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Review

A cross-national comparative study on the influence of individual life course factors on mammography screening

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ABSTRACT

Objectives: Drawing on insights from the life course perspective, the aim of this paper is to gain a better understanding of persistent socioeconomic inequalities related to the uptake of mammography screening in 13 European countries. We examine whether these inequalities originate in childhood and relate them to the history and progression of each country's screening programs.

Methods: Retrospective data from the third wave of the Survey of Health, Ageing and Retirement (SHARELIFE) is analyzed by means of event-history analyses to examine the role of childhood preventive health behavior on mammography screening initiation. The results are framed within the context of policy developments concerning mammography screening in each of the separate European countries.

Results: Childhood preventive health care behavior predicts mammography screening in 9 of the 13 countries after conventional measurements of socioeconomic position in childhood and adulthood are accounted for. Net effects of education and income are still found for respectively 6 and 7 countries, but in about half of these countries national screening programs are able to reduce the social gradient. Very strong cohort and period effects are found for every country.

Conclusions: In a substantial number of the European countries, socioeconomic inequalities in preventive health behavior originate in childhood, which point to the deeply rooted nature of these inequalities. A long-term perspective is essential to further unravel how health policies can reduce or eliminate these persistent inequalities.

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1. Introduction

Breast cancer is the most frequently diagnosed form of cancer among European women, totaling some 332,800

cases in 2008 and accounting for 30% of all cancer diagnoses in the EU-27 countries [1]. It is the leading cause of female death from cancer, with an estimated mortality rate of 16.7% [2]. Breast cancer will remain an important public health issue in the future, with more women likely to be affected due to the aging population [3]. As risk factors for breast cancer are either difficult to control (such as those linked with reproduction) or not well understood [4,5], secondary prevention, through mammography screening, is relied on to detect breast cancer at an early stage in order to improve disease prognosis [6]. Most European countries have followed the recommendations by the

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European Union (OJ C 68E, 2004) and the World Health Organization (WHO) [7], and have introduced national screening programs [8,9]. Participation has increased, especially in countries with national population-based and longstanding programs [4,10], but it remains strongly inversely associated with socioeconomic position (SEP) in many European countries [5,6,11–17].

To date, we are still some way from understanding the underlying mechanisms that drive these persistent socioeconomic inequalities, which leaves many policymakers frustrated. We try to move the debate forward by taking a long-term perspective and focusing on the origins of these inequalities. Central to the discussion is the role of the family in the formation of preventive health behavior and the (re)production of social inequalities. Socialization into healthy behaviors starts when children observe and learn from their parents' relevant attitudes, beliefs, and values [18,19]. Hence, it is contended that norms regarding healthy behavior are conditioned by the socioeconomic context in childhood [20]. Health sociologists have argued that from the earliest days of life, individuals accumulate 'cultural health capital', a form of cultural capital in Bourdieu's view [21], which is used to lead healthy lives [22,23]. According to Bourdieu [21], the hereditary transmission of cultural capital is a subtle and well-hidden process, even more so than other forms of capital. Learning in early life will give rise to dispositions that are durable, habitual and might exist beyond conscious acts [24]. This implies that not every use of available resources, including cultural health capital, is as conscious and rational as traditional models of health behavior assume [22,23].

Two studies provide initial empirical support for this theoretical contention and show that parents do indeed pass on advantages to their children. In Belgium, preventive health care habits in childhood, as a proxy for cultural health capital, seem to be a predictor for mammography screening many years later in life, even after controlling for conventional measurements of childhood and adulthood socioeconomic position [25]. Furthermore, the second study shows that childhood is, in life course epidemiological terms, a 'critical period' for preventive health behavior. For Belgium, childhood dental check-ups predict mammography screening independently from, and on top of, dental check-ups during the rest of adult life [26]. Now, are these results confined to the Belgian context or can these childhood disadvantages be overcome in other European countries? A cross-national comparative approach can yield further insights into how mammography screening practices are embedded within the institutional context of a country's health care system and mammography screening policies, particularly in light of the large variation in the organizational characteristics of screening programs in Europe [8–10].

To date, eight studies have addressed cross-national differences concerning socioeconomic inequalities in mammography screening practices in Europe. All eight can largely be divided into three groups according to the empirical strategy used. First, there are three studies that included separate analyses per European country [5,17,27]. They show that adulthood socioeconomic inequalities

persist, but are generally lower in countries with national screening programs than in countries with opportunistic screening. Second, Walsh et al. [28] reached the same conclusion in their study, but acknowledged that dividing the EU-15 countries into two samples (opportunistic versus population-based programs) might be an overly crude distinction. Third, Carrieri and Wübker [29] employ the regional variation within European countries in terms of the existence and the targeted age group of screening programs. They conclude that a home invitation as part of a screening program, can reduce educational inequalities in the uptake of mammography screening. Last, in three studies the total European sample was investigated using multilevel analysis to find out whether general macro-level indicators – such as gross domestic product (GDP), public health expenditure, or the number of physicians – can explain cross-national variation in screening practices. They show that none of these factors seem to do so [12,16,30]. Of these, Wübker [16] also looked at macro-level indicators more directly linked to mammography screening, such as the number of radiologists and mammography units, but these also could not explain cross-national variation. Instead, it is the characteristics of mammography screening policies that contribute to the large variation between countries regarding screening participation, both in terms of organizational characteristics (e.g. the type of screening program and age range covered) and in the reasons for not taking up mammography by women for whom screening is recommended (50–69 years) [7].

This paper aims to introduce a longitudinal approach in cross-national comparative research on socioeconomic inequalities in mammography screening. All eight studies employ a cross-sectional design, which does not allow investigation of the origins of mammography screening inequalities. Rather, adulthood socioeconomic position is focused on. It would be particularly interesting to investigate in what other European countries apart from Belgium, childhood experiences can be related to health behavior in later life. A further limitation is that cross-sectional studies cannot take into account substantial variation in the temporal order of the implementation of mammography screening programs in different European countries. For example in Sweden and the Netherlands, national screening programs were already established in the 1980s, while programs in other European countries, such as Poland (2007) and Denmark (2008) have just taken off. Moreover, these contextual changes over time cannot be separated from age effects in a cross-sectional design. The longitudinal data incorporated in the Survey of Health and Ageing (SHARELIFE, 2008–2009) enables better modeling of age, period and cohort effects, by providing retrospective information concerning the age at which women commenced regular mammography screening. Since the true separation of age, period and cohort effects has been called "a futile quest" [31,32], we have followed the author's suggestion to use a more informal and explorative approach. By performing separate longitudinal analyses for each of the 13 countries, we aim to gain detailed insights into the dynamics of each country. This data provides a unique opportunity to empirically scrutinize the origins of

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