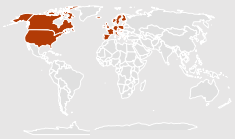


Women's cancers in Western countries

Total women (2024): 449 million
Life expectancy (2023): ~84 years
Women's cancer cases (2022): 375,529
Women's cancer deaths (2022): 253,997
Sources: World Bank, IARC

Disease burden

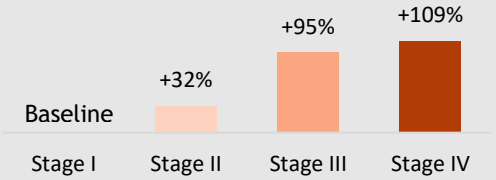
Breast cancer	Most common cancer among women, accounting for ~30% of new cases and ~16% of cancer deaths. Five-year survival approaches ~90% in many high-income countries (HICs), such as US, Canada, and much of Western Europe.
Cervical cancer	Accounts for ~2% of new cases and ~2% of cancer deaths among women. Five-year survival exceeds ~70% in the Nordic countries.
Ovarian cancer	Although it represents ~3% of new cases, it accounts for ~5% of cancer deaths among women. Five-year survival is below 50% in most HICs.
Endometrial cancer	It represents ~6% of new cases and ~3% of cancer deaths among women. Evidence from the Nordics and the US shows >80% five-year survival but little or no progress over ~20–25 years; in the US, five-year survival declined from 1975–77 to 2015–21.

Economic burden

Direct costs

Early detection, timely diagnosis, and effective treatment reduce costs. For example, a pooled global estimate (including studies from US, Portugal, Italy, Canada, UK, France) show that breast cancer treatment costs are ~109% higher in stage IV than in stage I.

Global breast cancer treatment costs



Indirect costs

There is limited region-specific, comparable economic data, but available evidence shows substantial indirect costs from lost productivity. In HICs, indirect costs compose 32% to 70% of the total economic burden of women's cancers.

The case for investing in women's cancers

High returns

- Scaling HPV vaccination and screening to WHO targets delivers per-capita savings of US$12.9–22.3 in Germany, Austria, and France, and US$5.5–6.3 in Poland and the Netherlands.
- In Sweden, comprehensive breast cancer treatment was estimated to return EUR 4.9 for every EUR 1 invested.
- In Switzerland, fiscal analysis estimates ~75% of the additional costs of immunotherapy + chemotherapy (for triple-negative breast cancer) are offset by higher tax revenue.

Rising incidence in working ages

- In many high-income countries, breast cancer in women under 50 is increasing. In the US, uterine cancer under 50 grew from 4.3 to 6.1 cases per 100,000 (1990–2021). While only ~6% of women's cancer cases occur <40 years in Europe and Northern America, these trends concentrate the burden in prime working years (20–49), magnifying productivity losses and caregiver impacts.

Strategic value of early investment

- Prevention through HPV vaccination requires decades before benefits fully emerge in terms of cancer reduction, but immediate benefits include preventing genital warts and precancerous lesions.
- Screening and early treatment lead to significant short- and medium-term cost savings, avoiding costly late-stage interventions.

Evidence gap

- Investment cases overwhelmingly focus on breast and cervical cancer, while endometrial and ovarian cancer are under-studied.
- In Europe, only ~5% of breast-cancer research funding goes to metastatic breast cancer, despite its high unmet need and poor prognosis.

Recommendations

Foundational enablers for women's cancer policy include universal health coverage, gender equity, a well-trained workforce, and robust data systems. Building on these foundations, Western HICs should:

Advocate for women's cancers as a health priority

Strengthen and streamline cancer care delivery & workforce capacity

Focus on prevention and early detection efforts

Leverage innovation across the women's cancer care continuum

Prevention challenges

- **HPV vaccination coverage gaps**: Most Western countries remain below the 90% WHO target (HIC average ~56%). Final-dose coverage sits at ~45–55% in several major EU countries (e.g., France, Germany, Italy), with only a few exceptions reaching ~90% (e.g., Iceland, Norway, Portugal). Despite political commitments and gender-neutral rollouts, uptake is suboptimal, hampered by low public confidence, patchy reminder/recall systems, and data gaps.
- **Underuse and inequities in genetic testing/counseling**: Family history–based testing misses ~50% of BRCA carriers; in the US, an estimated ~70% of carriers with cancer and ~95% of unaffected carriers remain undiagnosed. Genetic counseling faces regulatory, integration, and access challenges.
- **Rising overweight/obesity rates**: More and more women are overweight/obese, which are important risk factors for breast, ovarian, and uterine cancers.

Opportunities

- Gender-neutral HPV vaccination and catch-up programs
- School- & pharmacy-based HPV vaccination
- Population-based genetic testing
- New prevention strategies for gynecologic cancers

Detection and screening challenges

- **Population-based screening programs for breast and cervical cancer exist, but reach is still uneven**: Breast and cervical screening programs are widespread, yet coverage gaps persist due to system barriers (costs/co-pays in some settings, opportunistic models like in the US), stigma, limited health literacy, and logistical hurdles. Several Western countries only recently scaled organized cervical screening.
- **Provider/system factors delay diagnosis**: Examples include slower fast-track referrals for younger women with uterine cancer in England, plus missed counseling opportunities in primary care.
- **Fear, stigma, and exam discomfort suppress help-seeking**: These barriers are documented also in the US, affecting timely evaluation of symptoms and uptake of gynecologic exams.
- **Equity and administrative gaps**: Migrant and unregistered populations can be excluded from invitation systems (e.g., in the Netherlands), leading to missed screenings and later-stage presentation.
- **Obesity influences access and uptake**: In HICs, obesity is linked to delayed care-seeking (e.g., in Canada) and lower cervical screening participation.

Opportunities

- Mobile screening
- HPV self-sampling
- Patient navigation
- Integration of maternal health programs with screening programs
- Leverage trusted voices

Success story: **Slovenia** significantly reduced cervical cancer incidence by establishing a centralized, population-based screening program called ZORA. ZORA integrates a cervical cancer screening registry, centralized and automated invitations for first-time screeners, and standardized triage algorithms across public and private clinics.

Diagnosis challenges

- **Low availability of gynecologists**: In some Western countries (e.g., Finland, Canada, Ireland), there are <10 per 100,000 (OECD avg ~17), leading to longer waits and delayed diagnosis.
- **Low availability of pathologists**: Shortages strain turnaround times; in the UK, only 3% of departments reported adequate staffing and 78% had unfilled consultant posts, with an aging workforce compounding gaps.
- **Treatment start before full diagnosis**: Unpublished market research from 2021 indicated that in countries like France and the US, approximately 20–25% of patients with non-metastatic triple-negative breast cancer were taken directly to surgery without full assessment of their ER/PR/HER2 status. Also a 2023 population-based study from the US found that 4.7% of invasive breast cancers lacked complete receptor information at diagnosis, with the likelihood of missing data being higher among African American, among older patients, and among those with advanced disease or living in rural areas
- **No/partial reimbursement of biomarker testing**: Fewer than half of OECD countries automatically reimburse companion diagnostics with the matched medicine; Canada, France, Spain require separate or regional decisions, causing delays and out-of-pocket costs.

Opportunities

- Task-shifting in diagnostics by AI
- Scaling diagnosis with telemedicine and telepathology
- New molecular classifications
- AI prediction of biomarker status
- Gender-sensitive diagnosis

Treatment challenges

- **Shortage of oncologists and gynecologic oncologists**: Capacity is strained in many Western countries with, e.g., UK services reporting notable gaps and the US projecting a >2,300 oncologist shortfall by 2025, with rural maldistribution worsening waits and non-specialist care. Limited access to gynecologic oncologists persists despite evidence of better outcomes with subspecialist treatment.
- **High copayments and deductibles in the US:** Unlike most Western countries with strong financial protection, many insured US citizens still face substantial copays/deductibles, which drive financial distress and contribute to delayed treatment, regimen modifications, nonadherence, and discontinuation, with lower-income patients most affected.
- **Delayed reimbursement of new medicines**: In Western Europe, time from EMA approval to public reimbursement commonly exceeds 1 year, slowing access to innovations.
- **Few oncofertility options**: Despite availability (and partial coverage in some systems), uptake is low; fertility counseling is inconsistent (~21% in ovarian to ~71% in breast), with timing at the first oncology visit a key barrier.

Opportunities

- Minimally invasive surgeries
- More efficient use of radiation therapy
- New cancer medicines
- Link accessibility of medicines to clinical benefit
- Patient-centered rehabilitation pathways
- Gender-sensitive care