

6.6. Inequalities in cancer screening

Cancer is the second most common cause of death in OECD countries, responsible for 26% of all deaths in 2011. The early detection of breast, cervical, and colorectal cancers through screening programmes has contributed to increased survival rates over the past five years (see Indicators 5.9 to 5.11), 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 5.9 and 5.10).

Screening rates vary widely by education and socio-economic groups in OECD countries. Even in those countries where the practice is common, women in lower income groups are generally less likely to undergo breast and cervical screening (Figures 6.6.1 and 6.6.2). 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 services (von Wagner et al., 2011). In particular, women in higher socio-economic groups are more likely to have mammograms (Sirven and Or, 2010). However, in most OECD countries, 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.

Rates of colorectal cancer screening for people aged 50-75 vary by education level (Figure 6.6.3). On average across ten European countries, 22% of people with high education level have once participated in colorectal cancer screening whereas this proportion goes down to 14% for people with low education. These inequalities are particularly large in the Czech Republic, although the screening rates for people with low education is higher than the screening rates for people with high education in most other countries. The gap is much smaller in France. Rates of colorectal cancer screening vary across countries, with the highest rates in the Czech Republic and France. The Czech Republic and France completed nationwide rollout of colorectal cancer screening earlier than other countries (OECD, 2013e).

The utilisation of cancer screening services may largely depend on the availability of national public screening programmes. For instance, findings in Europe highlight that inequalities are larger in countries without population-based screening programmes (Palència et al., 2010). In addition, a number of demographic and socio-economic characteristics – such as income, ethnicity, younger age, higher level of education, employment status – as well as having a usual source of care are all important predictors of participation in screening.

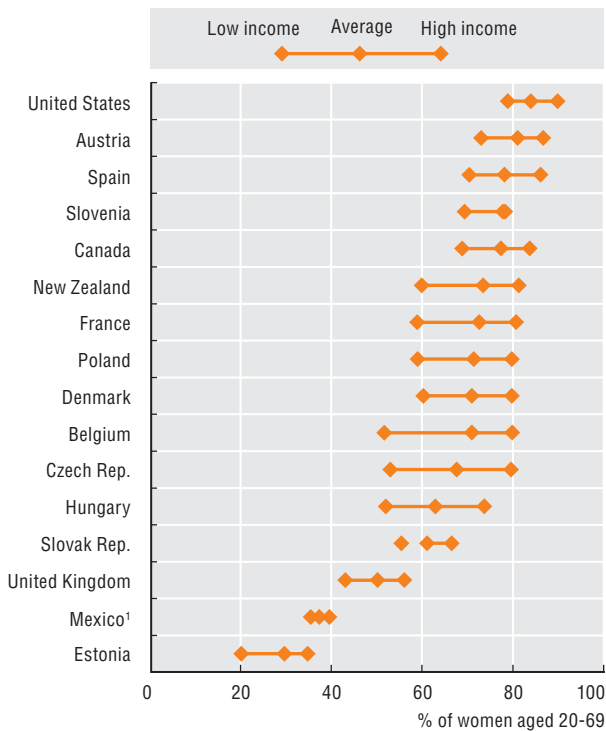
Given the variety of factors affecting the use of different cancer screening, no single action can be expected to overcome the barriers for all population groups (Gakidou et al., 2008). In countries with sufficient health system capacity, increased screening can be encouraged by ensuring services are free and available where needed. Some policy interventions may also 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 rates measure the proportion of women of a given age who have received a recent mammogram, breast exam, pap smear or pelvic exam. Rates by income group were derived from national health surveys. For cervical cancer, women aged 20-69 years were asked whether they had been screened in the three years prior to the survey, and for breast cancer, women aged 50-69 years in the past two years. The exceptions were Mexico and 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.

Rates of colorectal cancer screening by education level were derived from the European Health Interview Survey (carried out in some EU countries between 2006 and 2009). Screening rate was collected for people aged 50-75, based on the following question: "Have you ever had a faecal occult blood test (FOBT)?" However, in some countries, other types of tests (e.g. colonoscopy, flexible sigmoidoscopy) may be used (see Indicator 5.11).

6.6.1. Cervical cancer screening in past three years by income level, selected OECD countries, 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: Devaux and de Looper (2012).

StatLink <http://dx.doi.org/10.1787/888932918719>

6.6.2. Breast cancer screening in past two years by income level, selected OECD countries, 2009 (or nearest year)



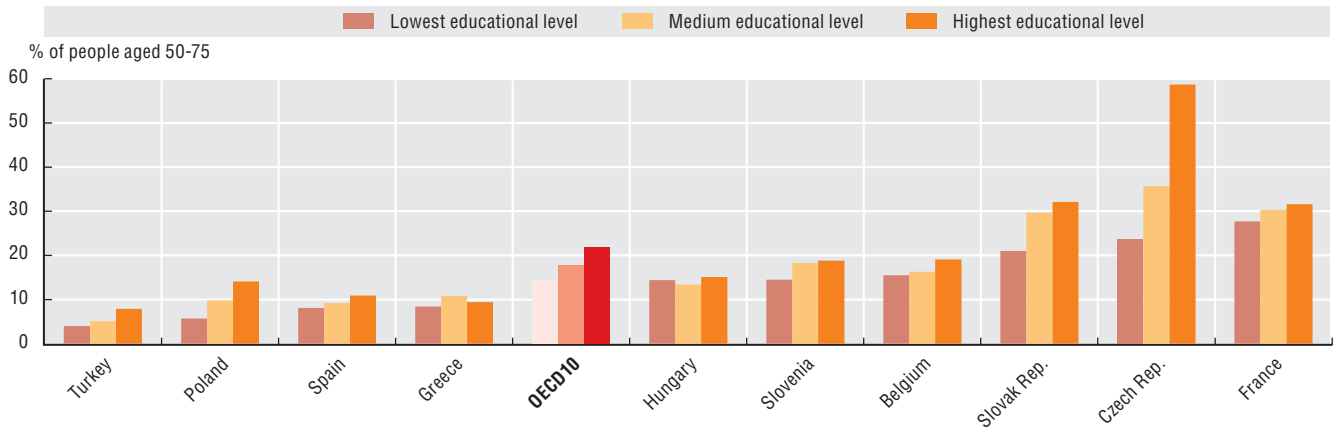
Note: The data source for some countries may be different to that used for reporting breast and cervical cancer screening in Chapter 5.

1. Visits in the past 12 months.

Source: Devaux and de Looper (2012).

StatLink <http://dx.doi.org/10.1787/888932918738>

6.6.3. Colorectal cancer screening once in lifetime by educational level, European countries, 2009 (or nearest year)



Source: Eurostat Statistics Database 2013.

StatLink <http://dx.doi.org/10.1787/888932918757>



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