Breast cancer is the cancer with both the highest incidence and prevalence for women across OECD countries. One in nine women will have breast cancer at some point in their life. Risk factors that increase a person’s chance of getting this disease include age, family history of breast cancer, genetic predisposition, reproductive factors, oestrogen replacement therapy, and lifestyles including obesity, physical inactivity, diet and alcohol consumption.

Most OECD countries have adopted breast cancer screening programmes as an effective way for detecting the disease early (OECD, 2013). However, due to recent progress in treatment outcomes and concerns about false-positive results, over-diagnosis and overtreatment, breast cancer screening recommendations have been re-evaluated in recent years. Taking into account recent research findings, WHO recommends organised population-based mammography screening if women are able to make an informed decision based on the benefits and risks of mammography screening (WHO, 2014).

Screening rates range from less than 20% in Mexico to over 80% in a few countries including Sweden, Portugal, Denmark, Finland and Slovenia (Figure 6.33). Screening coverage increased substantially among countries with low rates a decade ago. Mexico had an increase of more than ten-fold, and Lithuania an almost four-fold increase. On the other hand, several countries that had the highest screening rates in the mid-2000s experienced some reductions, including Finland, the Netherlands, and the United States.

Breast cancer survival reflects early diagnosis as well as improved treatments. All OECD countries have attained five-year net breast cancer survival of 80% except Chile, the Slovak Republic, Poland and Estonia (Figure 6.34). Net survival of people with colon and rectal cancers is also low in these countries (see indicators on “Survival and mortality for colorectal cancer”).

Over the last decade, the five-year net breast cancer survival has improved in OECD countries. Net survival has increased considerably in some Central and Eastern European countries such as Estonia and the Czech Republic, although survival after breast cancer diagnosis is still below the OECD average. Improvements may be related to strengthening of cancer care governance in these countries. For instance, the Czech Republic intensified its effort to tackle the burden of breast cancer through the introduction of a screening programme and a National Cancer Control Programme in the early 2000s (OECD, 2014).

With respect to mortality rates, most OECD countries showed a decline over the past decade (Figure 6.35). The reduction is a reflection of improvements in early detection and treatment of breast cancer. Improvements were substantial in the Czech Republic and Denmark with a decline of over 20% in a decade but Denmark still has one of the highest rates. On the other hand, within the OECD, in Iceland and Korea, the mortality rate from breast cancer increased by more than 10% over the past decade.

In Iceland the mortality is the highest in the OECD while in Korea, it remains the lowest.

### Definition and comparability

Screening rates are based on surveys or encounter data, which may influence the results. Survey-based results may be affected by recall bias. Programme data are often calculated for monitoring national screening programmes and differences in target population and screening frequency may lead to variations in screening coverage across countries.

Five-year net survival is the cumulative probability that cancer patients survive their cancer for at least 5 years, after controlling for the risks of death from other causes. Net survival is expressed as a percentage. Net survival for patients diagnosed during 2000-2004 is based on a cohort approach, since all patients had been followed up for at least 5 years by the end of 2014. For patients diagnosed during 2010-2014, the period approach is used, which allows estimation of five-year survival, though 5 years of follow-up are not available for all patients. Cancer survival estimates are age-standardised with the International Cancer Survival Standard (ICSS) weights.

Data collection, quality control and analysis were performed centrally as part of the CONCORD programme, the global programme for the surveillance of cancer survival, led by the London School of Hygiene and Tropical Medicine (Allemani et al., 2015). In some countries, not all regional registries participated, but survival estimates from the CONCORD programme are considered the best available data from those countries for international comparisons. See indicator “Mortality from cancer” in Chapter 3 for definition, source and methodology underlying cancer mortality rates.

### References


6.33. Mammography screening in women aged 50-69 within the past 2 years, 2005 and 2015 (or nearest years)

![Screening, survival and mortality for breast cancer](image)

1. Programme.
2. Survey.
3. Three-year average.

StatLink: [http://dx.doi.org/10.1787/888933603963](http://dx.doi.org/10.1787/888933603963)

6.34. Breast cancer five-year net survival, 2000-2004 and 2010-2014

![Breast cancer five-year net survival](image)

Note: 95% confidence intervals have been calculated for all countries, represented by grey areas. Expected updates in the data may reduce the survival estimate for Costa Rica.
1. Data with 100% coverage of the national population.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

StatLink: [http://dx.doi.org/10.1787/888933603982](http://dx.doi.org/10.1787/888933603982)

6.35. Breast cancer mortality in women, 2005 and 2015 (or nearest years)

![Breast cancer mortality in women](image)

1. Three-year average.

StatLink: [http://dx.doi.org/10.1787/888933604001](http://dx.doi.org/10.1787/888933604001)