

Cervical cancer is mainly the outcome of persistent infection with human papillomavirus (HPV), which accounts for approximately 95% of all cases (IARC, 1995; Franco *et al.*, 1999). Every year 61 000 new cervical cancers are diagnosed in Europe (IARC, 2011).

Precancerous changes can be detected and treated before progression to cancer occurs, making cervical cancer highly preventable. Population-based cervical screening programmes have been promoted by the Council of the European Union and the European Commission (European Union, 2003; EC, 2008c), but the periodicity and target groups vary among member states.

Figure 4.7.1 shows cervical screening rates across European countries in the years 2000 and 2010 for women aged 20-69 years. In 2010, Latvia, Germany, the United Kingdom, and Norway reported coverage close to 80% of the target population. Whilst overall screening rates across the European Union improved slightly over the past decade, several countries, including Finland, Hungary, Iceland, Norway, the Slovak Republic and the United Kingdom witnessed a decline in screening rates between 2000 and 2010.

Survival rates reflect both how early the cancer was detected and the effectiveness of the treatment. It is a key measure of the effectiveness of health care systems to treat potentially fatal diseases and track progress over time. Figure 4.7.2 shows a small gain in five-year cervical cancer survival rates in the European Union between 1997-2002 and 2004-09, although gains were not uniform across countries. Of the 11 EU member states reporting data in both periods, seven recorded modest gains in survival rates whereas four countries (Denmark, Finland, France and Germany) reported a small decline, although the reduction was not statistically significant. Norway reported the highest rates as well as the highest gain in cervical cancer survival, with 78.2% of patients surviving five years after diagnosis.

Mortality rates reflect the effect of cancer care in past years, the impact of screening, improved diagnosis of early-stage cancers as well as incidence. Mortality rates for cervical cancer declined in most European countries between 2000 and 2010, apart from Bulgaria, the Former Yugoslav Republic of Macedonia and Croatia, Greece and Ireland (Figure 4.7.3). For some countries such as Lithuania and Romania, mortality rates remain well above the EU average.

Since the development of a vaccine against some HPV types, vaccination programmes have been implemented in most EU countries. By May 2012, 17 out of 27 EU member

states had implemented routine HPV vaccination programmes. In most cases the vaccination programmes are financed by the national health systems. However, in Austria the vaccination is entirely covered by the recipient, and in Belgium and France recipients contribute 25% and 35% of the payment, respectively (ECDC, 2012b). Since its introduction, there has been an active policy and research debate about the impact of the vaccine on cervical cancer screening strategies (Goldhaber-Fiebert *et al.*, 2008; Wheeler *et al.*, 2009).

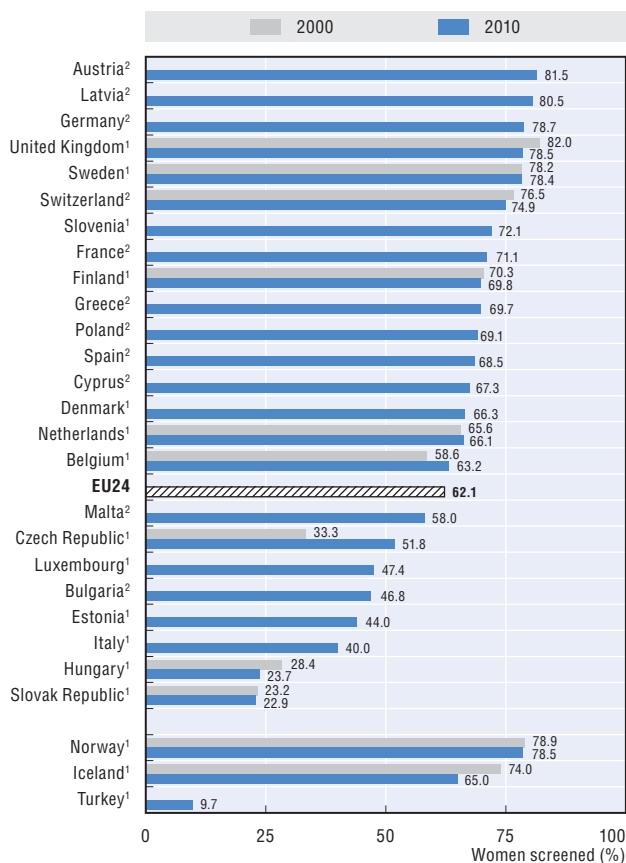
Definitions and comparability

Screening rates for cervical cancer reflect the proportion of women who are eligible for a screening test and actually receive the test. As policies regarding screening periodicity and target population differ across countries, the rates are based on each country's specific policy. Some countries ascertain screening based on surveys and others based on encounter data, which may influence the results. Survey-based results may be affected by recall bias. If a country has an organised programme, but women receive a screening outside the programme, rates may also be under-reported. Survey data are reported only when programme data are not available.

Relative cancer survival rates reflect the proportion of patients with a certain type of cancer who are still alive after a specified time period (commonly five years) compared to those still alive in absence of the disease. Relative survival rates capture the excess mortality that can be attributed to the diagnosis. For example, a relative survival rate of 80% does not mean that 80% of the cancer patients are still alive after five years, but that 80% of the patients that were expected to be alive after five years, given their age at diagnosis and sex, are in fact still alive. All the survival rates presented here have been age-standardised using the International Cancer Survival Standard (ICSS) population. The survival rates are not adjusted for tumour stage at diagnosis, hampering assessment of the relative impact of early detection and better treatment.

See Indicator 1.5 "Mortality from cancer" for definition, source and methodology underlying the cancer mortality rates.

4.7.1. Cervical screening, percentage women screened aged 20-69, 2000 to 2010 (or nearest year)

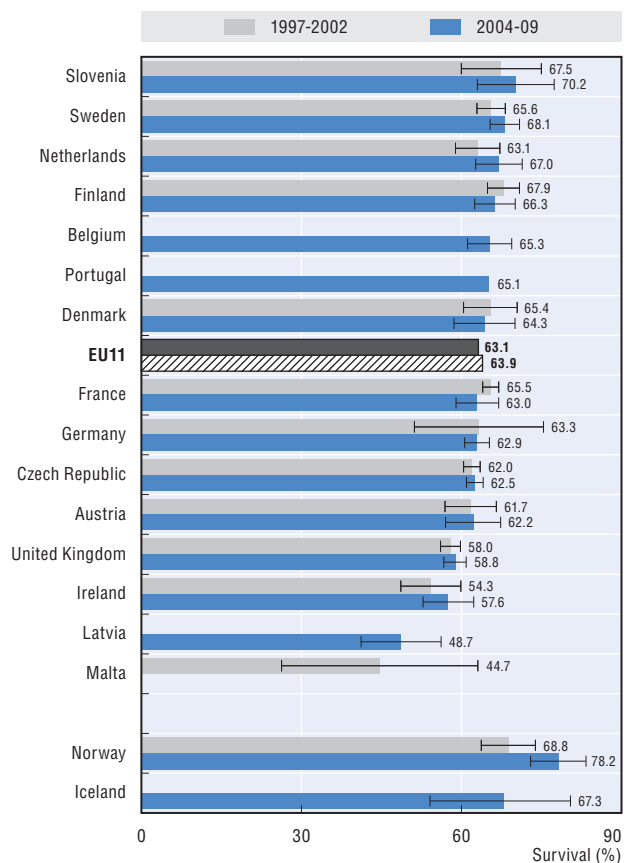


1. Programme. 2. Survey.

Source: OECD Health Data 2012; Eurostat Statistics Database.

StatLink <http://dx.doi.org/10.1787/888932705102>

4.7.2. Cervical cancer five-year relative survival rate, 1997-2002 and 2004-09 (or nearest period)

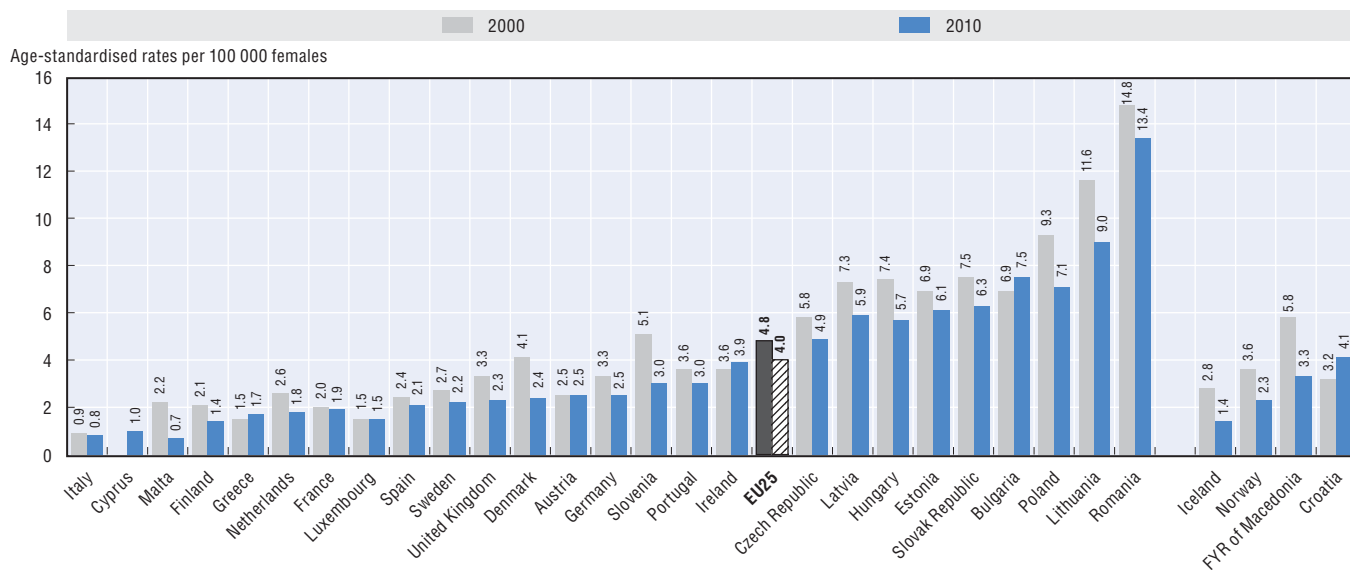


Note: 95% confidence intervals represented by I—I.

Source: OECD Health Data 2012.

StatLink <http://dx.doi.org/10.1787/888932705121>

4.7.3. Cervical cancer mortality, females, 2000 to 2010 (or nearest year)



Source: Eurostat Statistics Database.

StatLink <http://dx.doi.org/10.1787/888932705140>