CHILE

International Cancer Patient Coalition

BRIDGING THE GAP

Enhancing Equitable Access & Innovation in **Colorectal Cancer Care** in Chile

EXECUTIVE SUMMARY

Chile has substantial clinical capacity for colorectal cancer: organised screening activity exists in parts of the public system, tertiary centres provide high-quality diagnostics and treatment, and molecular testing and targeted therapies are available in major hospitals. However, regional inequities in screening coverage, colonoscopy capacity, molecular-test access and timely treatment hamper population-level impact.

With maturity **level 3** Chile can convert centre-level excellence into nationwide gains by standardising screening, expanding lab networks, strengthening referral pathways and using procurement/financing strategies to improve access to high-value therapies.

INTRODUCTION

Building on clinical foundations amid system gaps

Chile's health system — a mixed public–private model with strong tertiary hospitals and an established cancer-control agenda — provides a platform for accelerated CRC improvements. Key constraints are uneven screening uptake, delays in diagnostic follow-up, variable access to molecular diagnostics in the public sector, and financial barriers to some advanced therapies.

Focused policy, operational and financing reforms over 3–5 years can move Chile toward more equitable, measurable improvements in early detection and outcomes.

Chile at Level 3 – Colorectal Cancer Maturity Framework

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COLORECTAL CANCER IN CHILE

Current Landscape and Strategic Gaps

Pillar	Current Status	Strength	Policy Action
Early Detection & Diagnosis	Organised FIT-based screening exists in segments of the public system and some regional programmes; coverage and follow-up vary by region and socio-economic group.	Strong primary-care network and established cancer-control structures to build on.	Standardise a phased national FIT screening protocol (target 50–74), ensure active call/recall, and guarantee timely colonoscopy for positive screens with mapped capacity expansion.
Biomarker & Molecular Testing	MSI/MMR and RAS/BRAF testing and targeted-panel testing are available in tertiary/private labs; coverage in the public sector is inconsistent and turnaround times vary.	Established molecular and pathology labs in major hospitals that can act as hubs.	Create hub-and-spoke molecular lab networks with public access pathways; set turnaround targets and QA; subsidise key tests for public patients with clear referral flows.
Treatment Access	High-quality surgery, radiotherapy and systemic therapy available in tertiary centres; access to newest targeted agents and immunotherapies is uneven and often limited by cost and reimbursement rules.	Well-resourced oncology centres and surgical expertise concentrated in urban centres.	Standardise availability of essential chemotherapy regimens across public hospitals; pursue pooled procurement, outcome -based contracts or managed access for high-cost agents; strengthen regional surgical referral networks.
Clinical Guidelines & Quality Standards	National and clinical society guidance exist but adherence and audits vary across regions and providers.	Active professional societies and academic centres that can drive guideline adoption.	Adopt a unified, tiered national CRC guideline; implement clinician training, accreditation of CRC services and routine outcome auditing (stage at diagnosis, time-to-treatment).
Palliative & Survivorship Care	Palliative and survivorship services are available in major cities but limited in rural and underserved areas; survivorship programmes are not yet standard across providers.	Existing hospice and palliative models and NGO activity that can be scaled.	Integrate palliative care into oncology and primary care, ensure opioid availability and training, and develop standardised survivorship pathways (stoma care, rehab, psychosocial support) across regions.

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CONCLUSION & Call to Action

Chile stands at an inflection point: clinical and laboratory strengths exist, but inconsistent screening coverage, diagnostic bottlenecks, and unequal access to molecular-guided therapies limit population impact. The next phase should prioritise system-level scale-up — standardised national screening with guaranteed diagnostic follow-up, hub-and-spoke molecular lab expansion, procurement/financing approaches to widen access to high-value therapies, and strengthened palliative and survivorship services. This requires coordinated leadership from the **Ministry of Health, regional health services, tertiary centres, professional societies, and payers.**

KEY POLICY PRIORITIES

1. **Standardise & Scale Screening —** national FIT protocol with active call/recall, capacity mapping and guaranteed colonoscopy follow-up.
2. **Operationalise Molecular Lab Networks —** hub-and-spoke model, QA and public reimbursement/subsidy for MSI/RAS/BRAF and priority panels.
3. **Improve Treatment Equity —** ensure essential chem across public hospitals; negotiate pooled procurement/managed access for targeted/immunotherapies.
4. **Adopt National Clinical Pathways —** tiered guidelines, clinician training and routine clinical audits linked to improvement plans.
5. **Expand Palliative & Survivorship Care —** integrate into primary/oncology services, secure opioid access/training, and roll out survivorship clinics and stoma-care support.

CONCLUSION

At **Level 3**, Chile has the operational and clinical foundations to rapidly improve CRC outcomes by converting institutional excellence into system-wide, equitable services. Prioritising screening scale-up with guaranteed diagnostic follow-up, expanding accessible molecular diagnostics, reforming procurement/financing for high-cost drugs, and scaling palliative/survivorship support will deliver measurable reductions in late-stage presentation and improve survival across the country.