International Cancer Patient Coalition

Canada

Colorectal Cancer Factsheet: Insights & Key Developments

Key Insights on Colorectal Cancer Care and Infrastructure

Core Pillars:

1. Infrastructure
2. Treatment Access, Research Funding and Awareness Campaigns
3. Survival Rates, Early Detection and Palliative Care
4. Utilization of Biomarkers
5. Clinical Guidelines
6. Reimbursement
7. Colorectal Cancer Screening

Colorectal cancer remains one of the most prevalent cancers worldwide, affecting millions of individuals each year. Despite advancements in diagnostics, treatment, and awareness, disparities in access to care, molecular testing, and specialized centers persist.

This factsheet provides a comprehensive overview of key pillars shaping colorectal cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Among the top 2 cancers in Canadian men.
- Incidence rate: Around 51 per 100,000 men per year.
- Total new cases (2022): Approximately 12,000 men.
- Daily diagnoses (2022): About 33 men per day.
- Deaths (2022): Around 4,500 men.
- 5-year survival rate: Estimated 65–70%, due to strong screening and early intervention.
- Most affected age group: Men aged 60–79.
- Screening participation: Organized screening exists across all provinces, using FOBT or FIT starting at age 50; participation is generally high.

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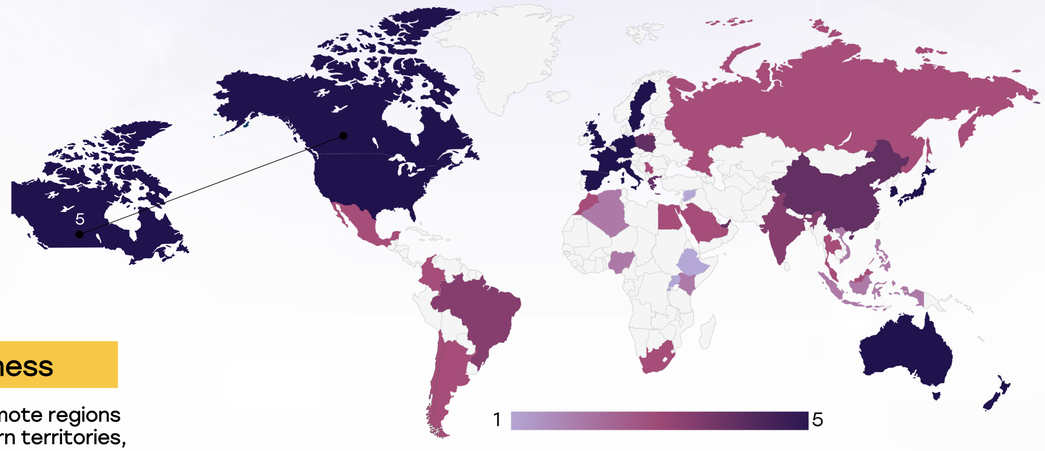
Infrastructure



Strengths

- Canada has a **comprehensive healthcare infrastructure** with leading cancer centers in each province (e.g., Princess Margaret Hospital, BC Cancer, the Jewish General).
- **Widespread availability of colonoscopy, pathology labs, and imaging** in major urban centers.

Weakness

- **Rural and remote regions (e.g., Northern territories, Indigenous communities)** have limited access to specialized diagnostic and treatment facilities.
- Molecular diagnostic capability is centralized—many community hospitals lack on-site capability for NGS-based CRC biomarkers.

S W O T

Opportunity

- Expand **telepathology and mobile endoscopy units** to underserved regions.
- Invest in establishing **regional molecular testing hubs** to decentralize access.

Threats

- Geographic and workforce challenges can delay care delivery in remote areas.
- Recruitment and retention of oncologists/pathologists in rural zones remain difficult.

5. Advanced nationwide infrastructure, widespread availability in public and private sectors, integration with clinical practice.

4. Strong infrastructure in major hospitals and cancer centers, some regional disparities.

3. Moderate infrastructure, primarily in private settings or research institutions.

2. Limited infrastructure, available only in select centers or for high-cost private testing.

1. Minimal or no infrastructure, testing mostly unavailable or sent abroad.

Country	Specialized Centers	Genetic & Molecular Testing Infrastructure
South Africa	3	3
Kenya	2	2
Nigeria	2	2
Egypt	2	3
Morocco	2	2
Algeria	2	2
Ethiopia	1	1
India	3	4
Japan	4	4
South Korea	4	4
China	4	4
Thailand	3	3
Singapore	4	4
United Kingdom	4	4
Germany	5	4
France	4	4
Netherlands	5	4
Sweden	5	4
Italy	4	4
Spain	4	4
Poland	4	3
Mexico	2	3
Brazil	3	3
Argentina	3	3
Chile	3	3
Colombia	2	3
United States	5	5
Canada	5	4
Australia	4	4
New Zealand	4	4
Greece	4	3
Rwanda	1	1
Uganda	1	1
Serbia	3	3
Saudi Arabia	4	4
UAE	4	4
Syria	1	1
Indonesia	2	2
Vietnam	3	3
Philippines	2	2
Russia	4	3
Malaysia	4	4

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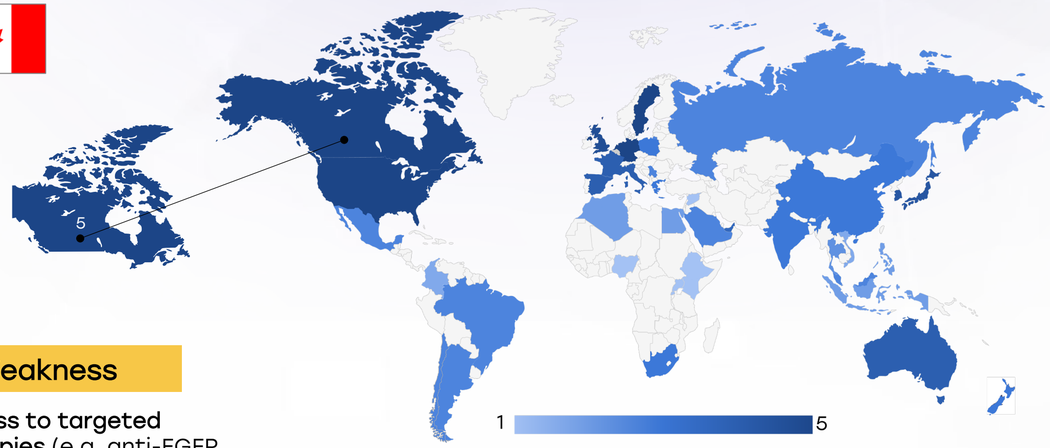
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Universal health coverage (via provincial health plans) ensures **free access to surgery, chemotherapy, radiotherapy, and standard diagnostics**.
- Canada is an active participant in global CRC clinical trials and **biomarker research**, supported by agencies like CIHR and CCS.

Weakness

- **Access to targeted therapies** (e.g. anti-EGFR or immunotherapy for MSI-high CRC) may vary regionally or face formulary delays.
- Public awareness campaigns for CRC are less visible than those for breast or lung cancer.

Opportunity

- Increase awareness, particularly in **high-risk sub-populations** (e.g. Indigenous men, low-income urban neighborhoods).
- Expand participation in **biomarker-guided clinical trials** across provinces.

Threats

- Provincial disparities in funding allocation may delay adoption of newer therapies.
- Competing health priorities could divert resources from CRC initiatives.

S W O T

5. Strong healthcare infrastructure with comprehensive treatment access, high research funding, and nationwide awareness campaigns. Patients have access to advanced therapies, clinical trials, and widespread early detection programs.

4. Well-developed system with good treatment availability, strong research funding, and effective but regionally focused awareness campaigns. Some disparities may exist in rural areas or between public and private sectors.

3. Moderate development, with specialized treatments available in major hospitals, research funding concentrated on specific cancers, and occasional but limited awareness efforts. Healthcare access may be restricted by cost or geography.

2. Limited system where cancer treatment is available only in select urban centers, research funding is minimal or sporadic, and awareness campaigns are rare or underfunded. Patients often face long wait times or financial barriers.

1. Poor infrastructure with severe barriers to treatment, little to no research funding, and lack of structured awareness campaigns. Cancer care is largely inaccessible, with many patients relying on out-of-pocket expenses or external aid.

Country	Treatment Access	Research Funding	Awareness Campaigns
South Africa	3	3	3
Kenya	1	1	1
Nigeria	1	1	1
Egypt	2	2	2
Morocco	2	2	2
Algeria	2	2	2
Ethiopia	1	1	1
India	3	3	3
Japan	4	4	5
South Korea	4	4	5
China	3	3	3
Thailand	2	3	2
Singapore	4	5	5
United Kingdom	4	5	5
Germany	5	5	5
France	4	4	4
Netherlands	5	5	5
Sweden	5	5	5
Italy	4	4	4
Spain	4	4	4
Poland	3	3	3
Mexico	2	3	3
Brazil	2	3	3
Argentina	2	3	3
Chile	2	3	3
Colombia	1	2	2
United States	5	5	5
Canada	5	5	5
Australia	4	4	4
New Zealand	3	3	3
Greece	3	3	3
Rwanda	1	1	1
Uganda	1	1	1
Serbia	2	3	3
Saudi Arabia	3	2	3
UAE	4	3	4
Syria	1	1	1
Indonesia	2	2	2
Vietnam	2	1	2
Philippines	3	2	2
Russia	3	3	2
Malaysia	3	3	3

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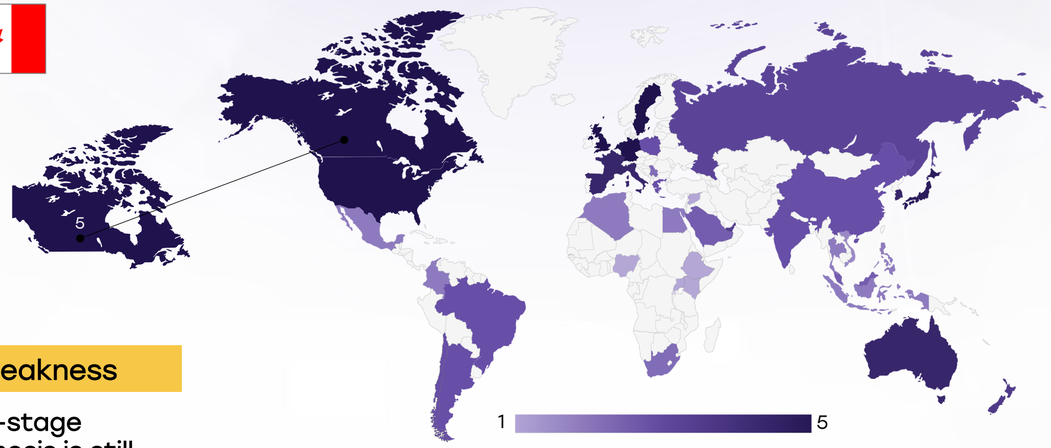
Survival Rates, Early Detection and Palliative Care



Strengths

- Five-year survival for early-stage CRC exceeds **65–70%**, among the best globally.
- **Palliative care services** are integrated into cancer care pathways and widely accessible.

Weakness

- **Late-stage diagnosis is still common among younger adults (<50)** and certain ethnic groups.
- **Disparities in palliative care access persist** for rural or remote communities.

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Opportunity

- Promote **awareness of early CRC signs in under-50 individuals** and high-risk groups.
- Improve **community-based palliative care models** with nurse-led and Indigenous-specific outreach.

Threats

- Rising incidence in younger adults may strain surveillance and diagnostic systems.
- Geographic barriers may continue to hinder access to timely palliative care.

5. High survival rates, strong early detection programs, and well-established palliative care services. Patients have access to timely diagnosis, advanced treatments, and comprehensive end-of-life care.

4. Good survival rates, effective early detection efforts, and accessible but regionally limited palliative care. Some disparities may exist in rural areas or for specific cancer types.

3. Moderate survival rates, early detection available but not widespread, and palliative care services mainly in urban centers. Some patients experience delays in diagnosis or limited end-of-life care.

2. Low survival rates, early detection efforts are inconsistent or underfunded, and palliative care is minimal or only available in select hospitals. Cancer patients face significant access barriers.

1. Very low survival rates, poor early detection infrastructure, and almost no palliative care services. Many patients are diagnosed late and lack proper support for pain management and end-of-life care.

Country	Survival Rates	Early Detection	Palliative Care
South Africa	2	3	2
Kenya	1	1	1
Nigeria	1	1	1
Egypt	2	2	2
Morocco	2	2	2
Algeria	2	2	2
Ethiopia	1	1	1
India	3	3	3
Japan	5	4	5
South Korea	5	4	5
China	3	3	4
Thailand	2	2	2
Singapore	5	5	5
United Kingdom	5	5	5
Germany	5	5	5
France	5	4	4
Netherlands	5	5	5
Sweden	5	5	5
Italy	5	4	5
Spain	5	4	5
Poland	3	3	4
Mexico	2	2	2
Brazil	3	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	2	2	2
United States	5	5	5
Canada	5	5	5
Australia	5	4	4
New Zealand	4	4	3
Greece	3	3	3
Rwanda	1	1	1
Uganda	1	1	1
Serbia	2	3	2
Saudi Arabia	3	2	3
UAE	4	3	4
Syria	1	1	1
Indonesia	2	2	2
Vietnam	2	1	2
Philippines	2	3	2
Russia	4	3	3
Malaysia	3	2	3

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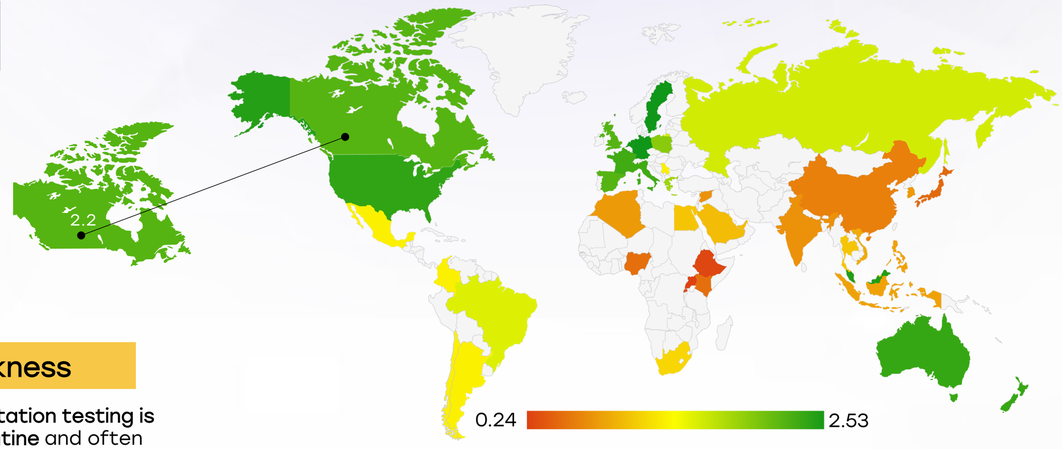
Utilization of Biomarkers



Strengths

- **KRAS, NRAS, BRAF, and MSI/dMMR testing are standard for metastatic CRC** in most provinces.
- MSI/dMMR testing is routinely performed and helps guide immunotherapy decisions; KRAS/NRAS/BRAF guide anti-EGFR therapy.
- Biomarker-informed treatment is standard at major cancer centers.

Weakness

- **PIK3CA mutation testing is not yet routine** and often limited to research contexts.
- Turnaround time and access to testing may vary across provincial labs.

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Opportunity

- Add **PIK3CA to standard diagnostic panels** for CRC.
- Standardize molecular testing protocols across provinces to ensure consistency.

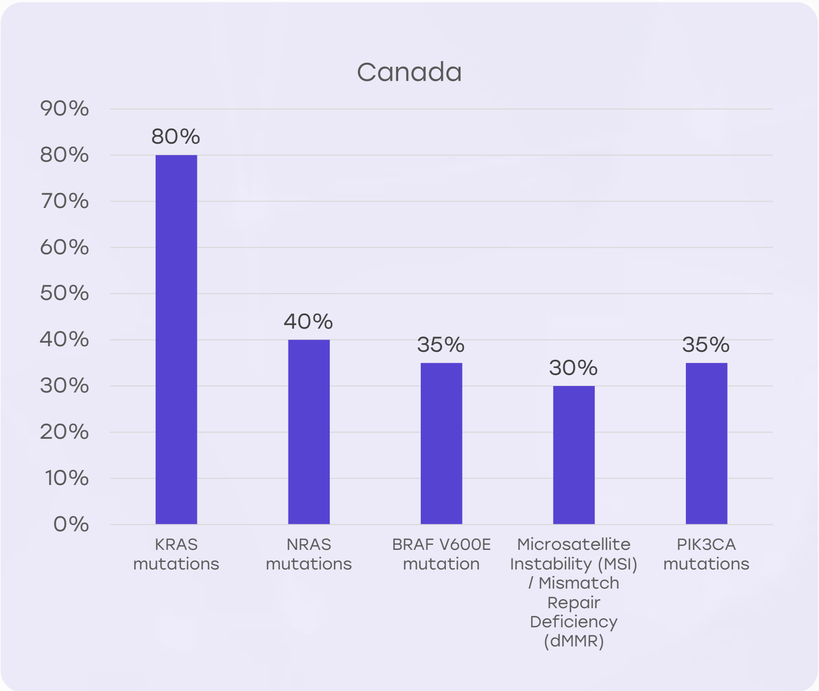
Threats

- Provincial budget constraints may limit expansion of biomarker testing.
- Delayed uptake of emerging biomarkers can affect personalized care.

Moderate utilization, often restricted to major hospitals or private healthcare settings. Some patients may not receive biomarker testing due to cost or limited availability in public healthcare systems.

Biomarker testing is available but underutilized, with significant barriers such as high costs, lack of awareness, or limited infrastructure. Many patients may not receive recommended biomarker assessments.

Biomarker testing is rarely performed, often due to lack of infrastructure, awareness, or financial barriers. Patients typically do not receive targeted therapies based on biomarker status.



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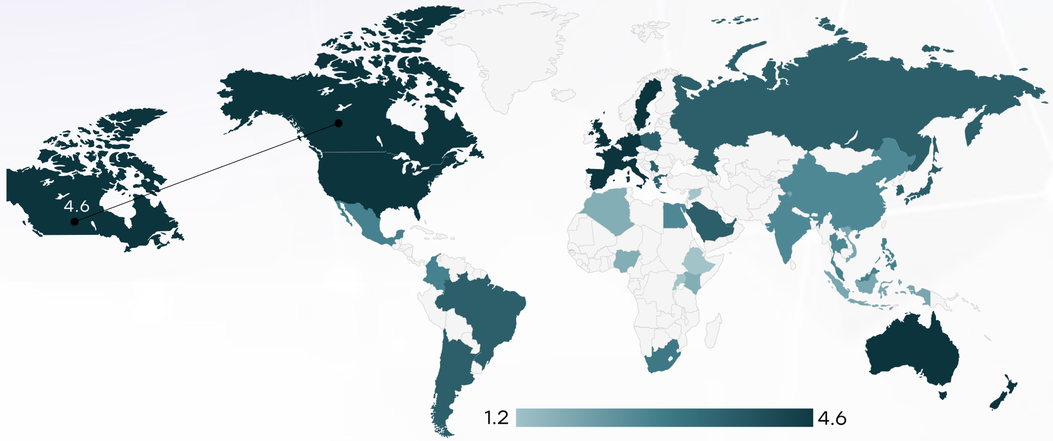
Clinical Guidelines



Strengths

- Healthcare providers follow **nationally endorsed guidelines** (Cancer Care Ontario, BC Cancer, CADTH) aligned with ESMO/NCCN; biomarker-informed algorithms are embedded in metastatic CRC care.

Weakness

- Limited local guidance on applying biomarkers in **non-metastatic or younger-onset CRC**.
- Implementation of guideline updates may lag in smaller or rural hospitals.

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Opportunity

- Enhance guidelines to include **PIK3CA and broader molecular stratification** in treatment pathways.
- Disseminate **digital clinical decision support tools** to ensure guideline uptake province-wide.

Threats

- Training and change-management delays could slow adherence to updated protocols.
- Resource limitations in smaller centers may hinder implementation.

	Very High	High	Medium	Low	Very Low
Clinical Guideline Implementation	O	✖	✖	✖	✖
Feasibility of Integration	O	✖	✖	✖	✖
Adoption of International Guidelines	O	✖	✖	✖	✖
Engagement with Updates	✖	O	✖	✖	✖
ESMO Guidelines Implementation	O	✖	✖	✖	✖

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Reimbursement

Strengths

- CRC treatments, including biomarker testing (KRAS, MSI) and targeted therapies, are funded via **provincial health plans**.
- PCI-based immunotherapies for MSI-high disease are publicly reimbursed in most provinces.

Weakness

- **New or less-established biomarkers (e.g., PIK3CA)** may not be reimbursed uniformly.
- Time-to-approval for novel agents varies across provinces.

S W O T

Opportunity

- Advocate for **public reimbursement of all essential biomarker tests** nationwide.
- Pilot **value-based reimbursement frameworks** for biomarker-driven care pathways.

Threats

- Budgetary constraints could restrict funding for expanded diagnostics and precision therapies.
- Provincial differences may lead to inequitable access.

● A structured reimbursement system exists, ensuring biomarker testing is covered through national healthcare systems, insurance, or public-private partnerships. Patients face no direct financial burden.

● A reimbursement framework is in place, but patients may still have out-of-pocket expenses such as co-pays, limited coverage, or financial caps on testing.

● No formal reimbursement system exists, meaning patients must fully cover the cost of biomarker testing out-of-pocket.

Country	Reimbursement Framework	No-cost Access
United States	●	○
United Kingdom	●	●
Canada	●	●
Australia	●	●
Germany	●	●
France	●	●
Netherlands	●	●
Sweden	●	●
Italy	●	●
Spain	●	●
Poland	●	●
Japan	●	●
South Korea	●	●
China	●	●
India	○	○
Singapore	●	●
Thailand	●	●
South Africa	○	○
Kenya	○	○
Nigeria	○	○
Egypt	○	○
Morocco	○	○
Algeria	●	●
Ethiopia	○	○
Mexico	●	●
Brazil	●	●
Argentina	●	●
Chile	●	●
Colombia	●	●
New Zealand	●	●
Greece	●	●
Rwanda	○	○
Uganda	○	○
Serbia	●	●
Saudi Arabia	●	●
UAE	●	●
Syria	○	○
Indonesia	●	○
Vietnam	●	○
Philippines	○	○
Russia	●	●
Malaysia	●	●

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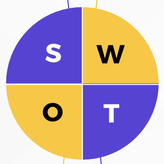
Colorectal Cancer Screening

Strengths

- All provinces have rolled out **organized FIT-based screening programs** (biennial or annual) for ages 50–74.
- High public trust in screening leads to reasonable participation rates (though variable by region).

Weakness

- **Uptake remains suboptimal (~50–60%)** in certain provinces and demographic groups (e.g. Indigenous peoples, men under 55).
- Follow-up colonoscopy rates post-FIT can be delayed due to capacity constraints.



Opportunity

- Improve **targeted outreach** to underserved populations through culturally appropriate education.
- Use **risk-adaptive models** combining family history, genetic risk, and FIT results for personalized screening.

Threats

- Endoscopy waitlist backlogs could delay diagnostic follow-up.
- Misinformation or fear around colonoscopy can reduce participation.

Country	Colorectal Cancer Screening
United States	Annual LDCT (50-80 years, high-risk smokers)
United Kingdom	LDCT for high-risk individuals (55-74 years)
Canada	LDCT for high-risk individuals (55-74 years)
Australia	No national program, high-risk groups advised LDCT
Germany	No national program, under evaluation
France	No national LDCT screening
Netherlands	Participating in European screening studies
Sweden	No national LDCT screening
Italy	Regional pilot LDCT screening
Spain	No national LDCT program
Poland	No national program
Japan	No national LDCT program
South Korea	LDCT for high-risk individuals (50-74 years)
China	No national LDCT program
India	No national LDCT program
Singapore	No national LDCT program
Saudi Arabia	No national LDCT program; some hospital-based opportunistic screening
UAE	No national LDCT program; early-stage pilot studies ongoing in select hospitals
Syria	No national LDCT program; screening not prioritized due to conflict
Malaysia	No program; high-risk CT pilots

Country	Colorectal Cancer Screening
Thailand	No national LDCT program
South Africa	No national LDCT program
Kenya	No national LDCT program
Nigeria	No national LDCT program
Egypt	No national LDCT program
Morocco	No national LDCT program
Algeria	No national LDCT program
Ethiopia	No national LDCT program
Mexico	No national LDCT program
Brazil	No national LDCT program
Argentina	No national LDCT program
Chile	No national LDCT program
Colombia	No national LDCT program
New Zealand	No national LDCT program
Greece	No national LDCT program
Rwanda	No national LDCT program
Uganda	No national LDCT program
Serbia	No national LDCT program
Indonesia	No national LDCT program; opportunistic screening in private sector
Vietnam	No national LDCT program; early pilot screening studies in Hanoi and Ho Chi Minh
Philippines	No national LDCT program; feasibility and awareness programs under discussion
Russia	No formal national LDCT program; regional pilot screening programs in large cities