

## 6. ACCESS TO CARE

### 6.7. Inequalities in cancer screening

Cancer is the second most common cause of death in OECD countries, responsible for 28% of all deaths in 2009. Among women, breast cancer is the most common form, accounting for 30% of new cases each year and 15% of cancer deaths in 2009. Cervical cancer adds an additional 3% of new cases, and 2% of female cancer deaths (see Indicator 1.4, “Mortality from cancer”).

The early detection of breast and cervical cancers through screening programmes has contributed to increased survival rates, and many countries have opted to make screening widely available. In most countries, more than half of women in the target age groups have had a recent mammogram, and a pelvic exam or Pap smear (see Indicators 5.8 and 5.9).

Screening rates vary widely among women in different socio-economic groups in OECD countries (Figures 6.7.1 and 6.7.2). Even in those countries where the practice is common, women in lowest income groups are generally less likely to undergo screening. Income-related inequalities in cervical cancer screening are significant in 15 of the 16 countries studied. However, pro-rich inequalities in breast cancer screening are significant in fewer countries (Belgium, Canada, Estonia, France, New Zealand, Poland and the United States).

In the United States, low-income women, women who are uninsured or receiving Medicaid (health insurance coverage for the poor, disabled or impoverished elderly) or women with lower educational levels report much lower use of mammography and Pap smears (NCHS, 2011). There is additional evidence in European countries for significant social inequalities in utilisation of early detection and prevention health care services (von Wagner *et al.*, 2011). In particular, women with higher level of assets are more likely to have mammograms (Sirven and Or, 2010).

In Mexico, cervical cancer detection programmes have been in place for some time, but problems with access and coverage remain, especially among disadvantaged groups, so that almost half of women aged 50 years and over have not had a Pap test in the last two years (Couture *et al.*, 2008). In most OECD countries, however, income should not be a barrier to accessing screening mammography or Pap smears, since the services are provided free of charge, or at the cost of a doctor consultation.

Participation rates also vary by geographic regions (Figure 6.7.3). Some areas, such as the Northern Territory (Australia), and London (the United Kingdom), exhibit significantly lower rates than do other regions within the country. The reasons for this are varied. In geographically isolated regions such as the Northern Territory, travelling

distance, the availability of screening services and access barriers for Indigenous women play a part. In inner urban areas of London, low levels of awareness of screening programmes, symptoms and risks are a concern among women who are poor, or from minority ethnic groups.

A number of socio-economic characteristics – such as income, ethnicity, younger age, higher level of education, employment status, residential area, marital status, having health insurance, good health status, having a usual source of care and use of other preventative services – are all important predictors of participation in screening.

Since a wide range of screening practices and different access barriers exist across OECD countries, no single strategy will meet all needs in promoting greater and equal coverage (Gakidou *et al.*, 2008). In countries with sufficient health system capacity, increased screening can be encouraged by ensuring services are free, and are available where needed. Policies and interventions may need to be better targeted in order to overcome inequalities. As a complementary tool, the promise of new cancer preventing vaccines also has important implications for resource-poor settings where maintaining screening programmes is challenging.

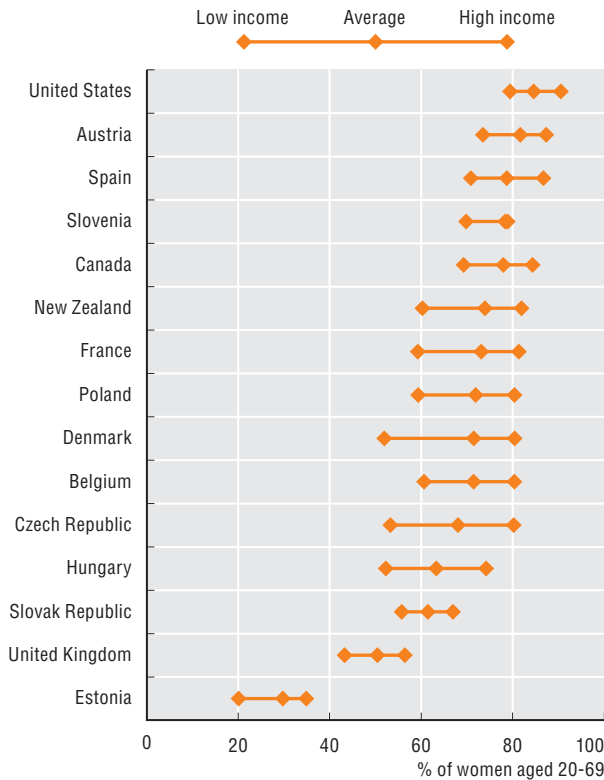
#### Definition and comparability

Breast and cervical screening participation rates measure the proportion of women of a given age who have variously received a recent mammogram, breast exam, pap smear or pelvic exam. Information is generally derived from health surveys, or from screening programme administrative data.

Rates by income groups were derived from health surveys. For cervical, women aged 20-69 years were asked whether they had been screened in the three years prior to the survey, and for breast, women aged 50-69 years in the past two years. The exception was Denmark (for breast only), where screening was reported for the past 12 months. Screening estimates based on self-reported health surveys should be used cautiously, since respondents tend to overestimate desirable behaviours.

The data for geographic regions include women in target age groups who had participated in national screening programmes. Target age groups and screening periodicity may differ across countries.

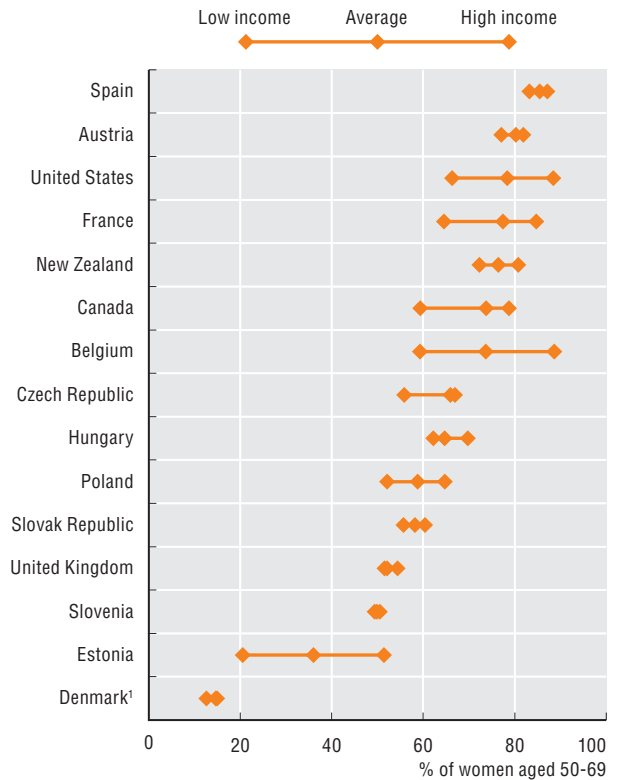
6.7.1 Cervical cancer screening in past three years, by income level, 2009 (or nearest year)



Note: The data source for some countries may be different to that used for reporting breast and cervical cancer screening in Chapter 5.  
Source: OECD estimates (2011).

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6.7.2 Breast cancer screening in past two years, by income level, 2009 (or nearest year)

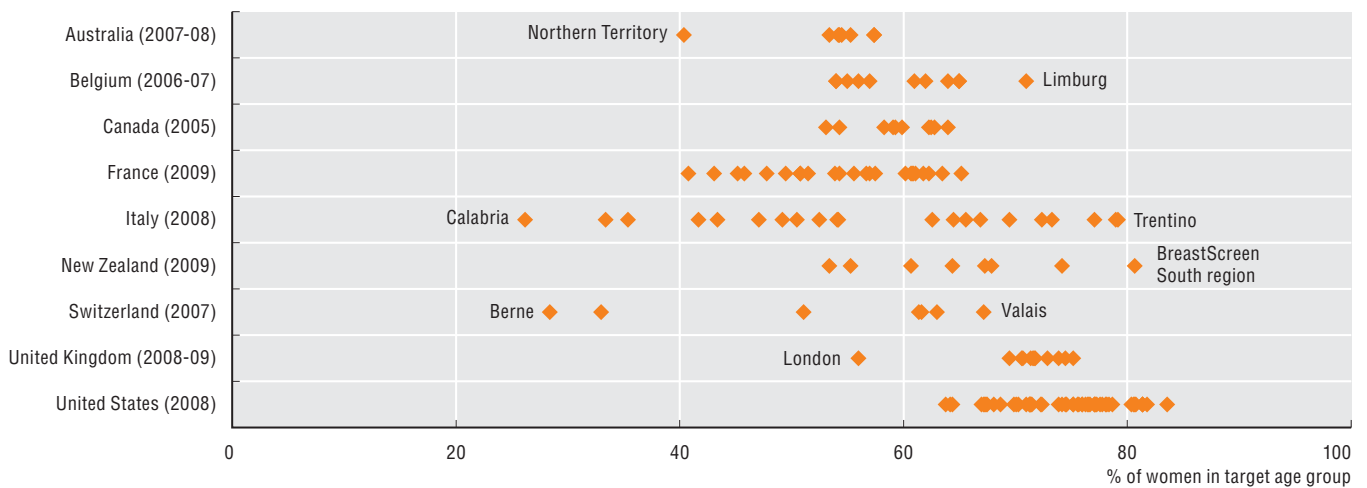


Note: The data source for some countries may be different to that used for reporting breast and cervical cancer screening in Chapter 5.  
1. Visits in the past 12 months.

Source: OECD estimates (2011).

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6.7.3 Participation in breast cancer screening programmes, regions in selected OECD countries



Source: AIHW (2010c); FDGS (2011); IMA-AIM (2010); INVS (2011); NHSBSP (2010); ONS (2010); Page and Taylor (2010); PHAC (2008); CDC (2010b).

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