

Cervical cancer is largely preventable. Screening by regular pelvic exam and pap smears can identify premalignant lesions, which can be effectively treated before the occurrence of the cancer. Regular screening also increases the probability of diagnosing early stages of the cancer and improving survival. Consequently, the Council of the European Union and the European Commission promote population based cancer screening programmes among member states (European Union, 2003; European Commission, 2008c) and European countries have instituted screening programmes with specific periodicity and target groups. In addition, promising cancer preventing vaccines have been developed based on the discovery that cervical cancer is caused by sexual transmission of certain forms of the Human Papilloma Virus. The efficacy and safety of those vaccines is now well established, but debates about cost-effectiveness and the implications of vaccination programmes for teenagers for a sexually transmitted disease continue in a number of countries (Huang, 2008).

Screening rates vary widely across countries with Austria, Norway, the United Kingdom and Sweden achieving coverage of around 80% of the target population (Figure 3.12.1). Some countries with very low screening rates, like Turkey and Latvia, did not have uniform national screening programme as of 2008; the low rates reflect local programmes or opportunistic screening. Screening rates in several countries declined slightly between 2000 and 2008.

Relative survival rates are commonly used to track progress in treating cancer over time as they reflect both how early the cancer was detected and the effectiveness of the treatment provided. Survival rates have been used to compare European countries in the EURO CARE study, in comparisons between European countries and the United States (Gatta et al., 2000), and in national reporting activities in many countries. Nearly all countries recorded five-year relative survival rates above 60% for the period 2002-07. The rates ranged from 71% in Iceland to 50% in Poland (Figure 3.12.2). Over the periods 1997-2002 and 2002-07, the five-year relative rates improved in most countries, although in all instances the increase is not statistically significant.

Mortality rates alone are not sufficient to draw timely inferences about quality of care, but current

cancer mortality rates reflect the effect of care in past years and changes in incidence. Mortality rates for cervical cancer are higher in eastern European countries (Figure 3.12.3). Between 1998 and 2008 the rates declined for most European countries, with larger improvements for Iceland, Denmark, Slovenia, the Czech Republic and Norway.

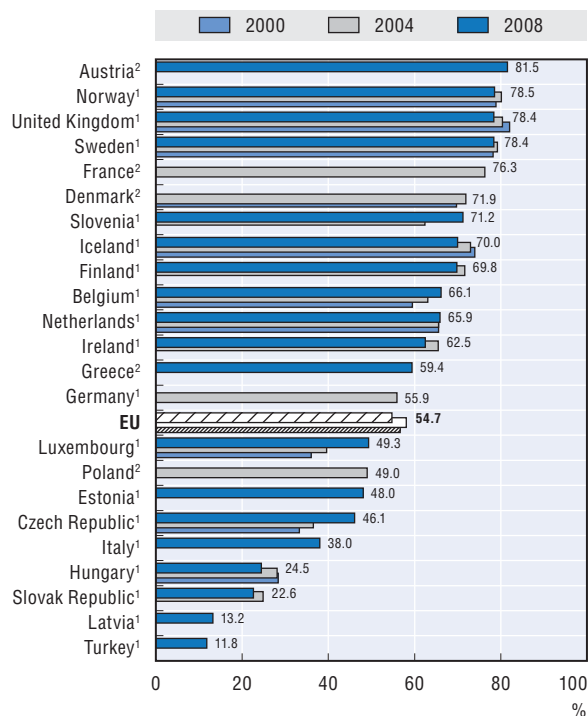
#### Definitions and deviations

Screening rates for cervical cancer reflect the proportion of women who are eligible for a screening test and actually receive the test. As policies regarding screening periodicity differ across countries, the rates are based on each country's specific policy. An important consideration is that some countries ascertain screening based on surveys and other based on encounter data, which may influence the results. If a country has an organised screening programme, but women receive care outside the programme, rates may be underreported. Survey-based results may also underestimate the rates due to recall bias.

Relative cancer survival rates reflect the proportion of patients with a certain type of cancer who are still alive after a specified time period (commonly five years) compared to those still alive in absence of the disease. Relative survival rates capture the excess mortality that can be attributed to the diagnosis. For example, a relative survival rate of 80% does not mean that 80% of the cancer patients are still alive after five years, but that 80% of the patients that were expected to be alive after five years, given their age at diagnosis, are in fact still alive. All the survival rates presented here have been age-standardised using the International Cancer Survival Standard (ICSS) population. The survival rates are not adjusted for tumor stage at diagnosis, hampering assessment of the relative impact of early detection and better treatment.

The definition of cancer mortality rates is provided under Indicator 1.5.

**3.12.1. Cervical cancer screening, percentage of women screened aged 20-69, 2000 to 2008 (or nearest year)**

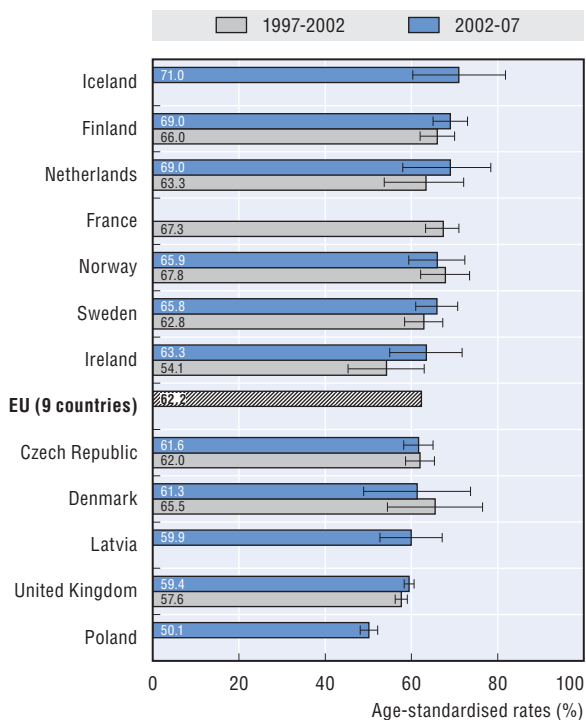


1. Programme.
2. Survey.

Source: OECD Health Data 2010.

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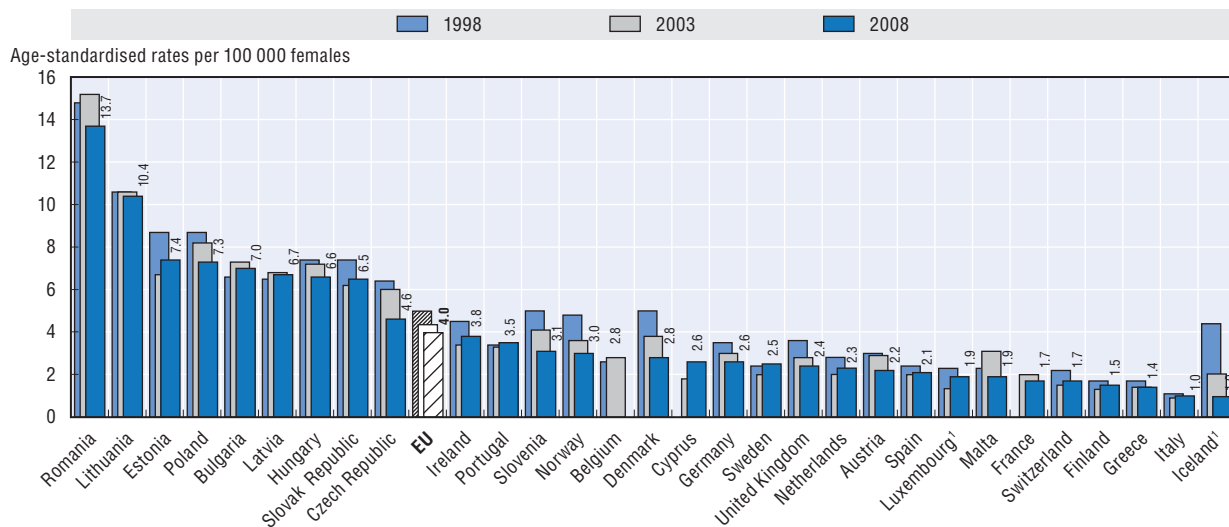
**3.12.2. Cervical cancer five-year relative survival rate, 1997-2002 and 2002-07 (or nearest period)**



Source: OECD Health Care Quality Indicators Data 2009 (survival rates are age-standardised to the International Cancer Survival Standards population and 95% confidence intervals are represented by I-I).

StatLink <http://dx.doi.org/10.1787/888932337224>

**3.12.3. Cervical cancer mortality, females, 1998 to 2008 (or nearest year available)**



1. Rates for Iceland and Luxembourg are based on a three-year average to reduce year-to-year variation due to small numbers.

Source: Eurostat Statistics Database (mortality data are age-standardised to the WHO European standard population).

StatLink <http://dx.doi.org/10.1787/888932337243>



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