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From Treating Tumors to Governing Women's Health: Institutional Divergence and Limited Convergence in Breast Cancer Prevention and Care in China and the United States, 1980–2025

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Abstract

Why do societies exposed to increasingly similar biomedical evidence develop different approaches to breast cancer prevention and care? This article compares the historical development of breast cancer prevention-and-care regimes in China and the United States from 1980 to 2025. It combines comparative historical analysis with structured-focused comparison and process-tracing inference across four periods: 1980-1991, 1992-2008, 2009-2018, and 2019-2025. The article conceptualizes a prevention-and-care regime as the institutional configuration through which a society defines breast cancer risk, selects eligible women, finances and delivers screening, regulates quality, links detection to treatment and survivorship, and represents women in policy making. It argues that converging biomedical evidence and global public-health norms did not directly produce convergent national systems. They were translated through five domestic institutional filters: governance structure, financing and eligibility, professional authority, organized advocacy and representation, and service capacity. In the United States, federal quality regulation, professional pluralism, insurance-based access, targeted safety-net programs, and survivor activism produced a mammography-centered regulated pluralist regime that institutionalized quality, rights, and choice but retained fragmented access and persistent social inequalities. In China, central agenda setting, targeted public-health projects, the maternal and child health and public-hospital networks, and mixed screening technologies produced a state-coordinated targeted programmatic regime capable of rapid priority-group expansion but marked by uneven local capacity, financing, referral, and follow-up. Since the late 2010s, both regimes have increasingly emphasized risk stratification, quality assurance, health equity, survivorship, and whole-woman health. This represents convergence in objectives rather than convergence in institutional means. The study shows that breast cancer control is not merely a technical response to disease burden; it is a historically constructed mode of governing risk, entitlement, expertise, and women's participation across the cancer-care continuum.

Keywords

breast cancer, comparative public health, China, United States, historical institutionalism, screening, women's health, health policy

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1. Introduction

Breast cancer prevention and care offer a rich subject for comparative public health research. Over the past four decades, the United States and China have been exposed to an increasingly common international repertoire of biomedical knowledge: the need for early diagnosis, standardised imaging, timely referral, multidisciplinary treatment, survivorship care, and attention to health inequalities at all stages of cancer. International initiatives have also promoted phased, resource-appropriate implementation rather than assuming that a single screening technology can be applied everywhere [6-9]. However, the two countries did not build the same institutional response. By 2025, both treated breast cancer as more than an isolated tumour, but they governed women's entry into prevention and care through different combinations of law, insurance, public-health projects, professional standards, service networks and organised representation.

The contrast is not well reflected in the typical divisions of state and market or collectivism and individualism. The United States does not have a single national screening centre. Breast cancer prevention is now carried out through federal and state regulations, multiple professional guidelines, employment-linked and public insurance schemes, clinical delivery systems, and a targeted public-health safety net for underserved women. China likewise cannot be described as having a universal, population-wide invitation system. The national response has been built on centrally prioritized but locally implemented projects, eligibility categories, public financing, maternal and child health institutions, public hospitals, grassroots outreach, and combinations of clinical breast examination, ultrasonography and mammography. It is not to be called an improved filter. It is a difference in the institutional structure that determines which women are considered high-risk, what constitutes a reasonable test, who bears the costs, who is held accountable for an abnormal finding, and whose knowledge is deemed authoritative.

Therefore, this paper investigates how and through which institutional mechanisms China and the United States developed different breast cancer prevention-and-care systems between 1980 and 2025, despite increasing convergence in biomedical evidence and global public health norms. It has both a history and current problems. Screening recommendations are still being debated; expanded participation does not guarantee a diagnosis or treatment; and a nominally free examination may still incur costs for transport, time, follow-up or treatment. Therefore, the object of comparison should extend beyond the screening test to the institutionalised sequence of risk communication, eligibility, examination, diagnostic workup, treatment, rehabilitation, survivorship and financial protection.

The three propositions are presented. First, biomedical evidence is politically consequential only after it has been processed by domestic institutions. Translation is not only adaptation of an epidemiological guideline. It distributes power among governments, professional organisations, payers, hospitals, women's organisations, patients and families, and also converts broad norms into administratively feasible categories. Second, the United States and China developed two different ideal types. The American model is best described as a regulated pluralist system: mammography has been included in quality laws, professional guidance, insurance regulations, targeted safety-net programs and rights-oriented survivor advocacy, but responsibility is still distributed unevenly among organisations. The Chinese model is a state-led targeted programme: national priorities and large-scale public works have promoted the rapid development of selected groups, and local fiscal and service capabilities have shaped the implementation, technology mix, and continuity of care. These are analytical ideal types, not claims that either country is internally homogeneous.

Third, convergence after the late 2010s has been actual but restricted. Both countries are increasingly using risk stratification, quality assurance, social inequality, patient-centredness and life after treatment. New Goals are added to the inherited infrastructure. The American reforms still operate through plural professional and payer institutions; the Chinese reforms still rely heavily on priority setting, public programs, and territorially uneven delivery capacity. Therefore, the appropriate conclusion is convergence of policy goals and persistence of institutional means.

The three bodies of scholarship are as follows. It extends the comparison of health systems by treating cancer prevention as a system that integrates eligibility, technology, financing, service continuity and representation, rather than as an independent clinical recommendation. According to the idea of historical institutionalism, the first regulatory and programme choices created feedback effects and thus prompted subsequent reforms [1-3]. It also adds women's health movements and patient representatives to the comparative public-health analysis. Breast cancer policies determine not only what health systems will do

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about tumours but also what kind of subjects women will become: passive patients, project beneficiaries, insured consumers, informed decision-makers, advocates, survivors or co-producers of knowledge.

The rest of this paper will present the analytical system, introduce the comparative design, trace four synchronous historical periods, identify the mechanisms of divergence and limited convergence, and discuss implications for public health. The primary way to analyse this is to compare the two countries at the same time and in response to the same questions, rather than presenting their histories separately.

2. Literature Review and Analytical Framework

2.1 From Tumor Treatment to a Cancer-control Continuum

The change in title from “Treating Tumours” to “Governing Women's Health” does not imply that prevention had taken precedence over treatment, nor that policy had followed a straightforward path of reversion and iteration in practice. Surgery, systemic therapy, radiotherapy, screening, early diagnosis, rehabilitation and survivorship have all accumulated and interacted. It is, in fact, an expansion of the policy object. A tumour-centred model considers how to treat a malignant tumour. A prevention-and-care system also specifies who should be consulted before the onset of symptoms, what risk information needs to be communicated, how false-positive and false-negative results should be handled, whether women can complete diagnostic tests, how treatment will affect the breast, fertility, work, sex life, mental health and family life, and what obligations remain after active treatment.

This is not an all-encompassing way to prevent cancer; it is only one way. The world is moving towards early detection and diagnosis together; otherwise, additional tests may cause anxiety, extra costs, delays or loss to follow-up without improving health outcomes [6-9]. The historical decline in breast cancer mortality in high-income countries has also been due to the combined effect of screening and better treatment, not a single measure [23]. Therefore, this paper uses the compound term “prevention-and-care” to cover risk reduction and health promotion, secondary prevention via screening and early diagnosis, and tertiary prevention through effective treatment, rehabilitation, recurrence monitoring, survivorship and quality-of-life support.

It will not be assumed that coverage automatically implies effectiveness. Program outputs, such as the number of women examined, are important, but a public-health pathway also includes invitation or mobilisation, participation, result notification, diagnostic resolution, initiation of appropriate treatment, financial protection and follow-up. Regimes perform well in one period and poorly in another. Based solely on the nominal test or headline screening rate, one cannot determine whether an institution will actually provide institutional support for benefit realisation.

2.2 Institutions, Path Dependence, and Policy Translation

Historical Institutionalism offers the main explanation system. Institutions decide which problems are considered feasible to be solved, which actors have veto or agenda-setting power, and which instruments are deemed administratively feasible [1,2]. Timing and sequence are important because early investments yield increasing returns; equipment, certification systems, reimbursement categories, trained workforces, organisational routines, data systems and political constituencies are all relatively less costly to establish later on [3]. A well-developed quality-regulated mammography sector will not dictate the future directions of reform but will offer a basis for such reforms. The same applies to a public programme organised by maternal and child health and county-level institutions.

The idea of policy translation adds a second component. International norms are not the result of institutional absence. Intermediaries interpret them, add them to the local classification, and align them with existing organisational practices [4-5]. Translation in global health refers to the adaptation of general ideas, such as early detection, equity and patient-centred care, into age groups, risk scores, benefit packages, quality indicators, referral rules and implementation responsibilities. Translation is thus both epistemic and distributive: it determines what is considered valid evidence and who is entitled to which services.

The two-country comparison is very suitable because both countries have a large and unevenly distributed population, advanced tertiary medical institutions, significant regional disparities, and multiple levels of government, but differ in the structure of authority and finance. China's health reform has strong central

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leadership but is implemented and managed locally [10, 11]. The United States has combined strong federal regulatory and financing tools with state powers, private and public payers, professional self-governance, and a fragmented public-health system [12]. These settings change the application of similar evidence.

2.3 Women's Health Movements, Advocacy, and the Construction of Patienthood

A system is also determined by who decides on illness. Breast-cancer activists in the United States helped to reduce the stigma of breast cancer and brought it into the public eye. Advocacy groups have shifted their focus from education and support to affecting research funding, trial design, treatment information and policy [14-16]. It did not eliminate professional authority, and not all women participated equally. It has nevertheless institutionalised the survivor and advocate as recognisable policy actors. State requirements for the disclosure of treatment options and subsequent federal protection of reconstruction coverage have also linked breast cancer to informed choice, embodiment and life after surgery [19-20].

The Chinese path had a different ecology of representation. Published accounts more frequently describe mobilisation through public institutions, the All-China Women's Federation and its local networks, professional associations, hospitals, workplaces and community organisations, rather than sustained national agenda-setting by autonomous survivor organisations. It does not mean that Chinese women were without agency or voice. It means that voice was more frequently organized through state-linked or professional channels and through participation in targeted programs. Women were often classified administratively as eligible rural women, urban low-income women, employees, high-risk women or project beneficiaries. The difference is not one of civilisation, but rather how experience is organised into evidence and policy demands.

This view does not consider culture to be the whole reason. Ideas of femininity, the breast, family responsibility, privacy and medical authority are necessary, but they produce policy effects through organisations, financing arrangements, professional routines and legal categories. A cultural narrative cannot explain why a federal quality statute was established, why different diagnostic sequences were used in urban and rural areas for a national project, or why certain age groups were exempt from free examinations.

2.4 Defining the Dependent Variable

A breast cancer prevention-and-care regime is defined here as the relatively stable institutional arrangement through which a society: (1) frames breast cancer as a clinical, population-risk, rights or women's-health problem; (2) allocates decision-making authority; (3) defines target populations and entitlements; (4) finances prevention, diagnosis and treatment; (5) organises service delivery and referral; (6) selects and regulates technologies; (7) assigns women roles in decision-making and governance; (8) recognises inequality; and (9) evaluates performance. The above multi-dimensional definitions are not to be treated as a rule or a filter.

Figure 1 is the causal structure. Global epidemiological changes, biomedical evidence and public health norms are all pressures. Five domestic filters - governance, financing and eligibility; professional authority; organised advocacy and representation; and service capacity - convert this pressure into policy tools. These instruments have created a system of observable effects on access, continuity, quality, harm, financial protection and survival. Outcomes then lead to policy feedback: Constituencies advocate for the benefits, controversies revise standards, and implementation failures result in additional regulations or programme adjustments.

Four propositions follow. First, centralised agenda setting can help rapidly select the main groups and coordinate the expansion of projects; however, the quality and continuity of the results will still be affected by local financing and delivery capacity. Second, a system focused on insurance entitlements and professional guidance should institutionalise choice and quality standards, maintain access restrictions according to insurance status, provider networks and social disadvantages. Third, where independent patient and survivor organisations gain stable access to research and policy platforms, the policy object should expand more visibly from detection and mortality to information, embodiment, reconstruction, survivorship, and long-term quality of life. Fourth, screening technology will also show differences in diagnostic performance by age group, breast-density patterns, equipment distribution, workforce, cost, and the capacity to complete diagnostic workup.

Figure 1: Institutional Translation Model for Breast Cancer Prevention and Care. Shared evidence and global public-health norms are filtered by five domestic institutional mechanisms and policy instruments, resulting in different U.S.

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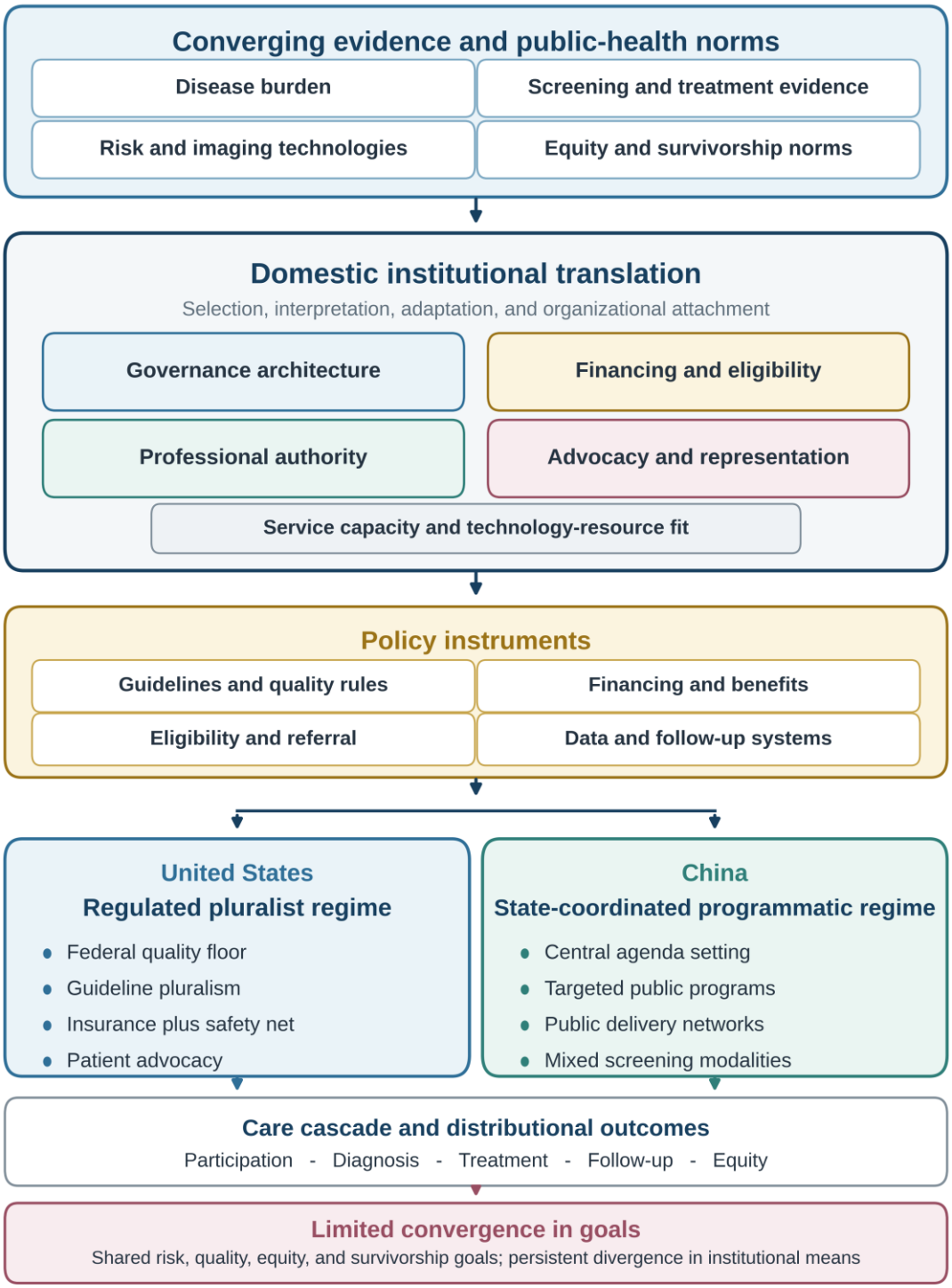
and Chinese regime configurations, care-cascade outcomes, and limited convergence of policy goals. Source: Author's synthesis



3. Methods and Materials

3.1 Comparative Design and Case Selection

The research will use comparative historical analysis, structure-focused comparison and process-tracing inference. The objective is not to estimate a single causal effect of "the Chinese model" or "the American model." Two national cases, changing diagnostic technologies, non-equivalent age groups, and simultaneous

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treatment advances make such an estimate inappropriate. Design identifies sequences and mechanisms that connect institutional conditions with policy instruments and implementation patterns.

China and the United States are chosen as the theoretical contrast. Both experienced increasing breast-cancer burden and access to global biomedical knowledge, both possess advanced specialist institutions alongside underserved populations, and both govern through multiple territorial levels. However, they differ in the relative positions of the central government, federal and subnational governments, professional associations, insurers, public-health agencies, women's organisations and independent advocacy. Therefore, the comparison keeps the general disease category and time period constant and only varies institutional translations.

The time period starts in 1980, before the major American federal screening institutions and before the later expansion of China's national project, and ends in 2025 to assess recent risk-, equity- and implementation-oriented reforms. Four periods are used: 1980-1991, when breast cancer became a more prominent public problem and the American federal safety-net program was authorised and started; 1992-2008, when American quality and rights institutions were strengthened and China conducted large-scale projects; 2009-2018, when China expanded targeted public programs and the United States saw renewed guideline controversies and insurance reforms; and 2019-2025, when both regimes have increasingly focused on risk, equity, implementation quality and survivorship.

3.2 Evidence and Comparison Protocol

The foundation of the evidence includes peer-reviewed historical, epidemiological, health-service and policy studies; national programme evaluations; major guideline statements; and authoritative international reports. The main areas in the United States are the National Breast and Cervical Cancer Early Detection Program, mammography quality regulation, professional screening guidelines, insurance reform, survivorship policy and disparities research. Key Areas in China include national and provincial screening projects, the rural “Two Cancers” programme, population surveys, technology comparison trials, participation and cost-effectiveness studies, and recent implementation research.

All periods are judged by the same set of questions: How was breast cancer presented? Which actors had agenda-setting, standard-setting, financing and distribution power? Which women were qualified? Which Technologies Were Selected and Why? How were Screening, Diagnostic Resolution, Treatment and Survivorship related? What was the Status of women? What inequalities have been revealed? What feedback did the arrangement provide for the next time? This protocol reduces the risk of describing a single case in detail and thus does not treat the other cases solely based on outcomes. Table 1 operationalizes these dimensions and presents the contrasting ideal-type expectations used in the comparison.

Table 1: Operationalisation of Breast Cancer Prevention-and-Care Regimes and Contrasting Ideal Types.

Dimension	Operational question / observable indicator	United States: regulated pluralist ideal type	China: state-coordinated targeted programmatic ideal type
Problem framing	Is breast cancer treated primarily as a clinical disease, population risk, rights issue, or whole-woman health concern?	Early detection, technical quality, informed choice, rights, disparities, survivorship.	Early diagnosis, public-health responsibility, priority populations, service equalization, life-course health.
Governance	Who sets priorities, standards, and implementation responsibilities?	Federal and state authorities, professional bodies, insurers, health systems, and advocacy organizations.	Central priority setting with provincial/local implementation through public agencies and institutions.
Target and eligibility	Which women are formally recognized and how do they enter the pathway?	Age/risk guidance, insurance coverage, provider recommendation, and targeted safety-net eligibility.	Age, residence, rural/urban or low-income priority, local program inclusion, and risk classification.
Financing	Who pays for screening, diagnostic resolution, treatment, and survivorship?	Public/private insurance, cost-sharing rules, federal-state safety-net grants, and charitable navigation.	Central/local public project funds combined with insurance, assistance, hospital budgets, and household costs.

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Dimension	Operational question / observable indicator	United States: regulated pluralist ideal type	China: state-coordinated targeted programmatic ideal type
Service delivery	Which organizations perform outreach, testing, referral, treatment, and follow-up?	Primary care, imaging facilities, integrated systems, specialists, public-health programs, and navigators.	Maternal and child health institutions, grassroots networks, public hospitals, cancer centers, and local government.
Technology and quality	Which modalities are used and how are quality and consequences regulated?	Mammography-centered ecosystem, federal facility standards, density reporting, supplemental risk-based imaging.	Clinical examination, ultrasound, and mammography in mixed sequences adapted to population and capacity; project quality control.
Role of women	Are women patients, consumers, beneficiaries, decision makers, advocates, or co-producers of knowledge?	Patient-consumer, informed decision maker, survivor, advocate, and research partner, with unequal capacity to exercise choice.	Program beneficiary, mobilized participant, patient, family member, and increasingly long-term survivor; voice commonly mediated institutionally.
Equity framework	Which inequalities are named, measured, and assigned to policy actors?	Race/ethnicity, insurance, income, geography, disability, and social determinants of health.	Urban-rural and regional gaps, local capacity, income, insurance, age eligibility, and priority-group status.
Evaluation objective	What counts as success?	Appropriate use, technical quality, diagnostic resolution, mortality, informed choice, disparities, survivorship.	Coverage and detection, protocol completion, early diagnosis, referral, quality, territorial equity, and program sustainability.

The country columns are suitable for comparison and do not assume internal homogeneity or an official unitary national model.

3.3 Evidentiary Limits

The comparisons have some defects. First, published evidence is more abundant for the United States and for China's post-2005 projects than for Chinese practice in the 1980s and early 1990s. Therefore, claims about the early Chinese period are intentionally limited to the absence of a stable, nationwide population-based entitlement and the predominance of clinical, local, research, workplace or demonstration activities. Second, the survey estimates differ in age range, recall period, definition of screening and inclusion of diagnostic examinations; therefore, they should not be compared as if they were harmonised indicators. Third, screening participation, stage at diagnosis, and mortality are related but not the same. Changes in treatment, risk factors, demographics and data quality have also changed the trend of mortality [23]. Fourth, national ideal types conceal state, province, urban-rural, racial, class and organisational heterogeneity. Therefore, a mechanism-based interpretation is more suitable than one based on outcomes.

4. Comparative Historical Findings

4.1 1980-1991: Making Breast Cancer a Public Issue

4.1.1 United States: Diffusion, Legislation, and the Rise of an Advocacy Constituency

In the 1980s, breast cancer prevention in the United States began to appear in policy through the combined efforts of imaging diffusion, state legislation, professional promotion and women's activism. The various states have established different regulations on mammography reimbursement, screening access and treatment-option disclosure, etc. [13] These measures did not constitute an all-China plan; instead, they established legal and reimbursement precedents that made the problem of early detection the government's responsibility rather than solely the fault of individual physicians and patients.

Breast-cancer activism also changed the public consciousness of the disease. Advocacy broke the silence and paternalistic communication, shifted the focus of research, and support networks created a collective identity for diagnosis and survival [14-16]. The institutional significance of the movement also included awareness campaigns. It has formed a constituency that can request research funds, public accountability, informed decision-making and recognition of life after treatment. Given this, the woman with breast cancer

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began to be regarded more as a rights-bearing patient and a potential advocate rather than merely as a medical case.

In 1990, there was a Federal Act to prevent breast and cervical cancer and, in 1991, the National Breast and Cervical Cancer Early Detection Program began. The program has established a public-health safety net for low-income, uninsured and underserved women through federal-state cooperation [18]. It has a particular Design Objective. Rather than replacing insurance-based and provider-based access with a universal national service, it addressed some deficiencies in the plural system. Therefore, the institutional solution exhibited a typical American pattern: federal funding and standards combined with state implementation and a limited safety-net entitlement.

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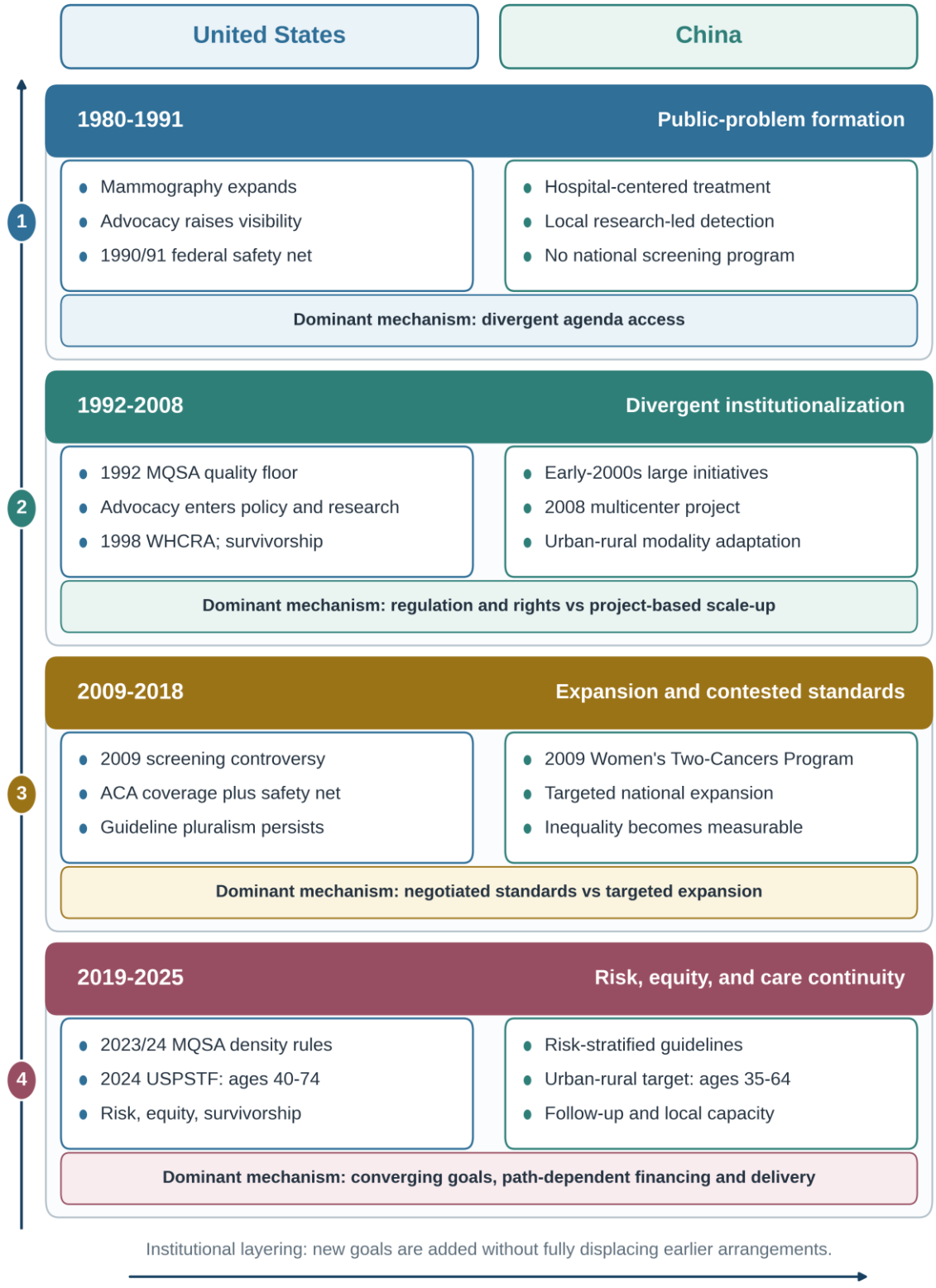
Figure 2: Comparative Institutional Timeline of Breast Cancer Prevention and Care in the United States and China, 1980-2025. Each period compares the main institutional path in the two countries and identifies the mechanism of divergence or limited convergence. Source: Author's synthesis of references [13-22, 24-27, 31, 33, 35-50]



4.1.2 China: An Emerging Burden Without a Consolidated National Screening Entitlement

At that time, in China, breast cancer was mainly dealt with by clinical oncology, local research, workplace or community examinations, and specialist initiatives. The country's public-health priorities and resources

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remained shaped by infectious disease, maternal and child health, and basic service expansion. Later reviews mention the growing professional attention and experiments, but not a stable nationwide population-based screening entitlement in the 1980s or early 1990s [32-34]. This distinction should not be read as policy absence. It shows that breast cancer had not yet been included in a large-scale national population programme with standardised eligibility, financing, technology and referral responsibilities.

The first institution has also limited women's participation in the system. Access was provided through employment, residence, local service availability, clinical presentation or participation in specific examinations, and not by a national screening right. Professional and government officials, rather than the autonomous survivor coalition, were responsible for determining the needs. The policy object was closer to a particular illness and thus selected detection initiatives rather than overall women's health measures.

4.1.3 Comparative Interpretation

The first divergence was therefore a difference in the construction of public problems and political constituencies, not technology. In the United States, mammography diffusion, state laws, federal safety-net development and activism created multiple institutional platforms. In China, specialists and local groups have built a system for cancer screening without a national cancer-screening architecture. These early choices set the stage for the following period: by the 1990s, the United States had formed a strong regulatory and advocacy network, and China had begun conducting national screening experiments through administrative projects and professional networks.

4.2 1992-2008: Divergent Routes to Institutionalization

4.2.1 United States: Federal Quality Regulation, Rights, and Survivorship

The Mammography Quality Standards Act of 1992 created an independent federal office; the government would not organise a national invitation programme but would set standards for the quality of facilities, equipment, personnel and reporting across a decentralized delivery market [17]. This was a strong form of government by standardization. It made mammography a federally regulated service but left the decisions on access, frequency, payment and follow-up to professional recommendations, insurance companies, doctors, public programs and patients.

Activism has also become more institutionalised. Survivor advocates have moved beyond education and mutual support to form alliances with researchers and policymakers [16]. This altered knowledge authority. The form of experiential knowledge can be expressed as research priorities, trial design, information disclosure and resource allocation. Not all of them were the same; some expected patient participation in the process of legal breast cancer treatment.

Rights-based policy extended beyond detection. State treatment-option laws were associated with an increased use of breast-conserving surgery, and information rules could thus alter clinical practice [19]. The Women's Health and Cancer Rights Act of 1998 expanded federal coverage for breast reconstruction and other services under group health plans that covered mastectomy, and later research has found changes in reconstruction utilisation [20]. Thus, the concept of successful care expanded from tumour removal to include bodily integrity and post-treatment life.

By the mid-2000s, “survivor” had been officially adopted as a term. The Institute of Medicine's “From Cancer Patient to Cancer Survivor: Lost in Transition” identified fragmentation after treatment and called for coordinated survivorship care [21]. The proposal for survivorship care plans also aimed to clarify responsibility, monitoring and communication after active treatment [22]. The changes show institutional layering; the system started as a detection-and-treatment model, and although rights and survivorship were added, basic insurance and provider fragmentation still existed.

4.2.2 China: Large-scale Experimentation, Fiscal Fragility, and Resource-adapted Technology

China's path to institutionalisation went through large-scale projects rather than federal-style service regulation or an insurance-based screening entitlement. The China Anti-Cancer Association's 2005 “One Million Women Breast Cancer Screening Project” was an ambitious attempt to mobilize hospitals and expand screening, but published reports indicate that it was suspended after about two years due to financial problems;

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later reviews have also pointed out issues such as false positives and a lack of stable national funding [7,36]. The main implementation problem of the episode was shown: political and professional commitment can start a movement, but stable funds and a full-process follow-up are needed to continue it.

In 2008, the Ministry of Health issued a national breast cancer screening plan for the 29 provinces. Evaluation of about 1.22 million women showed a deliberately differentiated sequence: clinical breast examination was followed by imaging, and mammography was used earlier in urban areas and ultrasonography was used earlier in rural areas, with abnormal findings prompting further tests [37]. It was not merely a lower-income-country model in the high-income country. It was an institutional adjustment caused by differences in equipment, workforce, cost, service organisation, as well as the age and breast characteristics of the women being served. Technology Selection is related to Delivery Capability.

Workplace and community interventions have further advanced the programme. A workplace-based intervention could increase screening knowledge and participation by using organised employment settings as the implementation platform [36]. However, the workplace projects also showed the limitations of relying on organisational membership; women outside formal employment or high-capacity urban institutions were harder to reach. Screening expansion thus proceeded through administratively accessible populations and demonstration sites rather than universal individual rights.

It is different from that in the US. China was building the capacity to mobilise a large number of women and to combine examinations in different resource areas. It had not established a national equivalent of the Mammography Quality Standards Act for an old-aged-related mammography sector, nor an independent advocacy group with the same influence over research and rights. The three main institutional problems were unstable public funds, territorial implementation capacity and the construction of referral networks.

4.2.3 Comparative Interpretation

Between 1992 and 2008, the two regimes were institutionalised in different venues. The United States has created a decentralized system of federal quality regulation, insurance law, professional guidance and advocacy participation. China governed by centrally promoted projects, professional organisations, public institutions and resource-adapted technology sequences. These places had different responses. American mammography facilities, payers, professional societies and advocates became long-term stakeholders in the later guideline discussions. Chinese local governments, maternal and child health institutions, public hospitals and project managers formed the organisational foundation for the subsequent targeted expansion.

4.3 2009-2018: Programmatic Expansion and Contested Standardization

4.3.1 United States: Guideline Conflict, Benefit-harm Reasoning, and Insurance Reform

The 2009 U.S. Preventive Services Task Force recommendation controversy made explicit that screening standards were not dictated by an uncontested body of evidence. The Task Force emphasized age-specific benefit-harm trade-offs and recommended against routine screening for some younger average-risk women, provoking political, professional, and advocacy opposition [24]. The dispute promoted professional pluralism; thus, the parties could present various supporting materials and start the trial at different times.

The American Cancer Society's 2015 guidelines and the Task Force's 2016 statement maintained the original differences in initiation, frequency and individual choice [25,26]. Disagreement did not cause paralysis of the regime institutionally. It has been added to clinician-patient communication, payer rules, legislative protection and competing professional authorities. The Price was complexity. Different people would get different advice based on their age, risk, doctor, insurance company and which organisation published the guidelines.

The Affordable Care Act expanded access to cancer-control services by increasing insurance coverage and requiring most plans to cover certain preventive care without a cost-sharing obligation [28]. It reduced some financial barriers, but it did not establish a single national delivery organization. The National Breast and Cervical Cancer Early Detection Program continued to serve as a targeted safety net; Medicaid expansion varied by state; and provider availability, transportation, paid leave, language, and continuity of primary care remained important factors. Reform thus added more layers of insurance coverage to the already multi-institutional system.

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At the same time, the two-edged sword of screening governance was also exposed. Public health needed to encourage reasonable participation while also considering false positives, overdiagnosis, extra imaging and uncertainty. The institutionalised ideal became informed or shared decision-making, but the actual ability to choose varied according to health literacy and access to stable clinical relationships.

4.3.2 China: The Rural "Two Cancers" Program and Priority-group Expansion

China's 2009 rural women's breast and cervical cancer screening programme was a large-scale national initiative. About 1.46 million rural women aged 35-59 were selected for breast cancer screening in the first stage, and later, this range was extended to include women aged 35-64 [38]. The programme connected the Ministry of Health, finance authorities, the women's federation, local governments, maternal and child health institutions, hospitals and grassroots mobilisation. It transformed breast cancer from a collection of projects into an ongoing government responsibility for certain priority groups.

The programmes have good coordination functions. Eligibility could be set nationally, public funds could reduce the immediate cost of the examination, and local women's networks could organise participants. Combining breast and cervical cancer screening also utilised the existing maternal and child health system and a well-known women's health framework [48]. This structure can help expand the population that is not covered by market- or work-based approaches.

However, the same architecture was only applicable in certain areas. A centrally defined benefit required local staff, equipment, transport, diagnostic expertise, data systems, referral arrangements and funding outside of the initial examination. Participation studies have identified limited awareness, competing work and family demands, fear, inconvenience, and weaknesses in recommendation and follow-up [42-44]. A free screening program does not guarantee that a woman will be chosen for follow-up tests or treatment.

National surveys show that the programmes are not available to all people. In 2010, only about one-fifth of adult women had been screened for breast cancer under regional and insurance programs [35]. According to the 2015 national estimates, there was an urbanisation gap: only 18.9% of women aged 20 and over, and 25.7% of women aged 35-64, had participated in labour force activities in urban areas [39]. Due to different measurement methods and groups of eligible ages, these figures cannot be directly compared with those in the US mammography data. However, they also show that a large national project did not eliminate structural differences in access.

The Technology Mix was unchanged. A randomized multicenter trial among high-risk Chinese women found ultrasonography more sensitive than mammography in that study population and supported consideration of ultrasound in resource- and population-appropriate strategies [38]. Cost-effectiveness modelling for rural China has also raised questions about the optimal organisation and intensity of screening [45]. These studies have supported a policy logic of selection and mixed modalities, rather than the automatic adoption of a uniform mammography-only pathway.

4.3.3 Comparative Interpretation

The two forms of standardisation are shown here. The standards had not been adopted by the expert organisations in the United States and were thus not in practice. Standardisation in China was relatively weak; although the government set up priority groups, project protocols and implementation responsibilities, technology and performance varied by region. American pluralism made the conflict of evidence visible and institutionalised individual choice; Chinese programme coordination expanded coverage but often shifted the controversy to implementation, capacity and follow-up.

4.4 2019-2025: Risk, Equity, Implementation Quality, and Whole-woman Health

4.4.1 United States: Earlier Initiation, Density Notification, and Social Determinants

In 2024, the U.S. Preventive Services Task Force recommended biennial mammography for average-risk women aged 40-74 [27]. The revised content has moved the recommended starting age for menopause earlier than in 2016 and now considers the impact of menopause on women in their forties, including racial differences. Professional pluralism still existed, and other organisations had different recommendations on the frequency of annual versus biennial screening, starting age, and continuation after age 74. The regime agreed to a screening but did not announce a specific time for it.

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In 2024, the federal breast-density notification requirements were introduced and, as of 2025, discussed in the clinical literature, institutionalized risk communication [31]. Density notification shows the scope and limitations of rights-oriented governance. It offers women standardised information on a factor that may affect mammographic sensitivity and risk, but this information alone does not determine whether further tests are required, affordable or accessible. The policy creates a new informed subject and shifts some of the interpretive burden to patient-clinician interaction.

Equity has also become more multi-faceted. The historical emergence of the Black-White mortality disparity cannot be explained by biology; rather, stage, treatment, social conditions and structural access are responsible [29]. According to the 2022 survey data, the proportion of women aged 50-74 using mammograms declined considerably due to negative social determinants and health-related social needs [30]. Insurance is still necessary, but so are stable transportation, housing, food security, employment, a regular source of care and trust. The American government is becoming more aware of these problems at present, but a single public service organisation has not yet been established to address them.

Survivorship and patient-centred care have also become the new standards. Responsibility for supervision, symptom control, psychological support, rehabilitation, employment consequences and financial toxicity has not been taken on. Therefore, the extension from tumour treatment to whole-person health is conceptually advanced but organisationally deficient.

4.4.2 China: Broader Eligibility, Risk-based Debate, and Implementation Science

China's estimated breast cancer screening coverage in 2018-2019 was about 22.3% for women aged 20 and over and about 30.9% for women aged 35-64, and considerable socioeconomic and provincial differences still existed [40]. Since 2022, the national policies and their implementation have gradually expanded urban and rural coverage, paid more attention to disadvantaged women, risk assessment, information systems, quality control and the connection between screening and referral. The trajectory is an extension of the target programme area and not a transition to a general mammography invitation system [49, 50].

Recently, risk-based approaches have been used to match the modality and intensity of screening according to age, family history, other clinical factors, breast characteristics and resource availability [46-49]. Although the development has brought China closer to the international discussion on stratified screening, the policy problem has not been the selection of a risk model. Risk assessment should be added to the first contact, imaging capabilities, diagnostic confirmation, treatment access and reliable long-term data.

A 2024 systematic review and meta-analysis of more than ten million women have documented the scale and heterogeneity of Chinese screening and early-diagnosis evidence [41]. According to the above studies, while expansion has provided rich organisational experience, there are differences in protocols, target groups, detection rates and quality. Large numbers should therefore be interpreted as implementation capacity and learning, not as proof of a single consolidated national regime.

Recently, application research has identified the remaining bottlenecks. A 2025 mixed-methods evaluation of rural screening found that organised outreach could reach large numbers of people, but distance, limited local capacity, awareness, follow-up, referral and maintenance remained barriers [47,50]. These are not peripheral details. Determine if the administrative promise of free or organised screening will result in early diagnosis and treatment. China's current transition is therefore from project scale to pathway quality, from counting examinations to governing continuity, risk and outcomes.

The Language of women's health has also expanded. Breast cancer is being addressed at all stages of life in health, including fertility and sexuality, psychosocial well-being, work, caregiving, rehabilitation and survivorship. Compared with the United States, this expansion is still more commonly presented in governmental and professional programmes than in autonomous survivor agenda-setting. However, the policy subject is no longer just the rural woman invited for a one-time examination; it increasingly includes women who face risks, diagnoses, treatments, recovery and long-term life [21, 22, 49].

4.4.3 Comparative Interpretation

The two countries now share more policy vocabulary than at any previous time: risk, equity, quality, informed participation, implementation, survivorship and continuity. However, they have not reached an agreement on the institutional design. The United States still governs by means of quality regulation, pluralistic

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rules, insurance coverage and safety-net systems, etc. China continues to govern through national priorities, targeted public programs, public delivery networks and capacity-adapted protocols. Convergence is strongest at the level of objectives and weakest at the level of eligibility, financing, delivery responsibility and organised representation. Table 2 shows the synchronous stages, main divergence reasons and path-dependent effects.

Table 2: Synchronized Historical Comparison of Institutional Development, 1980-2025.

Period	United States trajectory	China trajectory	Principal divergence mechanism	Path-dependent implication
1980-1991	State laws, mammography diffusion, activism, and the 1990-1991 federal safety-net turn made breast cancer a visible public issue.	Clinical, local, workplace, and research activity accumulated without a stable nationwide screening entitlement.	Different public problem construction and actor coalitions.	The United States entered the 1990s with regulatory and advocacy venues; China entered later national expansion through administrative and professional projects.
1992-2008	MQSA federalized technical quality; advocacy entered research and policy; reconstruction and survivorship broadened rights and care.	Large projects tested scale but exposed financing limits; the 2008 program used different urban-rural imaging sequences.	Regulation/insurance/advocacy versus program mobilization/capacity adaptation.	Durable U.S. facility, payer, professional, and advocacy constituencies contrasted with Chinese local public implementation networks.
2009-2018	Guideline conflict institutionalized benefit-harm reasoning; the ACA expanded coverage without unifying delivery.	The rural Two Cancers program scaled priority-group screening; participation, cost-effectiveness, referral, and local capacity remained uneven.	Plural standard setting versus centrally specified program eligibility and protocols.	American complexity was expressed as competing guidance; Chinese complexity was expressed as implementation variation and pathway discontinuity.
2019-2025	Earlier USPSTF initiation, density notification, SDOH research, and survivorship strengthened risk and equity language.	Coverage rose but remained unequal; policy and research emphasized broader eligibility, risk stratification, quality, referral, and maintenance.	Common objectives translated through inherited financing, governance, and representation structures.	Convergence in goals did not produce convergence in institutional means.

Note: All periods are compared using the same indicators: problem framing, actor structure, eligibility, financing, technology, continuity, representation and equity.

5. Mechanisms of Divergence and Limited Convergence

5.1 Governance: Authoritative Coordination Versus Regulated Pluralism

The first is the place of the top-level coordination. No single party in the United States manages the entire prevention-and-care path. Federal law can regulate the quality of mammography and insurance coverage; the federal government can provide targeted safety net funding; states regulate insurance and public health implementation; professional organisations issue competing recommendations; health systems deliver care; and advocates influence research and policy. There are several Doors to Innovation, Accountability and Rights Protection. The problem is that cooperation needs to be arranged separately and is not an intrinsic feature of the system [12].

China's central authorities can set national priorities, target groups and programme protocols more directly, and public institutions and women's networks can mobilize implementation [10,11]. It can be expanded quickly in the event of a political priority. Central Coordination is not the same as uniform local capacity. Fiscal decentralisation, workforce distribution, equipment, referral distance and managerial differences all affect what a nominally uniform programme delivers. Therefore, the mode is “central priority and decentralized implementation”, not a simple command-and-control system.

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These structures explain why the same evidence resulted in different policies. The government in the United States has provided some support for decentralised services by setting quality standards, establishing coverage rules, promoting disclosure and providing a safety net. In China, government actions have more frequently defined a programme, eligible population, implementation chain and performance tasks. Each way addressed a different coordination problem and thus resulted in a different set of deficiencies.

5.2 Financing and Eligibility: Insurance Entitlement Versus Program Eligibility

The second is the path through which a woman gains the right to care. American access is organised by age and risk recommendations, employment-based or public insurance, preventive-service rules, provider networks, and safety-net eligibility. The NBCCEDP is necessary because the general system does not ensure access for all low-income or uninsured women [18]. Although the Affordable Care Act reduced some problems, it did not eliminate state differences, underinsurance, network restrictions or other non-medical barriers [28]. Entitlement is relatively individualised and legally specified, but institutionally fragmented.

China's large public screening initiatives have generally used program eligibility: residence, age, rural or urban status, income or priority classification, and inclusion in a local implementation plan. This route can make the examination free at the point of use and concentrate resources on underserved groups. It is also administratively feasible and suitable for campaign-style mobilisation. However, project eligibility may create a division between the funded examination and the following services. Diagnosis and treatment will be covered by various funds, insurance, hospitals, aid organizations, etc. Therefore, the central continuity problem is not only whether screening is funded but also whether the funds remain aligned after an abnormal result.

Financing Arrangements Also Shape Political Expectations. Insurance-based entitlements promote claims based on coverage, non-discrimination and consumer information. Program-based entitlements support claims of inclusion in a public benefit, local implementation, and equalisation of basic services. Neither logic is inherently fair. Each is a kind of exclusion.

5.3 Professional Authority, Advocacy, and the Representation of Women

The third mode is the spread of knowledge authority. American professional pluralism has multiple bodies interpreting the evidence, and organised advocacy provides patients and survivors with an institutionalised, albeit unequal, platform to challenge experts and set agendas [14-16]. It can help explain why informed choice, right of reconstruction, research participation, density notification and survivorship are prominent. It also adds an interpretive layer; the conflicting instructions may make the individual women and clinicians responsible for the uncertainty.

In China, the most prominent national intermediaries have been central health authorities, cancer specialists, public hospitals, maternal and child health institutions, professional associations and state-affiliated women's organisations. Convert the technical evidence into administratively feasible protocols and organise an all-out campaign. The policies address the experiences of women, but they are often presented in the form of surveys, project feedback, local mobilisations and clinical meetings, and not through an independent national survivor movement with formal agenda-setting power. This arrangement supports coordinated education and recruitment but may make it more difficult for experiences of false positives, treatment discontinuity, body image, psychosocial distress or financial burden to become independent policy claims.

The difference should not be idealised. American advocacy may favour well-resourced organisations and media; a rights-based information system can also be too burdensome for women who lack the time, trust or stable clinical support. Chinese organisational mediation can reach women who would not self-refer and integrate screening with the existing grassroots network. The mechanism refers to whose voice is institutionalised and through which institutions, not a dichotomy of voice and voicelessness.

5.4 Technology as an Institutional Choice

The fourth is the match between technology and institutional capacity. Mammography has been promoted across the United States by equipment distribution, specialist facilities, insurance coverage, federal quality standards and other factors for many years [17]. After the existence of this ecosystem, research has focused on

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age, interval, density, supplementary imaging and the balance of benefits and harms. Even controversial recommendations operated in a mature mammography-centred field.

China's combined use of clinical breast examination, ultrasound and mammography varied by region and had different goals. The urban-rural sequences in the 2008 programme and trials of ultrasound among high-risk women show that the modality selected is related to available equipment, radiological expertise, cost, age, breast characteristics and referral capacity [37, 38]. Not all resource constraints are reasons to accept a lower quality. It is proposed that the evidence will only be effective if a service system can deliver and interpret the test results, and handle the consequences.

Technology Selection Also Creates Feedback. Training programs, procurement, quality-assurance routines and data systems have made the existing modalities more reproducible. Later, a risk-based screening system will probably need to change not only the rules but also the referral process, workforce qualifications, financing and information systems.

5.5 The Institutional Construction of Inequality

The fifth mechanism is the appearance and regulation of inequality. American research and policy are increasingly classifying disparities by race and ethnicity, insurance status, income, geography, disability, sexual and gender identity, and other social determinants of health [29,30]. The two categories show both the actual division and the availability of administrative and survey data. They point out differential mortality, stable sources of care, transportation, paid work, neighbourhood conditions and trust.

Chinese breast cancer policies more frequently make inequality legible through urban-rural residence, region, local fiscal capacity, insurance, income, age eligibility and participation in public programs [35,39,40]. These categories support territorial equalisation and priority-group policies, but they may underestimate inequalities among nominally eligible groups, such as migrant status, informal employment, disability, caregiving responsibilities, medical expenses, and the inability to travel for diagnosis.

In short, the policy does not exclude the unequal cases simply because they are unequal. Institutions should name, measure and be responsible for them. The American system generally spreads social disadvantages among many groups and institutions; the Chinese system often organises inequality by targeting specific populations and areas for administrative services. Both ways show some mechanisms but hide others.

5.6 Policy Feedback and Limited Convergence

The last one is policy feedback. In the United States, the groups that shaped the later guideline disputes were previously mammography facilities, quality regulators, insurers, professional organisations, advocacy groups and women used to be screened. Therefore, the reform proceeded by adjusting ages, intervals, information obligations and coverage, but kept the multiple institutional system. Large-scale public works created trained personnel, organisational routines, local performance indicators and expectations of government responsibility in China. Reform expanded the scope of eligibility, strengthened quality supervision, optimised technology and risk paths, and dealt with local implementation problems.

Although the world promoted convergence, these feedback effects were not eliminated. Both regimes now believe that screening without diagnostic and treatment facilities is insufficient, that a one-size-fits-all approach is inefficient, and that survival and quality of life extend beyond the initial treatment [6-9,21]. However, inherited actors and infrastructure determine who can implement these lessons. The observed pattern is not institutional convergence delayed in time, but rather a selective inclusion of the common goal into different regime logics.

6. Discussion

6.1 Direct Answer to the Research Question

China and the United States developed different breast cancer prevention-and-care systems because the same evidence was interpreted differently by their institutions. American federalism, insurance-based financing, professional pluralism, federal quality regulation, targeted safety-net provision and survivor

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advocacy created a regulated pluralist regime. Chinese central agenda setting, active state stewardship, program eligibility, public delivery networks, state-linked women's mobilisation and mixed-technology strategies created a state-coordinated targeted programme system. The decisive mechanisms were not abstract national values but the venues for the authority of evidence, money, eligible populations, implementation routines and political constituencies.

It also explains why the convergence has not occurred. Foreign and domestic evidence have changed the goals of both regimes: earlier diagnosis must be connected with treatment; quality and harm matter; risk and social inequality should guide policy; and women need long-term support. However, the aims were promoted by different groups. The United States has added them through revised guidelines, coverage rules, notification requirements, navigation programs and survivorship standards. China has added them in expanded projects, revised protocols, risk assessment, quality-control requirements, information systems and implementation reform. Therefore, the same vocabulary coexists with different responsibilities and entitlements.

6.2 Why Culture is an Insufficient Explanation

A culture-centred explanation may present the idea of individual choice differently in China. Such a contrast covers some of the public statements but fails to explain the observed sequence. It does not explain why American federal intervention took the form of facility regulation and targeted grants, why reconstruction became an insurance right, why professional guidelines remained plural, why China's large 2005 project encountered fiscal instability, or why rural and urban protocols used different imaging sequences. Each outcome resulted from the interaction of institutions, actor coalitions and capacity.

Culture is better understood as material that institutions organize. Ideas about the breast, femininity, family duty, cancer stigma, privacy and trust affect participation and care-seeking behaviour [42-44]. The policy consequences will depend on whether clinicians discuss them, advocates publicize them, women's organisations mobilise around them, payers reimburse relevant services, and programmes measure the resulting barriers. Therefore, institutional analysis is not in opposition to culture but studies how cultural meanings are expressed in public health behaviour.

6.3 Public-health Implications

Three Conclusions follow. First, the screening policy should be seen as a path of care. Increasing the number of tests will not help if the abnormal results are not handled in time and the women do not receive timely medical attention. Therefore, the quality indicators should include notification, diagnosis completion, treatment initiation, time interval, loss to follow-up, financial burden and patient-reported outcomes.

Second, the technology should be regulated in the context of a system. Debates over mammography, ultrasonography, risk scores and artificial intelligence should cover workforce, quality assurance, referral, data interoperability and opportunity cost. A high-performing test in a study may yield poor population benefits if the delivery system cannot complete the pathway; a resource-adapted test still requires strict quality and evaluation.

Third, equity is not only about eliminating the price of the first test. Transportation, time away from paid and unpaid work, documentation, stable primary care, diagnostic fees, treatment costs, trust, health literacy and geographic distance can all turn formal eligibility into practical exclusion [30,42-44,47]. Each country can learn from the institutional strengths of others without adopting their whole systems. The United States has experience in national quality regulation, rights-based information and survivor participation; China has had experience in centrally organised outreach, large-scale mobilisation and adaptation across heterogeneous service environments. Transfer should occur at the level of functions and mechanisms, not institutional labels.

6.4 Theoretical Implications and Limitations

Based on the above analysis, the government should adopt a system of national cancer control rather than a single policy. Governance, Finance, Technology, Representation and Equity are related. A country may be centralised in agenda setting but decentralised in implementation; pluralistic in standards but highly regulated in technical quality; formally generous in screening but discontinuous after detection. Configuration analysis can see these combinations more clearly than a one-dimensional state-market scale.

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The results are not final at present. Based on published and documentary evidence, this article does not contain original archival interviews. It does not know if the two policies have changed the death rate, and it also disregards regional differences. Chinese early-period evidence is particularly scarce, and American scholarship may have overrepresented the most visible advocacy organisations. In the future, we will compare the results of abnormal screenings in different provinces and municipalities to learn how women have experienced the transition from eligibility to treatment and survivorship themselves. The above deficiencies do not invalidate the institutional comparison; rather, they are subjects for further study on the mechanism.

7. Conclusion

Between 1980 and 2025, breast cancer has gradually been added to the list of public health governance in both China and the United States. The scope of the policy has expanded from treating diagnosed tumours to managing population health risks, early detection, quality of life, informed participation, rehabilitation, survivorship and inequality. This expansion was not a general rule based on biomedical evidence.

The United States has built a regulated pluralist system for mammography quality through laws, professional guideline competitions, insurance entitlements, targeted public-health programs and survivor advocacy. It has a good-quality infrastructure for long-term care, multiple rights-claim paths, and institutional recognition of patient choice and survivorship. At present, the deficiencies are fragmented access for payers, providers, jurisdictions and social groups. China constructed a state-coordinated targeted programmatic regime through national priority setting, public financing for designated populations, maternal and child health and public-hospital networks, organized outreach, and mixed technologies. Strengths of this type include the ability to undertake large-scale projects and focus on neglected groups. The continuous deficiencies are uneven local capabilities and an incomplete chain of screening, diagnosis, treatment and long-term care.

Therefore, the main answer to the research question is institutional translation. Biomedical knowledge and global public health norms provided a shared repertoire, but domestic institutions determined which actors could speak, which women were deemed eligible, which technologies were feasible, who paid, and who bore the responsibility after detection. Recently, there has been convergence in risk, equity, quality and whole-woman health, but the path dependence has not disappeared. Breast cancer prevention and care are still historically constructed systems that determine who should be protected, how, by whom, at what cost, and with what voice through negotiations among states, professions, payers, organisations and women.

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Conflicts of Interest

The authors declare no conflict of interest.

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