

Breast cancer is the most prevalent form of cancer among women, with 367 000 new cases diagnosed each year in Europe (IARC, 2012). Risk factors that increase a person's chance of getting this disease include, but are not limited to, age, family history of breast cancer, oestrogen replacement therapy, lifestyle, nutrition and alcohol. Variation in breast cancer care across European countries is indicated by mammography screening rates in women aged 50-69 years, relative survival, and mortality rates.

European Guidelines (European Commission, 2006) promote a desirable breast cancer screening target of at least 75% of eligible women in European member states, but in 2010 only six countries had reached this target. There is considerable uniformity amongst national breast screening programmes, in terms of the target age group and recommended time interval between screens. Participation, however, continues to vary considerably across European countries, ranging from 8% in Romania and 16% in the Slovak Republic, to over 80% in Finland, Denmark, Austria and the Netherlands (Figure 4.7.1). This variation may, in part, be explained by programme longevity, with some countries having well established programmes and others commencing programmes more recently. However, screening rates fell in a number of countries in the past decade, including Finland, Ireland, Italy, the Netherlands, Norway and Iceland. Rates in Estonia and Czech Republic have increased substantially, although they remain below the EU average.

Breast cancer survival reflects advances in improved treatments as well as public health interventions to detect the disease early through screening programmes and greater awareness of the disease. The introduction of combined breast conserving surgery with local radiation and neoadjuvant therapy, for example, have increased survival as well as the quality of life of survivors. The availability and use of newer and more effective chemotherapy agents for metastatic breast cancer have also been shown to improve survival among women.

The relative five-year breast cancer survival has improved in many countries in recent periods (Figure 4.7.2), reaching over 80% in all EU countries except Poland. In part, this may be related to more limited access of care in Poland where there are fewer cancer care centres and radiotherapy facilities (OECD, 2013). Five-year survival for breast cancer has increased considerably in central and eastern European countries, where survival has historically been low, as well as in Ireland. Recent studies suggest that some of the differences in cancer survival could be due to variations in the implementation of screening programmes. In addition to well organised breast cancer screening programmes, a recent OECD report on cancer care showed that shorter waiting times and the provision of evidence-based best practice are also associated with improved survival in OECD countries. Developing comprehensive breast cancer control plans, setting national targets with a specified time frame,

having guidelines, using case management and having mechanisms for monitoring and quality assurance were found to be associated with improved breast cancer survival (OECD, 2013).

Mortality rates from breast cancer have declined in all EU member states over the past decade except for Bulgaria, Latvia and Croatia (Figure 4.7.3). The reduction in mortality rates reflects improvements in early detection and treatment of breast cancer and is also influenced by the incidence of the disease. Improvements were substantial in Austria, the Netherlands, the Czech Republic, as well as in Malta. Denmark also reported an important decline over the last decade, but its mortality rate was still the highest in 2011.

Definitions and comparability

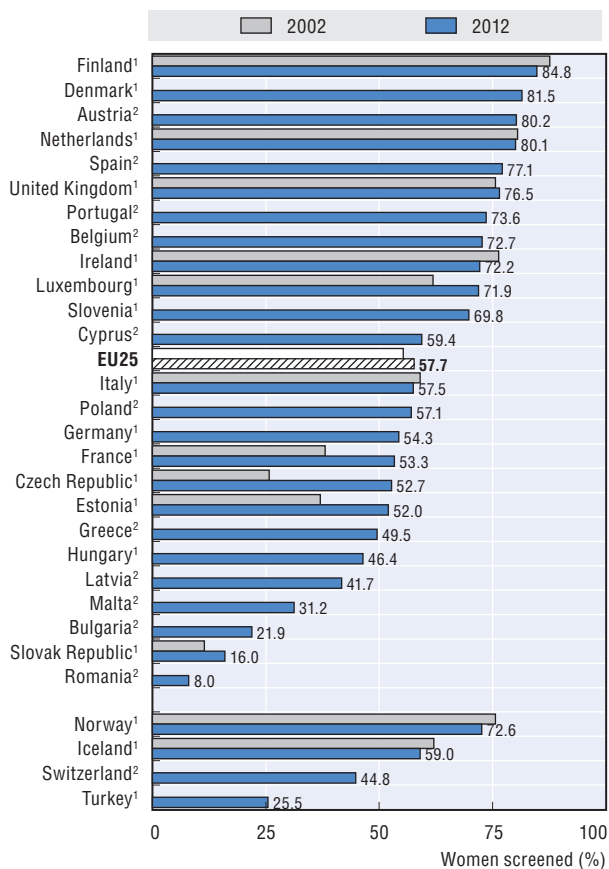
Mammography screening rates reflect the proportion of eligible women who are actually screened. As policies regarding target age groups and screening periodicity differ to some extent across countries, the rates are based on each country's specific policy. Some countries ascertain screening based on surveys and others based on encounter data, and this may influence results. Screening rates reported by member states are calculated from Health Interview Surveys on self-perception around preventive measures, which might correspond to different periods and sample across member states. Survey-based results may also be affected by recall bias. If a country has an organised programme, but women receive a screen outside of the programme, rates may also be underreported.

Survival is defined in Indicator 4.6 "Screening, survival and mortality for cervical cancer". See Indicator 1.5 "Mortality from cancer" for definition, source and methodology underlying the cancer mortality rates.

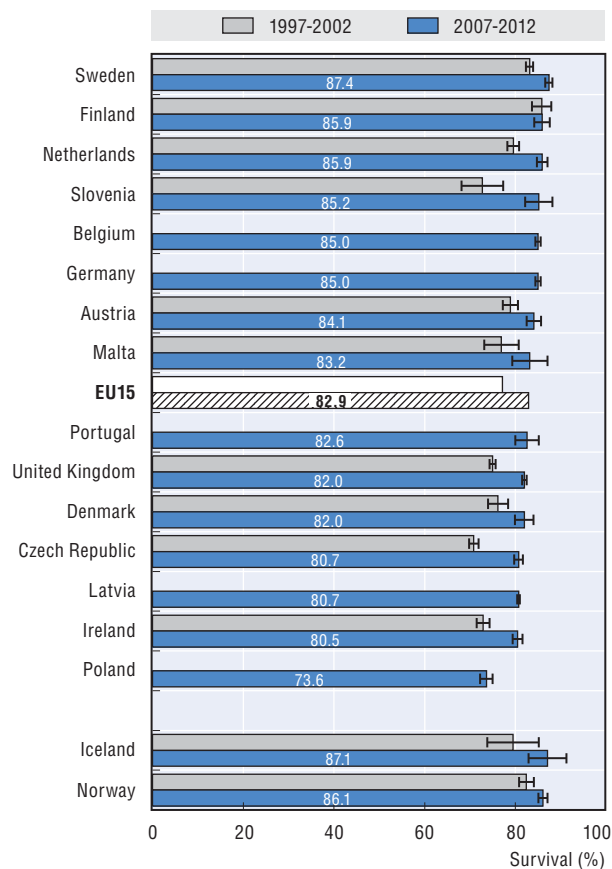
References

- European Commission (2006), *European Guidelines for Quality Assurance in Breast Cancer Screening and Diagnosis*, 4th edition, Luxembourg.
- IARC – International Agency for Research on Cancer (2012), *GLOBOCAN 2012: Cancer Fact Sheet*, available at: http://globoacan.iarc.fr/Pages/fact_sheets_cancer.aspx.
- OECD (2013), *Cancer Care: Assuring Quality to Improve Survival*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264181052-en>.

4.7.1. Mammography screening in women aged 50-69, 2002 to 2012 (or nearest year)



4.7.2. Breast cancer five-year relative survival, 1997-2002 and 2007-2012 (or nearest period)



1. Programme.

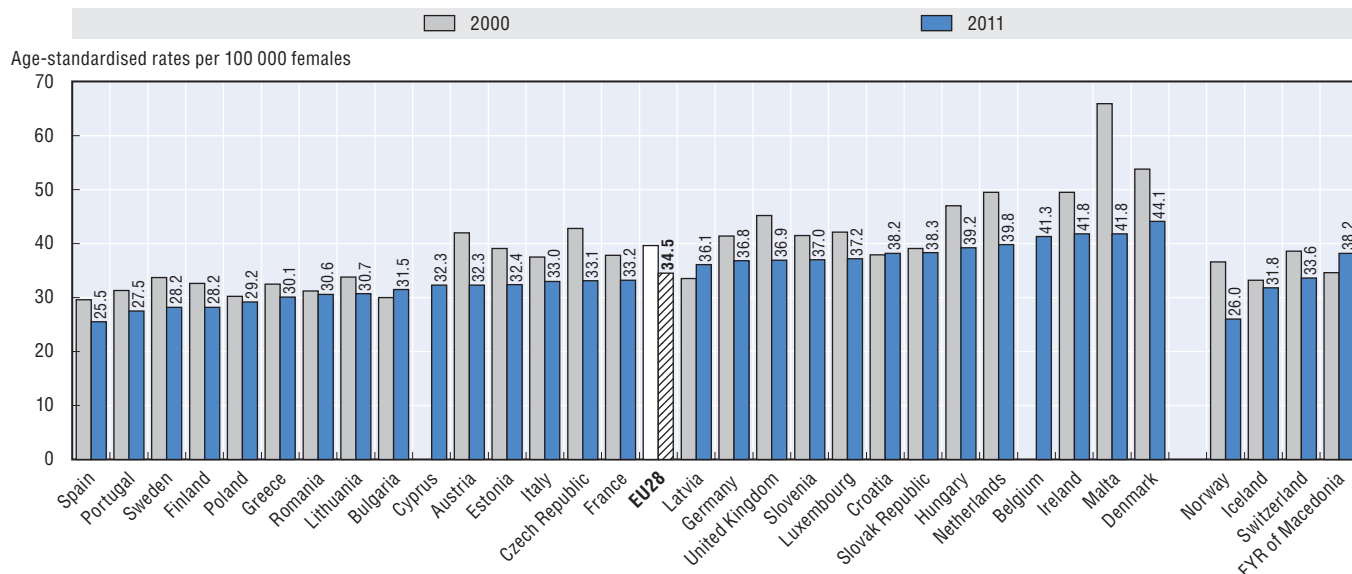
2. Survey.

Source: OECD Health Statistics 2014, <http://dx.doi.org/10.1787/health-data-en> completed with Eurostat Statistics Database for non-OECD countries.

Note: The 95% confidence intervals are represented by H.

Source: OECD Health Statistics 2014, <http://dx.doi.org/10.1787/health-data-en>.

4.7.3. Breast cancer mortality, females, 2000 to 2011



Source: Eurostat Statistics Database.

StatLink <http://dx.doi.org/10.1787/888933155729>



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