

## 6. ACCESS TO CARE

### 6.7. Inequalities in cancer screening

Cancer is the second most common cause of death in OECD countries, responsible for 27% of all deaths in 2006. Among women, breast cancer is the most common form, accounting for 30% or more of new cases each year and 16% of cancer deaths in 2006. Cervical cancer accounts for an additional 5% of new cases, and 3% of female cancer deaths (see Indicator 1.5 “Mortality from Cancer”).

The early detection of breast and cervical cancers through screening programmes has contributed significantly to increased survival rates and declines in mortality from these diseases, and many countries have opted to make screening widely available. In most countries, more than half of women in the target age groups for screening have had a recent mammogram, and pelvic exam or Pap smear (see Indicator 5.7 “Screening, survival and mortality for cervical cancer” and Indicator 5.8 “Screening, survival and mortality for breast cancer”).

Screening rates vary widely among women in different socio-economic groups in OECD countries (Figures 6.7.1 and 6.7.2). 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, 2009). Even in those countries where the practice is common, women in the lowest wealth quintiles are generally less likely to undergo screening (Gakidou et al., 2008; WHO, 2008b). There are exceptions, with women in the lowest wealth quintiles in Luxembourg and the Netherlands as likely to have had a mammogram as those in higher wealth quintiles. The same is true regarding cervical cancer screening in the Czech Republic, Italy and the United Kingdom.

Participation rates also vary by geographic regions (Figure 6.7.3). Some areas, such as the Northern Territory (Australia), and London (United Kingdom), exhibit significantly lower rates than do other regions within the country (AIHW, 2008a; NHSBSP, 2008). The reasons for this are varied. In geographically isolated regions, travelling distance and number of available screening facilities play a part. In inner urban areas, 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 preven-

tative services – are all important predictors of participation in screening.

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.

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.

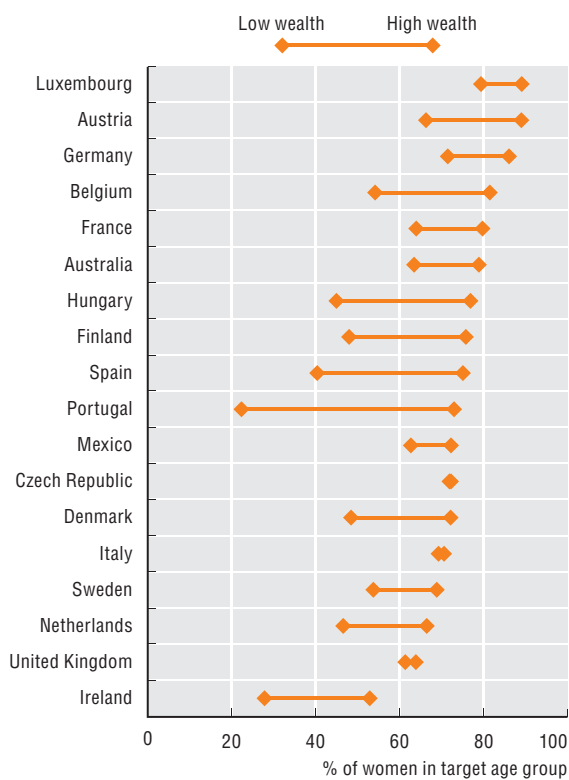
#### Definition and deviations

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.

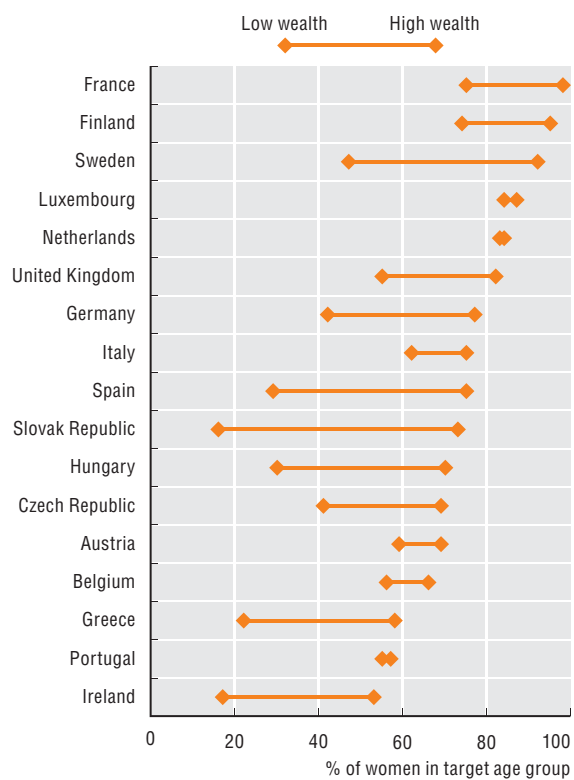
For this indicator, rates by wealth quintiles were derived from health surveys of women aged 25-64 years (cervical) and 50-69 years (breast) who reported that they had been screened in the three years prior to the survey. Screening estimates based on self-reported health surveys should be used cautiously, 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 selected OECD countries, by wealth quintile, 2002-04



### 6.7.2 Breast cancer screening in selected OECD countries, by wealth quintile, 2002-04



Note: The data source for some countries may be different to that used for reporting breast and cervical cancer screening in Chapter 5. Since these studies were conducted, a number of countries, including Ireland, have introduced national population-based screening.

Source: Gakidou et al. (2008).

Source: WHO (2008b).

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



Source: AIHW (2008a); IMA-AIM (2009); PHAC (2008); ONS (2008); Taylor et al. (2008); NHSBSP (2008).

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