Survival for other major cancers

In order to improve poor cancer outcomes (see indicator "Main causes of mortality" in Chapter 3), many OECD countries have broadened their efforts in cancer control. For example, the EU's renewed political commitment is articulated in its Europe's Beating Cancer Plan. However, the COVID-19 pandemic has disrupted primary and secondary prevention, diagnosis and treatment for cancers to a variable extent. OECD countries may therefore find it difficult to continue to improve cancer outcomes.

Invasive cervical cancer is preventable if pre-cancerous or pre-invasive changes are detected and treated before progression occurs. Over half of OECD countries have population-based cervical cancer screening programmes (OECD, 2013[43]; European Commission, 2017[50]). Most OECD countries also have human papillomavirus (HPV) vaccination programmes, although vaccination coverage ranges widely: between 1% of women in the target age group in Japan and 99% in Mexico (WHO, 2021[51]). During 2010-14, age-standardised five-year net survival for cervical cancer ranged from 53.9% in Latvia to 77.3% in Korea (Figure 6.35). The incidence of invasive cancer may be lower in countries – such as the United States – where there is intensive screening activity, which can detect and remove in-situ cancers and slower-growing invasive tumours. Women who are diagnosed with cervical cancer despite screening tend to have more aggressive tumours that are more difficult to treat, leading to lower survival rates for all stages combined.

Cervical cancer screening uptake and HPV vaccination coverage were sometimes adversely affected by the COVID-19 pandemic, as were breast cancer screening and childhood vaccination programmes (see indicators "Routine vaccinations" and "Breast cancer care"). In Slovenia, for example, less screening, diagnosis and treatment was provided in 2020 than in the previous three years, although the time from diagnosis to treatment and the time to laboratory test were maintained at a similar level (Ivanuš et al., 2021[52]). Timely detection of changes in access to cervical cancer care and the quality of care requires recording and monitoring of data on the stage of disease at the time of diagnosis, together with case loads and waiting times.

Melanoma of the skin is mainly caused by exposure to ultraviolet radiation, and people with a low level of skin pigmentation, a family history of the disease or poor immune function are at higher risk. Incidence rates vary widely, from below 1 per 100 000 population per year in Japan and Korea to over 30 per 100 000 population per year in Australia and New Zealand (GLOBOCAN, 2020[53]). Age-standardised five-year net survival ranges from under 50% in the People's Republic of China (China) to over 93% in Switzerland and Germany (Figure 6.36). In countries with high incidence rates, such as Australia, Denmark, New Zealand, the United Kingdom and the United States, public health efforts have focused on raising awareness of the importance of recognition of the early symptoms of melanoma, helping to achieve the highest levels of survival among OECD countries. In some countries, a less favourable distribution of histologic sub-types – such as a higher proportion of nodular and acral lentiginous melanomas, which have a poorer prognosis – may also help to explain some of the international differences in survival. This requires health policies to target specific populations to improve awareness, early diagnosis and access to treatment.

In recent years, net survival from melanoma of the skin has increased in most OECD countries. The introduction of immunotherapies and targeted treatments for metastatic melanoma has led to unprecedented clinical benefit, and may have contributed to improving short-term survival, as shown in a recent population-based study in the United States (Di Carlo et al., 2020[54]). During the initial phase of the COVID-19 pandemic, in Ontario (Canada) and Italy, for example, skin biopsies became less common. In Italy, the stage distribution worsened, but treatment for patients at an advanced stage was managed promptly (Intergruppo Melanoma Italiano, 2021[55]).

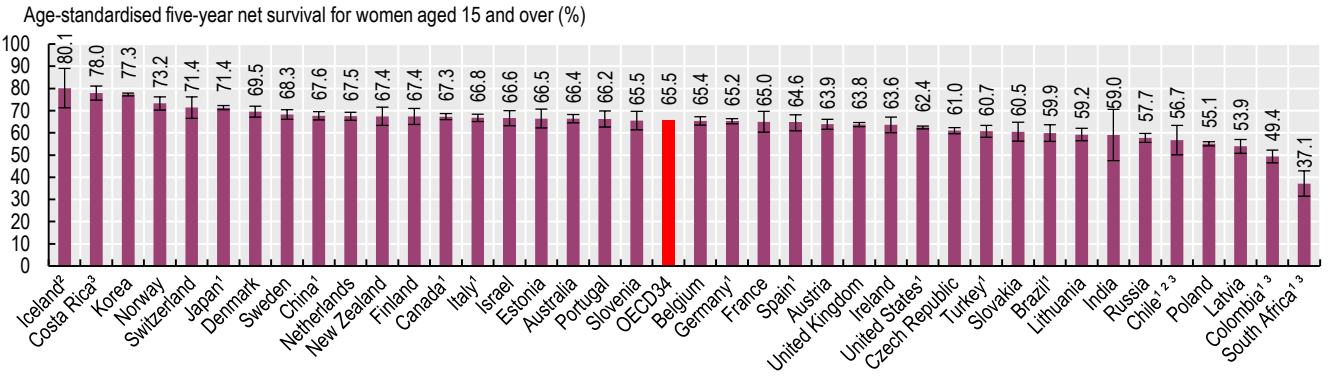
Oesophageal cancer has the sixth highest incidence rates and fifth highest mortality rates in OECD countries. The risk is higher among men, and among people who smoke and drink alcohol. Age-standardised five-year net survival for oesophageal cancer has improved since the early 2000s. For adults diagnosed during 2010-14, the highest five-year net survival was in Korea (31.3%) and Japan (36.0%), and the lowest in Estonia (5.4%) and Lithuania (5.6%) (Figure 6.37). Countries with population-based gastric screening programmes, such as Korea and Japan, have experienced massive improvements over the past few decades, and now have the highest levels of oesophageal cancer survival worldwide.

Definition and comparability

Five-year net survival is the cumulative probability that cancer patients survive their cancer for at least five years following diagnosis, after controlling for the risks of death from other causes, and taking into account that competing risks of deaths are higher among elderly people. The period approach is used to allow estimation of five-year survival when five years of follow-up are not available. Cancer survival estimates are age-standardised with the International Cancer Survival Standard weights.

Quality control and analysis for age-standardised five-year net survival were performed centrally as part of CONCORD, the global programme for the surveillance of cancer survival, led by the London School of Hygiene and Tropical Medicine (Allemani et al., 2018[48]).

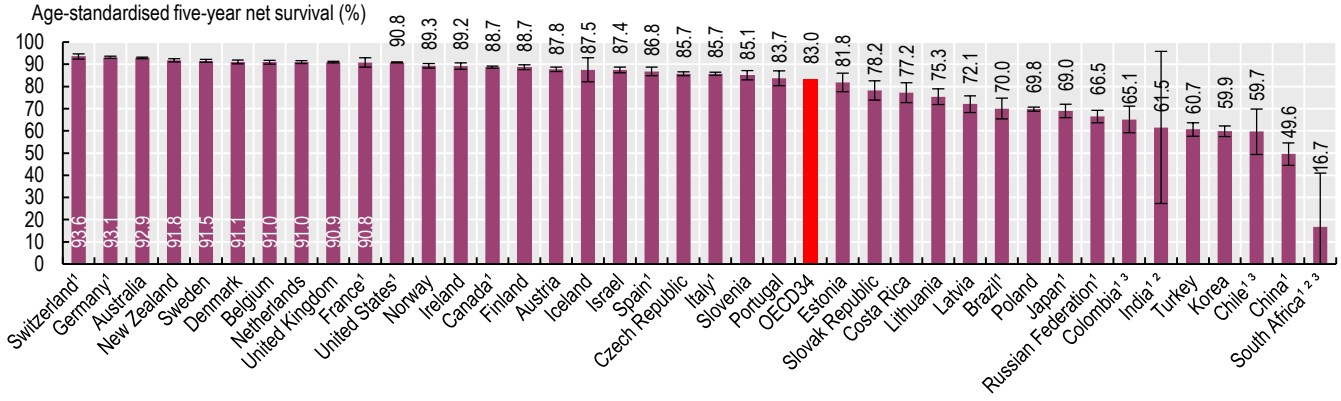
Figure 6.35. **Cervical cancer five-year net survival, 2010-14**



Note: H lines show 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[48]) for more information. 3. Survival estimates are not age-standardised.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

StatLink https://stat.link/fvbu2r

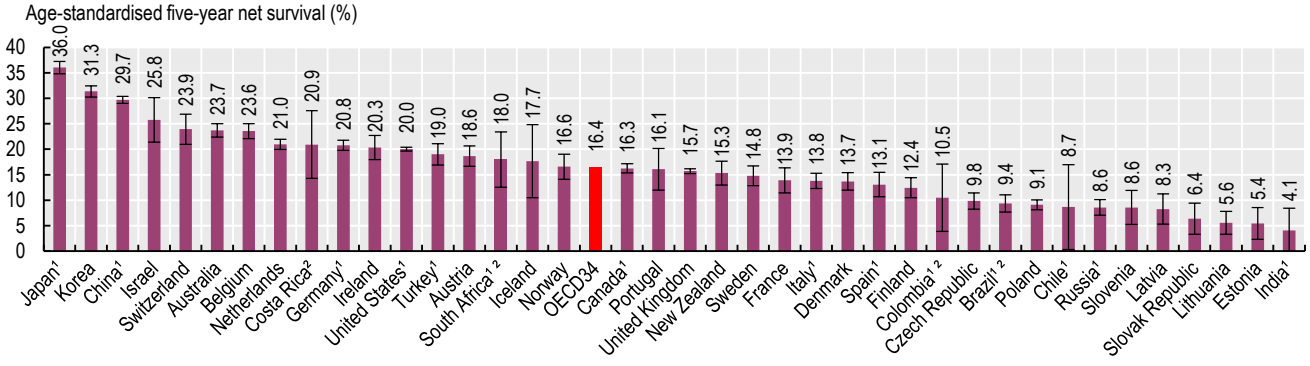
Figure 6.36. **Melanoma five-year net survival, 2010-14**



Note: H lines show 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[48]) for more information. 3. Survival estimates are not age-standardised.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

StatLink https://stat.link/2isbg9

Figure 6.37. **Oesophageal cancer five-year net survival, 2010-14**



Note: H lines show 95% confidence intervals. 1. Data represent coverage of less than 100% of the national population. 2. Survival estimates are considered less reliable.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

StatLink https://stat.link/ueybw7