Survival for other major cancers

Lung cancer is the main cause of cancer death for both men and women in OECD countries (see indicator "Cancer incidence and mortality" in Chapter 3). The main risk factors for lung cancer are smoking; passive smoking; exposure to radon and/or certain chemicals and substances such as arsenic, asbestos, beryllium, cadmium, coal and coke fumes, silica and nickel; air pollution; and a family history of lung cancer. Following the declining trend of smoking in recent decades (see indicator "Smoking among adults" in Chapter 4), incidence rates of lung cancer have declined across OECD countries. However, together with ischaemic heart disease, road accidents and alcohol-related deaths, lung cancer continues to be one of the main causes of preventable mortality in OECD countries.

Compared to other cancers such as breast and colorectal cancers (see indicators "Breast cancer outcomes" and "Screening and survival for colorectal cancer"), lung cancer continues to be associated with very poor survival. On average in OECD countries, for patients diagnosed with lung cancer, the cumulative probability of surviving their cancer for at least five years is less than 20% (Figure 6.35). Across OECD countries, age-standardised five-year net survival ranged from 32.9% in Japan to 4.6% in Chile in 2010-14, and is low in Lithuania, the Czech Republic, the Slovak Republic, Finland and the United Kingdom. In recent years, age-standardised five-year net survival has increased substantially in Denmark, Ireland, Korea and France. Lung cancer screening is not common in OECD countries, but in Japan, an annual chest X-ray is recommended for people aged 40 and over, and sputum cytology is also recommended for smokers aged 50 and over who have smoked more than 600 cigarettes over their lifetime (OECD, 2019[1]) while the English National Health Service is launching its Targeted Lung Health Checks Programme.

Stomach cancer is another commonly diagnosed cancer and fifth highest cause of cancer death in OECD countries (GLOBOCAN, 2018[2]). The main risk factors for stomach cancer include age, gender, smoking, *Helicobacter pylori* infection, diet, genetic predisposition, pernicious anaemia, peptic stomach ulcer and stomach surgery. WHO recommends that countries with a high burden of stomach cancer should explore the introduction of population-based *H. pylori* screening and treatment based on local contexts, such as health priorities and cost–effectiveness (IARC, 2014[3]). Incidence of stomach cancer is high in some OECD countries, such as Chile, Korea and Japan; in these countries, stomach cancer screening is available for people in certain age groups (OECD, 2019[1]; OECD, 2019[4]).

Age-standardised five-year net survival for stomach cancer is particularly high in Korea and Japan (60% or higher), while it ranges between 20% and 40% in other OECD countries (Figure 6.36). Net survival is low in Chile, suggesting that there is room to improve stomach cancer screening strategies through stronger stakeholder engagement, better communication strategies to increase public awareness and better access to cancer screening (OECD, 2019[4]).

Leukaemia is the most common cancer among children aged 0-14; it accounts for over 30% of all cancers diagnosed in children worldwide (GLOBOCAN, 2018[2]). The causes of leukaemia are not well known, but some known risk factors include inherited factors, such as Down syndrome and a family history of leukaemia, and non-inherited factors, such as exposure to ionising radiation. There are different types of leukaemia but about three-quarters of cases among children are acute lymphoblastic leukaemia (ALL). The prognosis for leukaemia depends on various factors including age, initial white blood cell count, gender, initial reaction to induction treatment and type of leukaemia. Children with acute leukaemia who are free of the disease for five years are considered to have been cured, as remission after five years is rare.

Age-standardised five-year net survival for ALL among children was on average 83.7% during 2010-14 in OECD countries (Figure 6.37), and it improved over the period, mainly due to progress in chemotherapy and stem cell transplantation technology. However, countries have not benefited equally from progress in medical technologies. Survival estimates are high in Finland and Denmark but low in Chile and Mexico. Chile is making progress in improving access and quality of care for childhood cancer – for example, by including access to care for childhood cancer as part of its guaranteed health care coverage plan (OECD, 2019[4]).

Definition and comparability

Net survival is defined in indicator "Screening and survival for breast cancer".

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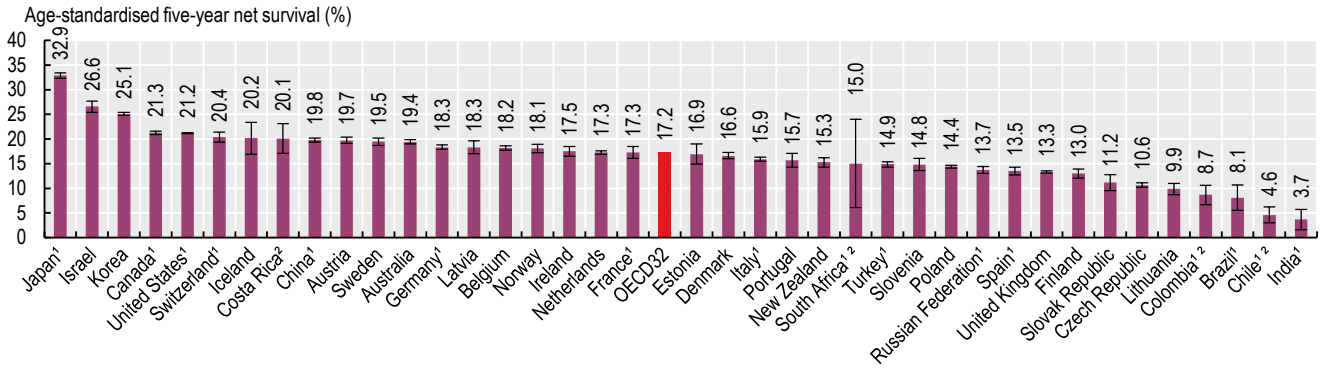
[3] IARC (2014), *Helicobacter pylori Eradication as a Strategy for Preventing Gastric Cancer*.

[4] OECD (2019), *OECD Reviews of Public Health: Chile: A Healthier Tomorrow*, OECD Publishing, Paris, *https://dx.doi.org/10.1787/9789264309593-en*.

[1] OECD (2019), *OECD Reviews of Public Health: Japan: A Healthier Tomorrow*, OECD Publishing, Paris, *https://dx.doi.org/10.1787/9789264311602-en*.

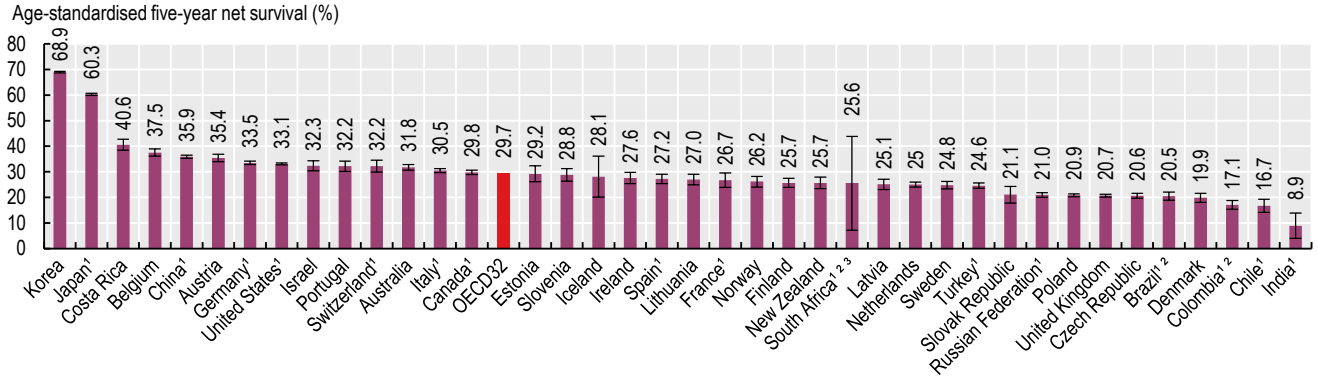
Figure 6.35. **Lung cancer five-year net survival, 2010-14**



Note: H line shows 95% confidence intervals.1. Data represent coverage of less than 100% of the national population. 2. Survival estimates are considered less reliable: see Allemani et al. (2018) for more information.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

StatLink https://doi.org/10.1787/888934016607

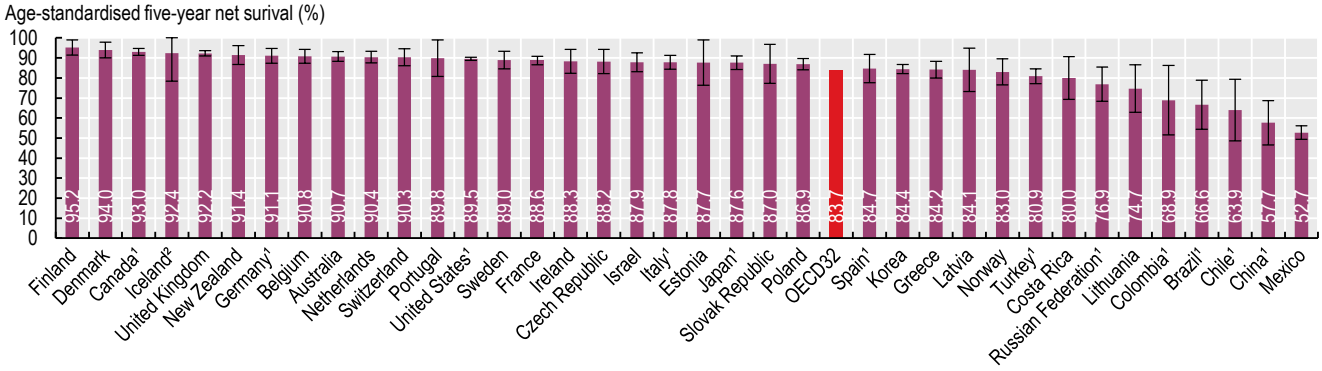
Figure 6.36. **Stomach cancer five-year net survival, 2010-14**



Note: H line shows 95% confidence intervals. 1. Data represent coverage of less than 100% of the national population. 2. Survival estimates are considered less reliable. 3. Survival estimates are not age-standardised.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

StatLink https://doi.org/10.1787/888934016626

Figure 6.37. **Childhood acute lymphoblastic leukaemia five-year net survival, 2010-14**



Note: H line shows 95% confidence intervals. 1. Data represent coverage of less than 100% of the national population. 2. Survival estimates are not age-standardised.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

StatLink https://doi.org/10.1787/888934016645