

Sweden

Lung Cancer Factsheet: Insights & Key Developments

Key Insights on Lung 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. Lung Cancer Screening

Lung 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.

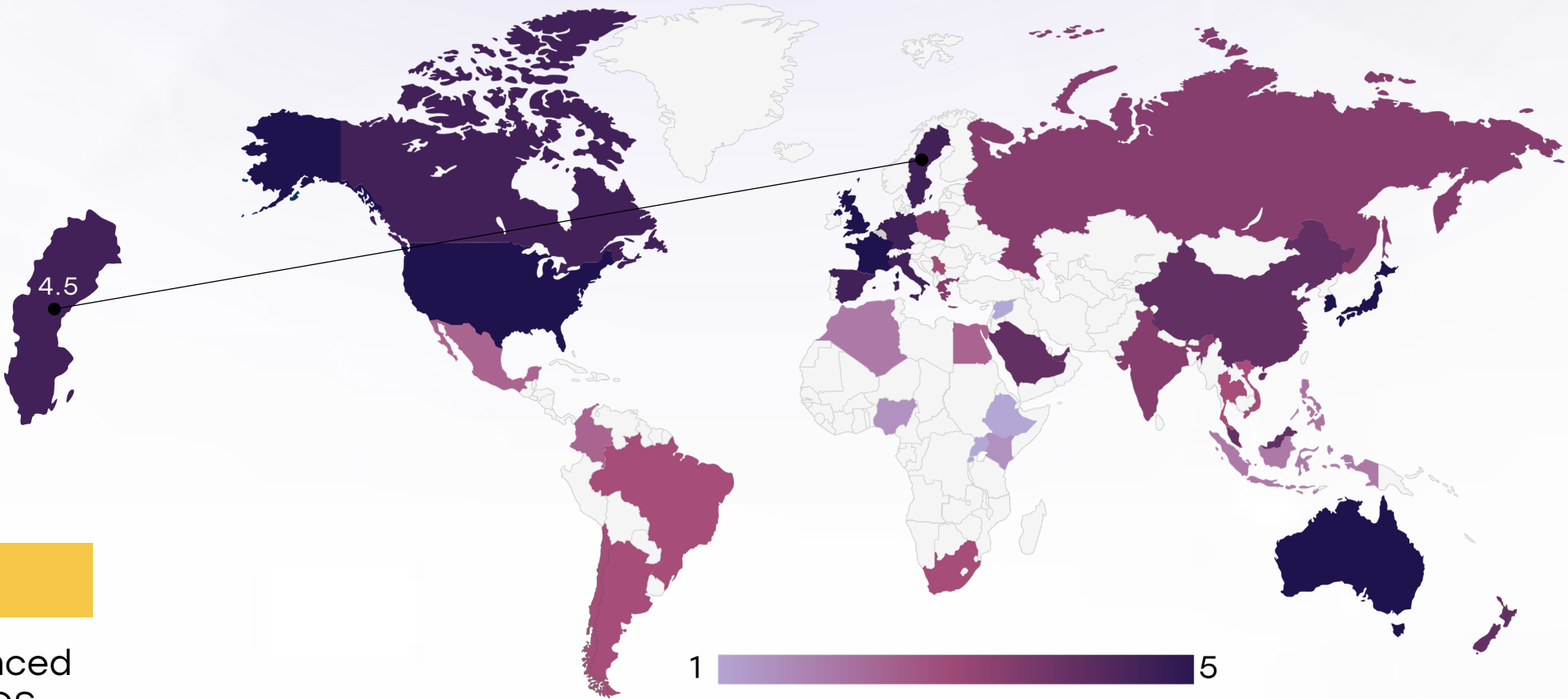
This factsheet provides a comprehensive overview of key pillars shaping lung cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Lung cancer incidence: ~4,000–4,200 new cases per year
- Incidence rate: ~40 per 100,000 population
- Lung cancer deaths annually: ~3,200
- Most common in age group: 65–79 years
- Higher incidence in men, but rates in women have been increasing
- 5-year survival rate: ~21% overall
- Non-small cell lung cancer (NSCLC): ~85% of cases
- Small cell lung cancer (SCLC): ~15% of cases
- EGFR mutation prevalence: ~10–15% in NSCLC patients
- ALK rearrangement prevalence: ~3–5%
- Molecular testing availability: High across cancer centers
- Access to targeted therapies and immunotherapies: Standard practice
- Low-dose CT lung screening: Not part of national screening program yet
- Smoking prevalence (daily smokers): ~6%
- Smoking is the leading risk factor, though non-smoker cases are increasing
- Sweden has one of the lowest smoking rates in Europe

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Infrastructure



Strengths

- Sweden has a highly developed and decentralized healthcare infrastructure with specialized oncology services available in all six healthcare regions. Leading cancer centers include Karolinska University Hospital (Stockholm), Sahlgrenska University Hospital (Gothenburg), and Skåne University Hospital (Lund).

Weakness

- Access to advanced services (e.g., NGS, clinical trials) may be more limited in northern and rural regions.

Opportunity

- National reforms in digital health and precision medicine (e.g., Genomic Medicine Sweden) are improving infrastructure standardization.

Threats

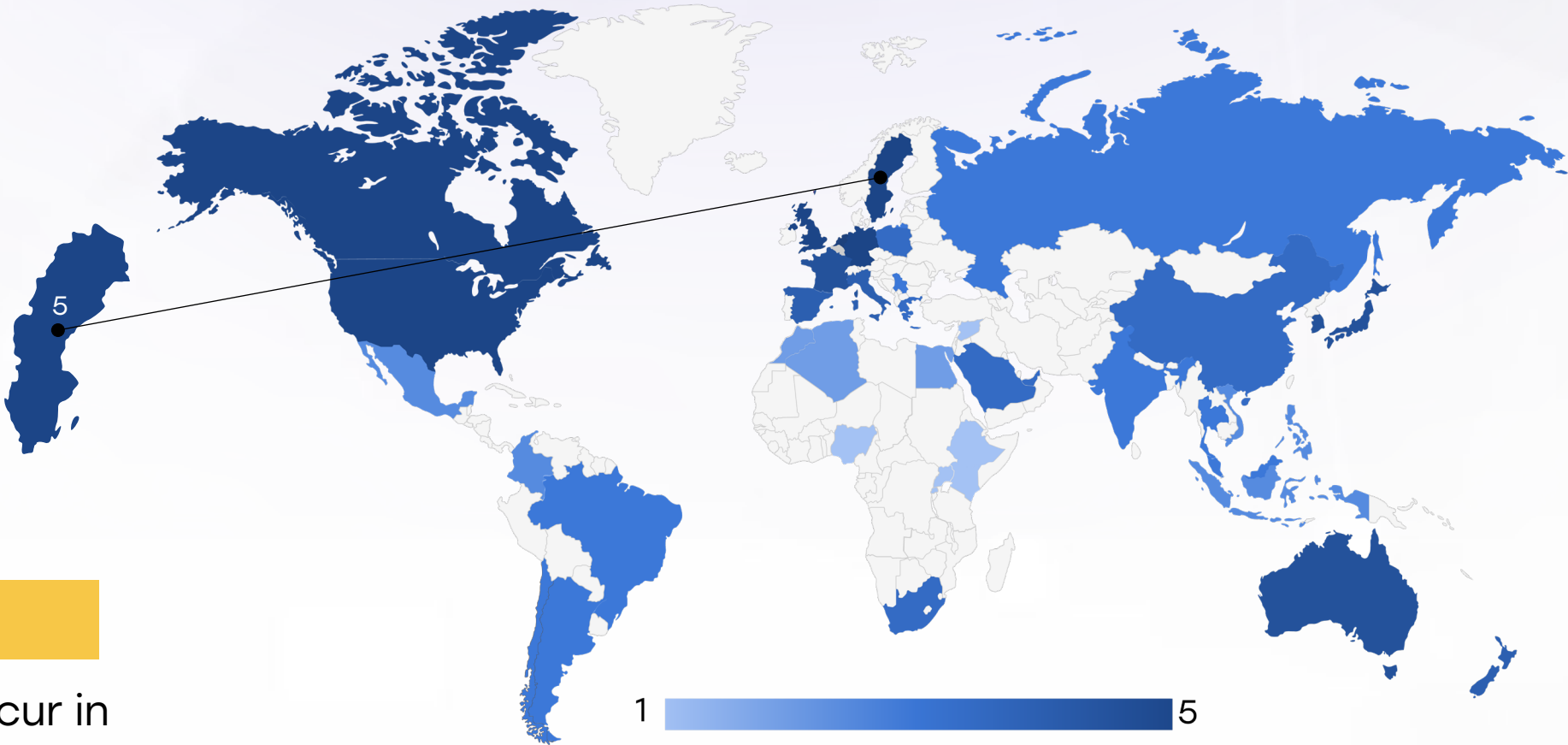
- Regional budget disparities could challenge equal implementation of infrastructure improvements across counties.



| Country | Specialized Centers | Genetic & Molecular Testing Infrastructure |
|----------------|---------------------|--|
| South Africa | | |
| Kenya | | |
| Nigeria | | |
| Egypt | | |
| Morocco | | |
| Algeria | | |
| Ethiopia | | |
| India | | |
| Japan | | |
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Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Universal coverage ensures equitable access to guideline-based lung cancer treatments, including immunotherapy and targeted drugs.

Weakness

- Delays may occur in national reimbursement processes for newly approved treatments due to assessment by TLV (Dental and Pharmaceutical Benefits Agency).













































































































Opportunity

- Sweden ranks high in clinical research per capita, with over 60 active lung cancer trials, supported by the Swedish Cancer Society and Vinnova funding.

Threats

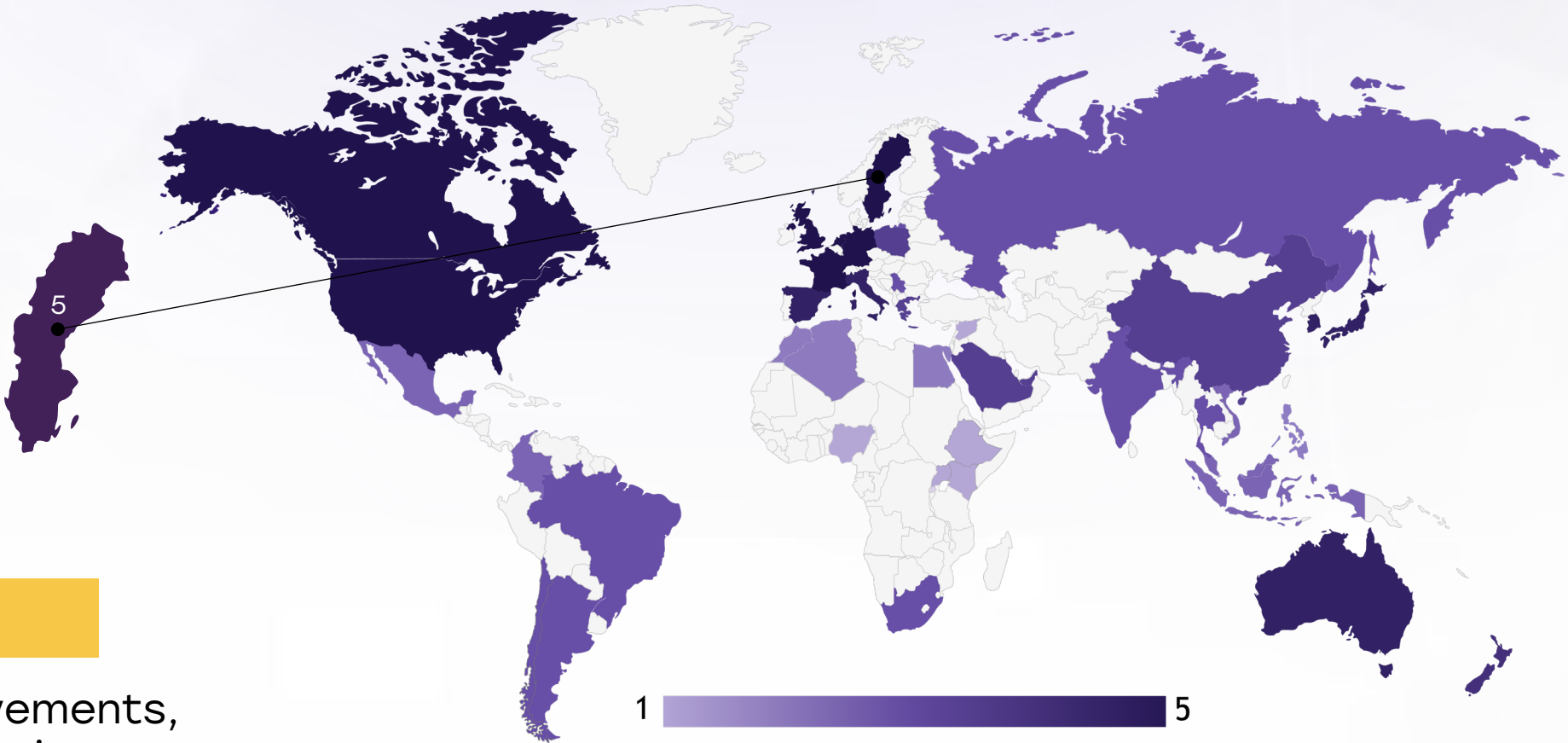
- Public awareness of lung cancer remains limited compared to breast or prostate cancer, despite higher mortality.

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 |  |  |  |
| Kenya |  |  |  |
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| Egypt |  |  |  |
| Morocco |  |  |  |
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Survival Rates, Early Detection and Palliative Care



Strengths

- Lung cancer 5-year survival has improved to around 23% (2023), largely due to early detection and access to therapies.

Weakness

- Despite improvements, disparities exist in early-stage detection between urban and rural patients.

Opportunity

- Palliative care is highly integrated into Sweden’s healthcare system—over 85% of cancer patients receive palliative support, including home-based and hospice care.

Threats

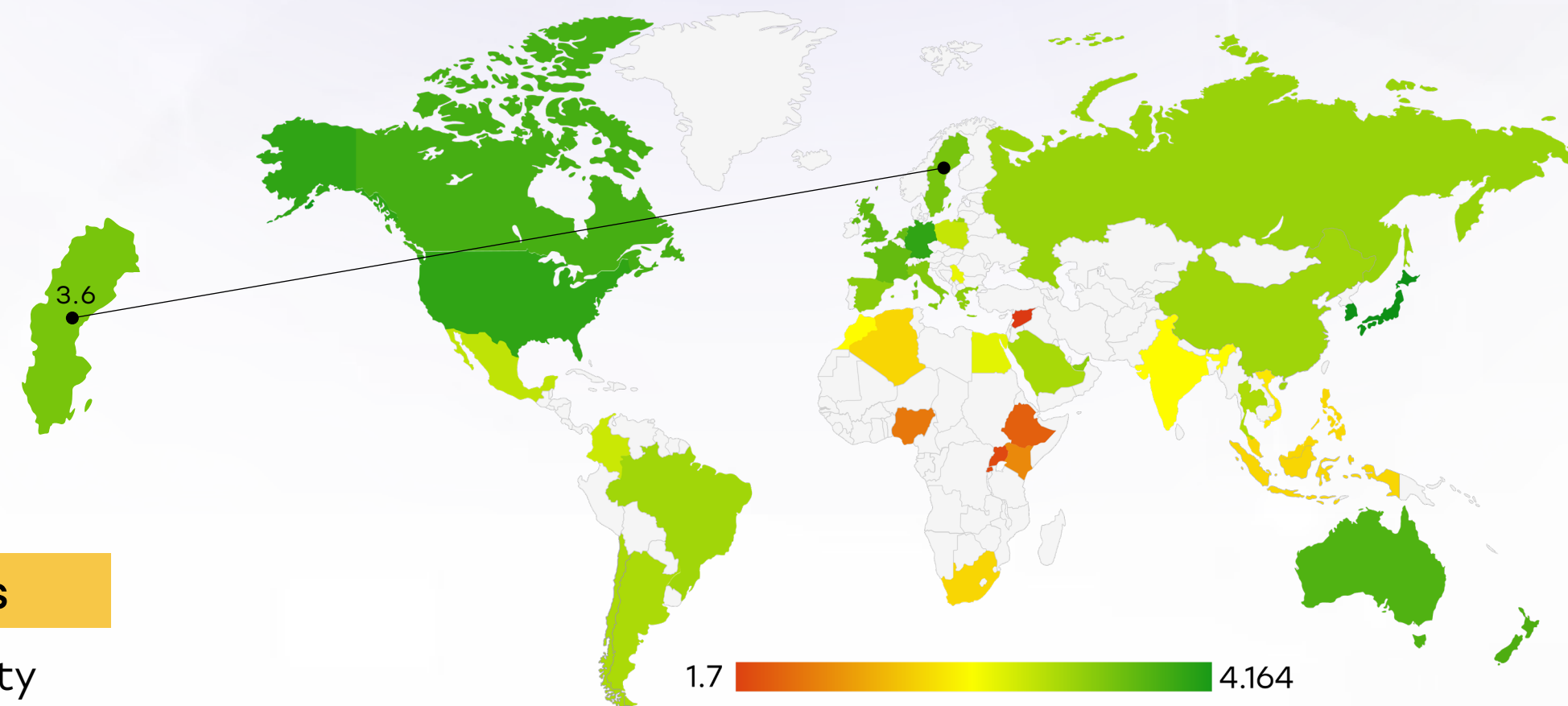
- Growing incidence among older populations could strain end-of-life care systems, especially in sparsely populated regions.

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 |
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Utilization of Biomarkers

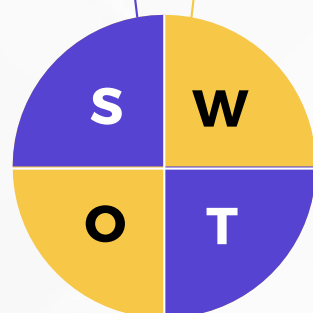


Strengths

- Biomarker testing (EGFR, ALK, ROS1, BRAF, PD-L1) is routine, and NGS is increasingly used in advanced-stage lung cancer.

Weakness

- Some variability exists in NGS access across regions, especially in remote counties.



Opportunity

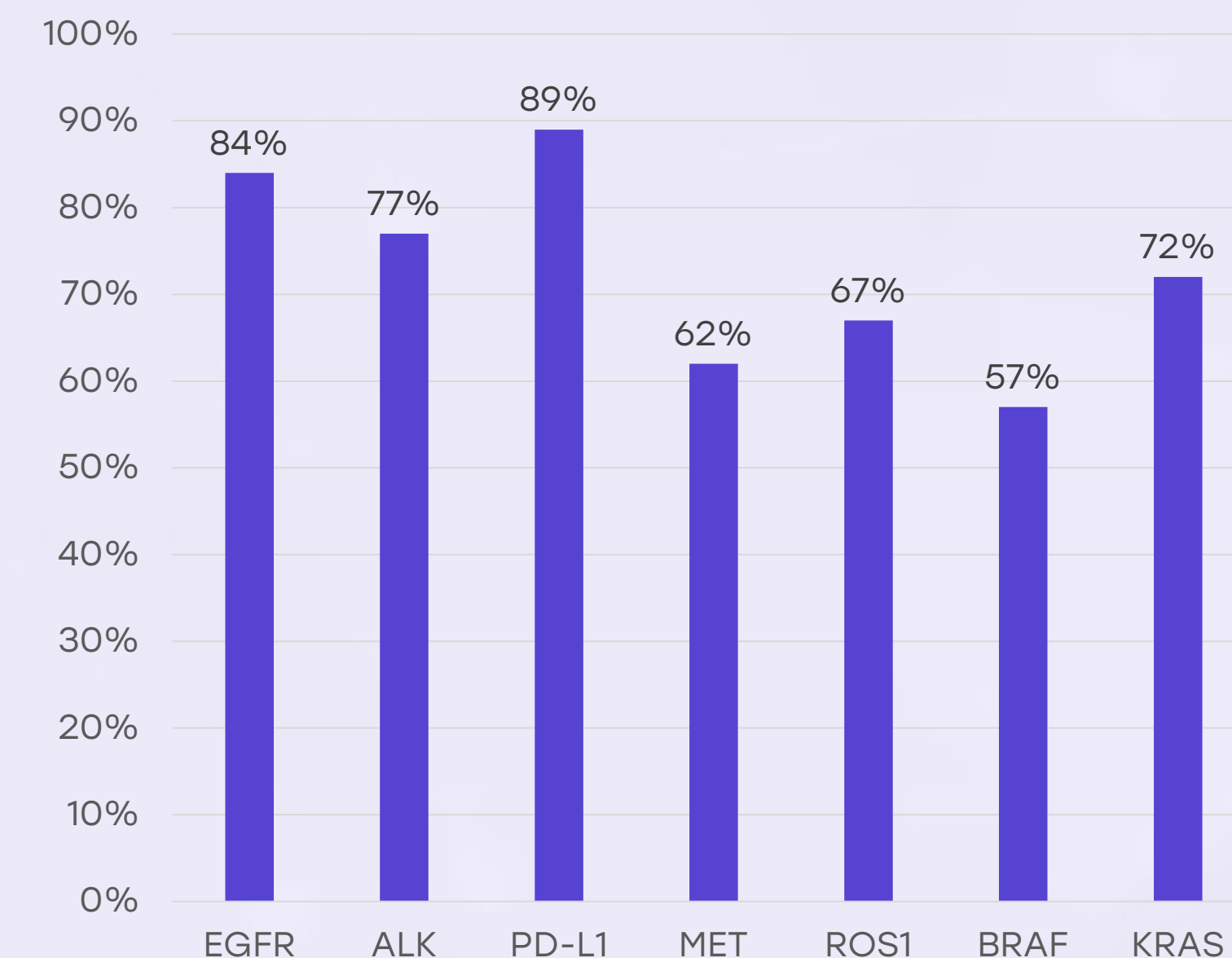
- The **Genomic Medicine Sweden (GMS)** initiative is driving the national integration of NGS and biomarker-guided therapy.

Threats

- Long-term funding and consistent workforce training remain necessary for sustained nationwide biomarker utilization.

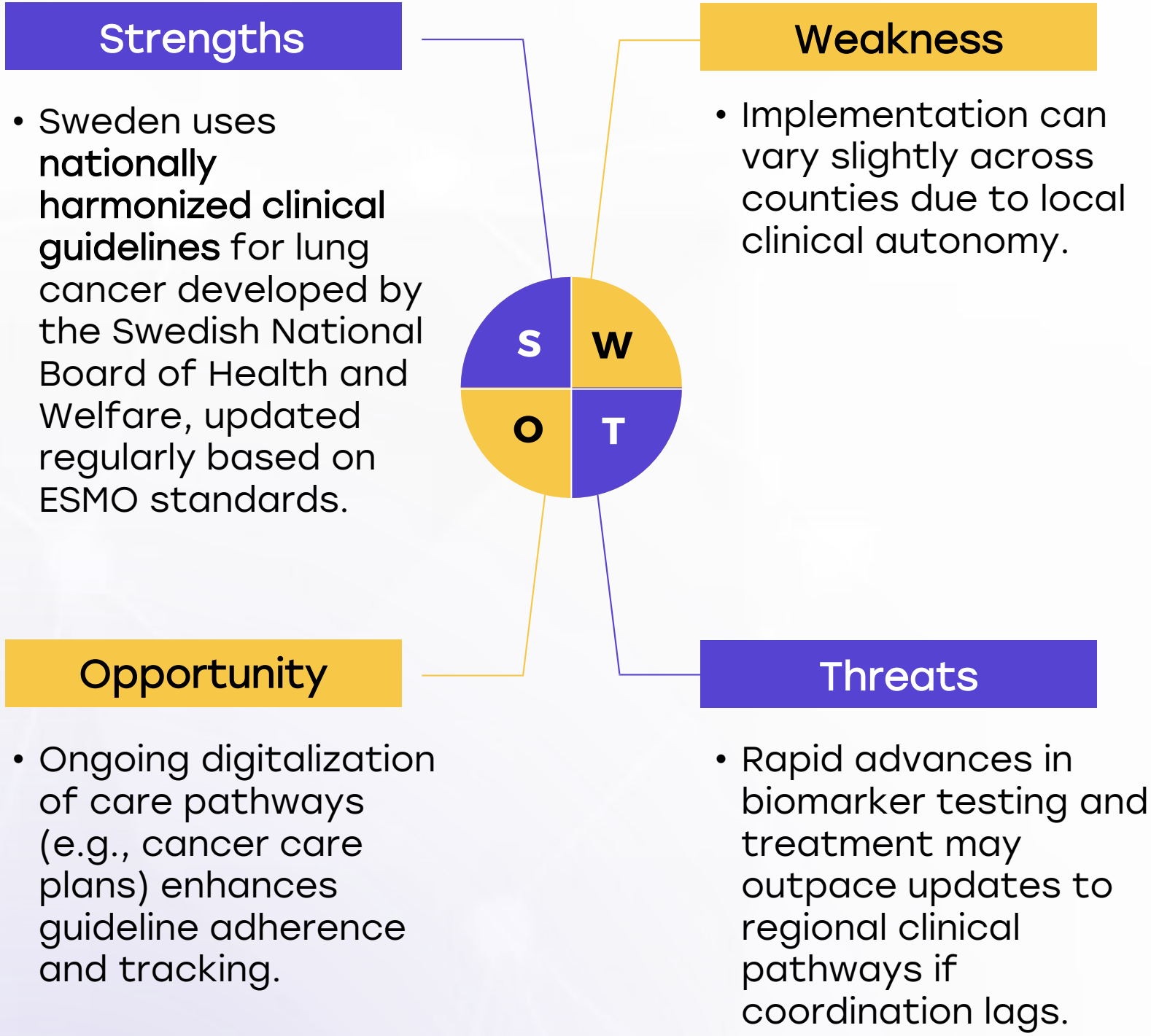
5. Biomarker testing is widely available and routinely performed as part of standard clinical practice. Strong integration into treatment decisions, with national coverage and reimbursement ensuring accessibility.
4. Biomarker testing is commonly used, but access may be limited in certain regions or patient groups. Some disparities exist in coverage or affordability, but it is still a crucial part of cancer diagnostics
3. 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.
2. 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.
1. 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



| | Very High | High | Medium | Low | Very Low |
|--------------------------------------|-----------|------|--------|-----|----------|
| Clinical Guideline Implementation | ○ | ✗ | ✗ | ✗ | ✗ |
| Feasibility of Integration | ○ | ✗ | ✗ | ✗ | ✗ |
| Adoption of International Guidelines | ○ | ✗ | ✗ | ✗ | ✗ |
| Engagement with Updates | ✗ | ○ | ✗ | ✗ | ✗ |
| ESMO Guidelines Implementation | ○ | ✗ | ✗ | ✗ | ✗ |

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Reimbursement



Strengths

- The TLV provides national reimbursement for approved cancer drugs, ensuring most therapies are covered in the public system.

Weakness

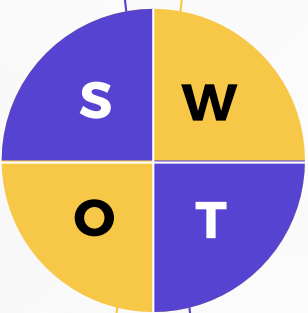
- Introduction of new treatments can face delays of 6–12 months post-EMA approval due to evaluation and pricing negotiations.

Opportunity

- The TLV's collaboration with other EU HTA bodies under EUnetHTA 21 could streamline access timelines in the future.

Threats

- Increasing costs of novel therapies and precision diagnostics could challenge sustainable public reimbursement.



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.



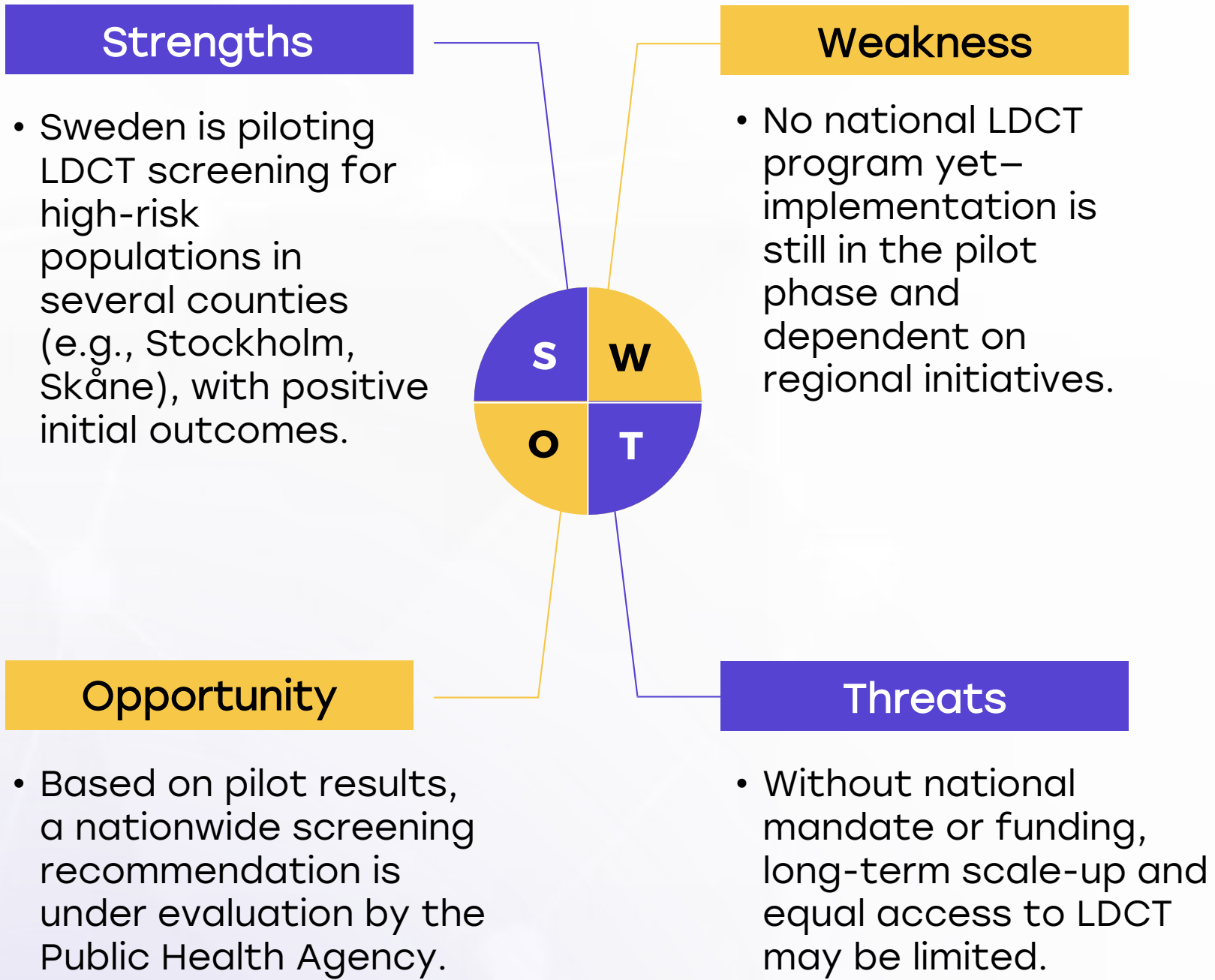
No formal reimbursement system exists, meaning patients must fully cover the cost of biomarker testing out-of-pocket.

| Country | Reimbursement Framework | No-cost Access |
|----------------|-------------------------|----------------|
| United States | | |
| United Kingdom | | |
| Canada | | |
| Australia | | |
| Germany | | |
| France | | |
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| Russia | | |
| Malaysia | | |

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Lung Cancer Screening



| Country | Lung 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 | Lung 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 |
| 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 |