survival in Wales by stage at diagnosis and condition in 2011 to 2014 for all cancer combined excluding non-melanoma skin cancer. Conditions are based on conditions recoded in the Patient Episode Database for Wales in the year before cancer diagnosis. This graph shows that one-year net survival varies by different long-term conditions to varying amounts at each stage of cancer diagnosis.

# 3: What needs to change? Implications for policy and practice

By commissioning a review of the literature and combining this with data analysis and the insight from people with lived experience, we can see where some of the key problems and challenges lie in supporting people with cancer and other long-term conditions. Living with cancer and other long-term conditions is now the norm rather than the exception. Yet too many people are still receiving care designed around individual diseases rather than the whole person. For people with cancer, this is leaving them overwhelmed and exhausted and is leading to poorer experiences and outcomes.

From this evidence base, as well as from the insight and evidence we have gathered from previous interventions Macmillan has funded, conversations with external experts and people with lived experience, and from working in partnership with others, we have identified three key areas that should be prioritised for improvements:

1. **Shared decision-making:** People living with cancer must be supported and empowered to be part of shared decision-making that enables making the right choices for them, across all their conditions
2. **Supported self-management:** People living with cancer need the right information and support available at the right time to manage their cancer and other conditions well.
3. **Personalised care and treatment:** People living with cancer must receive tailored treatment, care and support that is responsive to their physical and mental health needs.

To achieve improvements in these areas, we need to see the following:

- **People with cancer** being offered timely, easy-to-understand information and support that is tailored to their health conditions and is available when and where they need it.
- **Healthcare professionals** applying learning, developing new knowledge and skills and delivering care that fits the person, not just the condition.
- **Health and care systems** that talk to each other to provide joined-up care, sharing data and working in sync to treat the whole person, not just their parts.
- **Better quality data and research** that drives better decisions and shapes health and care that truly works for people with cancer and other conditions.

Specific actions that would drive improvements include the following:

**Supporting people with cancer and other long-term conditions**

- Ensure universal access to personalised, holistic needs assessments and care planning.
- Improve information and resources to support self-management.
- Enable good quality conversations and shared decision-making to ensure choices reflect individual preferences and circumstances.
- Provide navigation support to help people manage the additional burden of multiple systems of treatment, care and support.

**Enabling healthcare professionals**

- Raise awareness of diagnostic overshadowing to reduce avoidable diagnostic delays.
- Optimise multi-disciplinary working to ensure effective communication and decision-making.
- Address knowledge gaps for both cancer and non-cancer specialists regarding the complexities of managing other long-term conditions alongside cancer.

**Transforming health and care systems**

- Address treatment burden by promoting joined-up care delivery and better information sharing between systems.
- Improve medicines management by addressing the challenges and risks associated with polypharmacy. Promote innovative models of care, such as moving care closer to home and improving the quality of conversations in primary care.
- Look at ways to take a more neighbourhood and community-based approach that brings together health services, local organisations and communities to create support that is more connected, personal, and closer to home.

**Improving data and research**

- Advocate for the inclusion of those with multiple conditions in clinical trials to build the evidence base for treatment.
- Encourage research covering the full range of long-term conditions by improving data linkage between primary and secondary care.
- Support analysis of how specific conditions impact cancer survival, quality of life, and patient experience to inform decision-making.
- Promote high-quality research into the complex interactions between long-term conditions, health inequities, and variation in care.

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# Appendices

## Appendix A: National Bridges to Health Segmentation Dataset

Long-term condition prevalence estimates in this report are based on the Outcomes Based Healthcare (OBH) National Bridges to Health Segmentation Dataset, accessed via the Population and Person Insights Dashboard (PaPI)[58]. The National Bridges to Health Segmentation Dataset is a person-level, longitudinal population health dataset covering the GP-registered population of England. It integrates data from multiple national health and care sources and applies clinically curated definitions to identify people living with long-term conditions.

The dataset incorporates information from primary and secondary care and other national sources, including Secondary Uses Service (SUS) data covering A&E, inpatient and outpatient activity, mental health and community data, and the National Diabetes Audit. Sociodemographic and geographic characteristics are also available, including age, gender, ethnicity, deprivation and geography. Sex/gender is derived from the 'administrative gender' field in the Master Patient Index/Personal Demographics Service source dataset. This field only includes the binary categories of male and female, and how this field is used in relation to people's biological sex or gender identity will vary between healthcare providers. In this report we have used the terms 'men and people assigned male at birth' for people in the male category, and 'women and people assigned female at birth' in the female category. Other outputs using this data may use the terms 'men' and 'women', however the underlying data used for both types of wording is the same.

For the long-term conditions reported here, the methodology uses clinically defined condition registers based on available coded healthcare data. The use of data across multiple care settings improves identification of conditions that may be recorded outside primary care or presented through hospital services. However, the dataset will not identify every person with a given condition. In particular, people with milder or less frequently coded conditions may have no relevant recorded healthcare interaction.

## Appendix B: Estimating UK-wide prevalence of cancer and other long-term conditions

To estimate the UK-wide prevalence of cancer and other long-term conditions using the OBH data, we carried out the following steps. Cancer prevalence in 2026 by age band and nation were estimated as part of the Macmillan Cancer Support and Scottish Widows Cancer prevalence projections project[59]. The proportion of people living with cancer with a given number of long-term

conditions (0, 1, 2, 3, 4, 5+) within each age band was taken from the PaPI dashboard (2024)[60]. These proportions were applied to the cancer prevalence projections under each corresponding age band, summed to give nation-level estimates, and combined to give a UK total.

There are three key limitations to this estimation. First, a single set of age-specific long-term condition rates are applied across all four nations, so national differences in comorbidity rates are not captured. Second, the complete cancer prevalence population is different to the OBH cohort. Complete cancer prevalence includes everyone alive who has ever had a cancer diagnosis estimated from national registration data. OBH is everyone alive with records of attending a specialist service for cancer or cancer hospital care after 2003. This means OBH will include some cancers diagnosed before 2003 but not all and so the population included has a different characteristic and a younger profile. Therefore, applying age-specific rates from OBH to the complete prevalence population produces a higher overall long-term conditions percentage (80%) than OBH's own published figure (77%), but this is a better approximation for the long-term conditions rate for the complete cancer prevalence population. Third, the method assumes that within a given age band the complete cancer prevalence population carries the same long-term conditions burden as OBH's cohort.

## Appendix C: Other sources of long-term condition prevalence

A range of other studies have sought to describe the population living with cancer and other long-term conditions. These vary in their population samples, their definitions of long-term conditions, and their methodology. To assess which was the best source to use for this analysis, we used three criteria: alignment with the NICE definition of multimorbidity[61], how comprehensively they captured the UK cancer population, and the recency of the data.

Study samples varied by setting of data collection, cancer types included, and population size. Sources covering only selected cancer types, which examine variation in the prevalence and type of conditions between cancers[62] rather than overall prevalence, were excluded. With the exception of a Scotland-based study by Public Health Scotland and Macmillan[63], all eligible studies covered England only. Findings from the Scotland study are referenced elsewhere in this report, but datasets covering England were used for the rate of long-term conditions by age.

The categorisation of long-term conditions varies between studies, both in the scope of conditions included and in the interpretation of what counts as a long-term condition. Definitions used in studies range from fewer than 20 conditions, based on adaptations of the Charlson Comorbidity Index[64], an index derived from conditions most linked to

mortality, to more than 200 conditions[65], drawn from a defined and publicly available list[66]. One study used linked primary care, secondary care and cancer registry data in England to explore associations between 109 pre-existing conditions and 19 adult cancers[67]. Although methodologically comprehensive, it includes several conditions which can present acutely as manifestations of the cancer itself[68], and additionally only includes patients who have received at least one active treatment modality.

The National Bridges to Health Segmentation dataset (v5.0, 2024)[69] is the most recent of the sources considered, and covers all GP-registered patients in England. The dataset was selected as a broad definition largely consistent with the NICE definition of multimorbidity. It comprises 35 conditions[70], and captures a range of symptom complexes and non-disease states that NICE explicitly references: chronic pain, frailty, learning disability, physical disability.

## Appendix D: Cancer patient-reported long-term condition prevalence

Surveys of people living with cancer often include questions on the individual's long-term condition status. These results enable a patient-reported long-term condition prevalence figure for the cancer population, dependent on the specificity and scope of the questions asked. In a survey of more than 2,100 people with cancer in the UK conducted by Macmillan/ YouGov in January 2026, 78% of respondents report living with at least one other long-term condition[71], closely aligning to the hospital reported figure.

National cancer patient experience surveys (CPES), conducted separately across each nation of the UK, also ask about the individual's long-term condition status. These surveys employ different definitions for long-term conditions, and different study samples. For example, England's survey options are based largely around specific conditions. The Wales CPES is the closest aligned with England's with some slight differences, whilst the Northern Ireland CPES represents a reduced specific condition option, and Scotland's options in contrast largely focus on problems caused by conditions such as 'mobility (for example, walking short distances or climbing stairs)' or 'Dexterity (for example, lifting or carrying objects, or using a keyboard)'. These options and differences can be seen in figure 11 below and as such, the scores cannot be compared like for like.

Figure 11: Table showing rates of UK national cancer patient experience survey respondents reporting they have one or more long-term conditions

| Nation | Long-term condition selection options in most recent national cancer patient experience survey (CPES) | Respondents selecting one or more of these options (%) | Year of most recent survey | Total survey sample |
|---|---|---|---|---|
| England | Breathing problem, such as asthma, Blindness or partial sight, Dementia or Alzheimer's disease, Deafness or hearing loss, Diabetes, Heart problem, such as angina, Joint problem, such as arthritis, Learning disability, Autism or autism spectrum condition, Mental health condition, Neurological condition, such as epilepsy, Other long-term condition | 62% | 2025 | 64,268 responses |
| Scotland | Vision (for example, blindness or partial sight), Hearing (for example, deafness or partial hearing), Mobility (for example, walking short distances or climbing stairs), Dexterity (for example, lifting or carrying objects, or using a keyboard), Learning or understanding, or concentrating, Memory, Mental health, Stamina or breathing, or fatigue, Socially or behaviourally (for example, associated with autism spectrum disorder (ASD) which includes Asperger's, or attention deficit hyperactivity disorder (ADHD)), Other, Prefer not to say | 41% | 2023 | 4,540 responses |

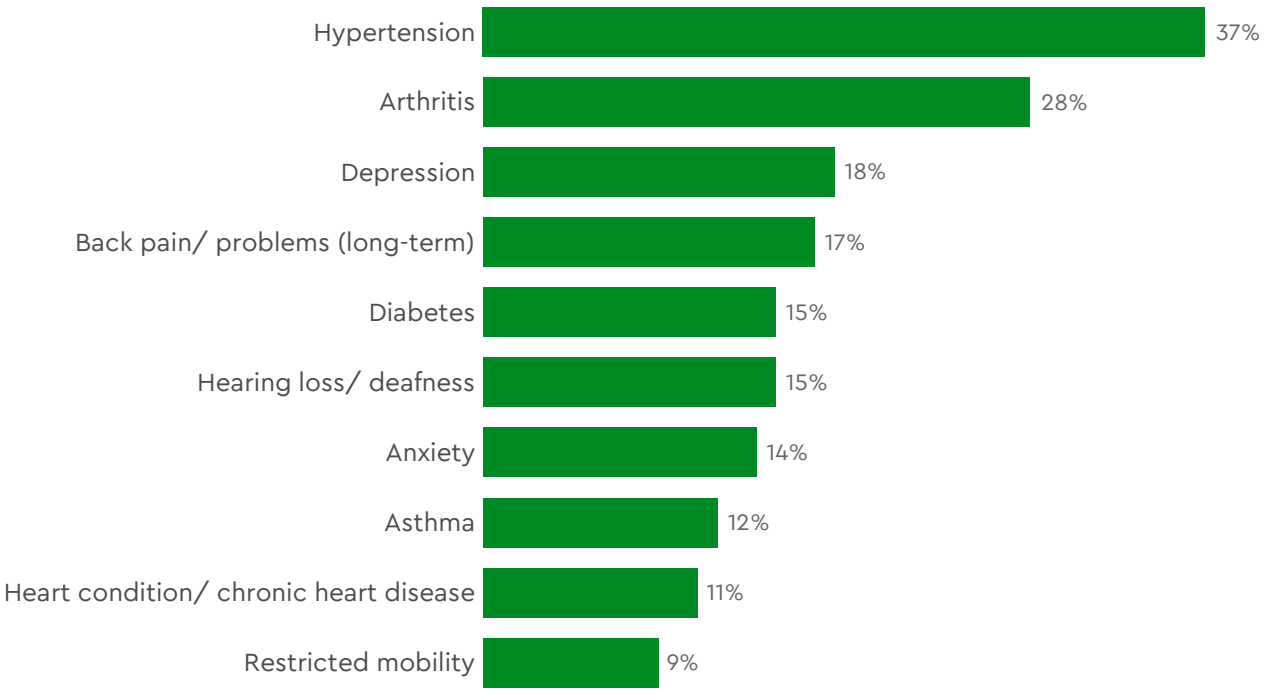
| Nation | Long-term condition selection options in most recent national cancer patient experience survey (CPES) | Respondents selecting one or more of these options (%) | Year of most recent survey | Total survey sample |
|---|---|---|---|---|
| Wales | Breathing problem, such as asthma, Blindness or partial sight, Dementia or Alzheimer's disease, Deafness or hearing loss, Diabetes, Heart problem, such as angina, Joint problem, such as arthritis, Kidney or liver disease, Learning disability, Mental health condition, Neurological condition, I do not have any of these conditions | 68% | 2020 | 6259 responses |
| Northern Ireland | Deafness or severe hearing impairment, Blindness or partially sighted, A long-standing physical condition, A learning disability, A mental health condition, A long-standing illness such as HIV, diabetes, chronic heart disease, or epilepsy | 36% | 2018 | 3,500 responses |

Despite differences in the recording of conditions between hospital and patient-reported data, hypertension and arthritis are also the two most common conditions in patient-reported data (figure 12). Secondary care data often lacks recording of conditions that are not diagnosed by the clinician and not explicitly reported by the patient. Deafness and hearing loss in particular are often not routinely recorded.

Patient-reported data on the other hand often under-represents conditions with low survival rates or those that have limited impact on an individual's daily life. Chronic kidney disease and hypertension are under-represented in the patient-reported datasets, likely because early stages of these have limited impact on an individual's daily life so may not be reported.

Prevalence of most common self-reported long-term conditions among people living with cancer, UK-wide survey, 2026

Top 10 conditions by prevalence




Macmillan Cancer Support/YouGov – The lived experiences of people with cancer (2026). The figures have been weighted and are representative of people living with cancer in the UK (aged 18+).

Figure 12: Results from a 2026 Macmillan Cancer Support/YouGov survey of people with cancer. This graph shows 10 common other long-term conditions and how common they are among respondents to the survey. Question wording: "Have you ever been diagnosed with any of the following condition(s)? Please select all that apply:" Base: All people living with cancer: Jan 26 (2,107) (bases vary by group)

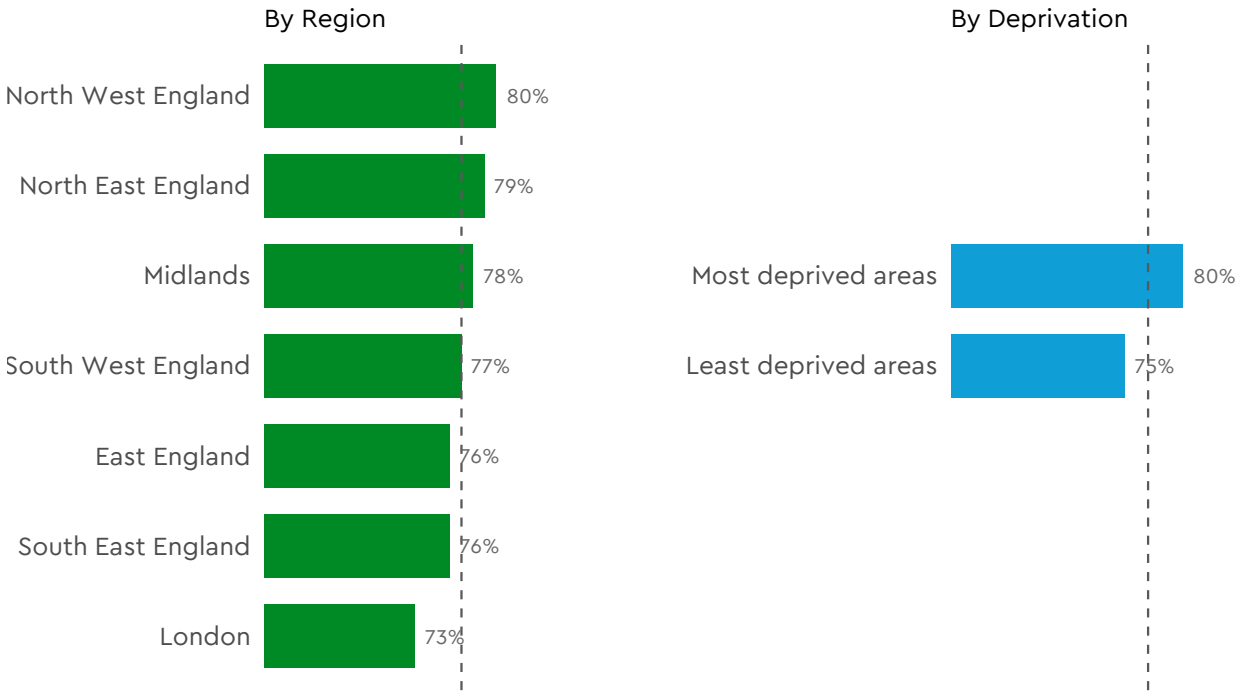
## Appendix E: Population-level data on the proportion of people living with cancer who have long-term conditions

At an overall population level, the most deprived areas of the UK have a higher proportion of people with cancer and one or more other long-term conditions than the least deprived areas. In England, North-West England is the region with the highest proportion of people with cancer with another condition (figure 13).

In general, areas where a high proportion of the population is White will usually have a higher overall proportion of people with cancer and another condition, due to the older age profile of the White population in the UK. However, as described in the main section of this report, after population demographics and risk factors are adjusted for, the risk for individuals within these populations can show different relationships to the population-level patterns.

Prevalence of long-term conditions among people living with cancer, by region and area deprivation, England, 2024

Dashed line = overall prevalence in the England cancer population (77%)




Produced by Macmillan from the Population and Person Insight (PaPI) Dashboard (NHS England); National Bridges to Health Segmentation Dataset v5.0 (Outcomes Based Healthcare) (2024).

Figure 13. Long-term condition prevalence among demographic population subsets of the England cancer population. This graph shows that the prevalence of other long-term conditions among people with cancer in England varies from 73% in London to 80% in North-West England (linked to variation in regional age profile and deprivation), and from 75% in the 20% least deprived areas of England to 80% in the most deprived areas.

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have continued to need someone to help with practical tasks at /outside of home; I regularly used or have continued to use a stick, walker or wheelchair to get about; I had or continued to have health problems that require me to stay at home. If the respondent answers yes to 3 or more of the options of being over 85, being male, having a disability and any of the statements referenced there are classified as having risk factors that could indicate suspected frailty. This is derived from the PRISMA-7 Questionnaire.

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**Macmillan Cancer Support has spent more than 100 years helping people living with cancer. We know that cancer can disrupt your whole life.**

**And it can be made worse simply because of who you are and where you live.**

**But we're here to change that.**

**The number of people diagnosed with cancer is growing, and every one of them needs the best support to meet their unique needs.**

**That's why we'll do whatever it takes to help everyone living with cancer across the UK get the support they need right now and transform cancer care for everyone who will be diagnosed in the future.**

MACMILLAN CANCER SUPPORT

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