



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.

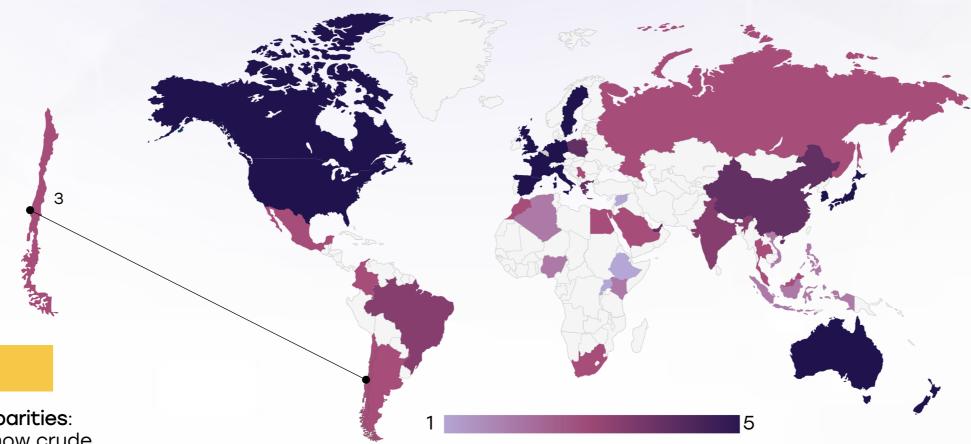




- Major urban hospitals such as in Santiago and Punta Arenas have advanced diagnostic services (colonoscopy, imaging, surgery) and can support oncologic care.
- Pilot CRC screening studies (e.g. PRENEC/PREVICOLON) demonstrated high-quality colonoscopy completion (>94%) and high adenoma detection rates (~42%)

Opportunity

- Develop regional centers with molecular and endoscopy capacity, leveraging pilot screening infrastructure.
- Build telemedicine units to support rural and underserved areas.



 Strong regional disparities: southern regions show crude incidence and mortality as high as 34.6 and 20.7 per 100,000 respectively, while northern regions remain low.

Weakness

• Limited molecular diagnostic capacity in most public labs.

Threats

remains centralized in

centralized distribution

delay regional expansion..

Santiago; resource

constraints and

· Healthcare infrastructure

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- 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		
Kenya		
Nigeria		
Egypt		
Morocco		
Algeria		
Ethiopia		
India	<u> </u>	0
Japan		
South Korea		
China		
Thailand	0	<u> </u>
Singapore		
United Kingdom		
Germany		
France		
Netherlands		
Sweden		0
Italy		
Spain		
Poland		<u> </u>
Mexico		<u> </u>
Brazil	<u> </u>	<u> </u>
Argentina	<u> </u>	<u> </u>
Chile	\bigcirc	<u> </u>
Colombia		0
United States		
Canada		
Australia		
New Zealand		
Greece		<u> </u>
Rwanda		
Uganda		
Serbia	\bigcirc	0
Saudi Arabia		
UAE		
Syria		
Indonesia		
Vietnam	\bigcirc	<u> </u>
Philippines		
Russia		<u> </u>
Malaysia		



Chile

Treatment Access, Research Funding and Awareness Campaigns



Strengths

- The GES program (Guaranteed Access) promises timely diagnosis and treatment across all insurers.
- International collaborations (e.g., with Japan) support research and screening program development

Opportunity

Weakness

- Public awareness of CRC remains low relative to breast or cervical cancer.
- Inequity in outcomes persists between public (FONASA) and private (ISAPRE) patients-5year survival: ~39% vs ~63% respectively

 Promote nationwide awareness campaigns focused on early symptoms and FIT GES. screening.

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 Encourage locally driven biomarker research and clinical trials

- **Threats**
- Socioeconomic inequity undercuts treatment efficacy, even under
- Inconsistent drug supply and funding pressures may limit treatment access.

- 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	<u> </u>	<u> </u>	<u> </u>
Kenya			
Nigeria			
Egypt			
Morocco	0		
Algeria	0		
Ethiopia			
India	<u> </u>	<u> </u>	<u> </u>
Japan	0		
South Korea	0	0	
China	0	<u> </u>	<u> </u>
Thailand		0	
Singapore	0		
United Kingdom	0		
Germany			
France	0	0	0
Netherlands			
Sweden			
Italy	0	0	0
Spain	0		0
Poland	<u> </u>	0	<u> </u>
Mexico		<u> </u>	<u> </u>
Brazil	0	0	<u> </u>
Argentina	0	<u> </u>	<u> </u>
Chile	0	<u> </u>	<u> </u>
Colombia			
United States			
Canada			
Australia			
New Zealand	\bigcirc		
Greece			
Rwanda			
Uganda			
Serbia			
Saudi Arabia	\bigcirc		
UAE			
Syria			
Indonesia	<u> </u>		<u> </u>
Vietnam			<u> </u>
Philippines	<u> </u>		
Russia	<u> </u>	0	<u> </u>
Malaysia		<u> </u>	



Chile

Survival Rates, Early Detection and Palliative Care

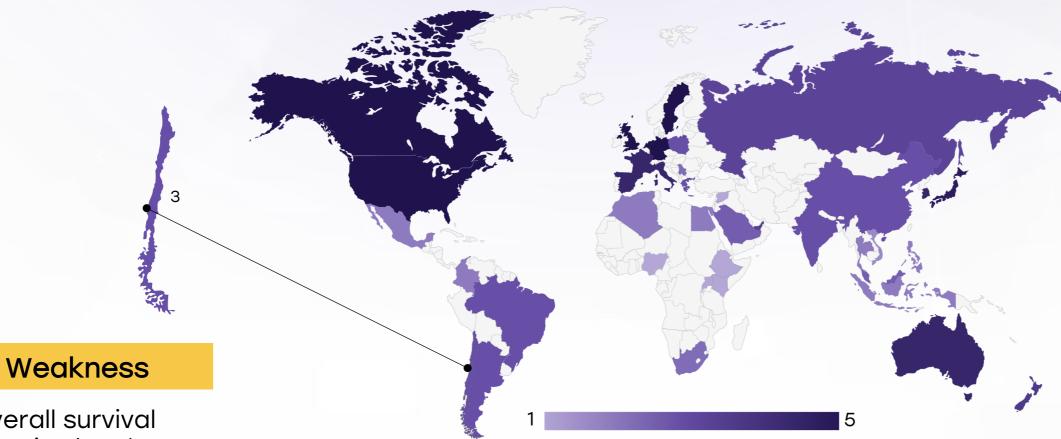
Strengths

- Higher survival observed in private insurance patients (~63% 5-year), similar to developed countries
- Screening pilots have detected early-stage CRC significantly (e.g., PRENEC found 83% in stage pTis/pT1)

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Opportunity

- Train primary care providers in early CRC signs and expand palliative care to regional hospitals.
- Build community-level follow-up and survivorship programs.



- Overall survival remains low (~43% 5-year overall) due to late-stage diagnosis in public system
- Palliative care services are not uniformly available outside metro centers.

- Late detection and poor follow-up fuel high mortality.
- Poor palliative infrastructure leads to suboptimal endof-life support.

- 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		<u> </u>	0
Kenya			
Nigeria			
Egypt	0		
Morocco			
Algeria			
Ethiopia			
India	\bigcirc	<u> </u>	<u> </u>
Japan		0	
South Korea		0	
China	\bigcirc	<u> </u>	0
Thailand		0	0
Singapore			
United Kingdom			
Germany			
France		0	0
Netherlands			
Sweden			
Italy			
Spain			
Poland	<u> </u>	<u> </u>	
Mexico			
Brazil	<u> </u>		0
Argentina	<u> </u>	0	0
Chile	<u> </u>	0	0
Colombia	0	0	0
United States			
Canada	0		
Australia		0	0
New Zealand		0	0
Greece		0	0
Rwanda			
Uganda			
Serbia		0	0
Saudi Arabia			0
UAE		0	0
Syria			
Indonesia			
Vietnam			
Philippines			
Russia			
Malaysia	\bigcup		



Chile L Utilization of Biomarkers

Strengths

- Leading urban centers have begun KRAS and BRAF testing, primarily for metastatic disease decision-making.
- Interest growing among oncologists to adopt molecular profiling.

Opportunity

- Scale up public-sector biomarker testing capacity, including MSI and KRAS at minimum.
- Partner with international labs to subsidize biomarker panels and building local expertise.

Weakness

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 NRAS, MSI/dMMR, and PIK3CA testing remain rare and technically unavailable in most public settings.

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 No national registry or protocol integrating biomarker-informed treatment.

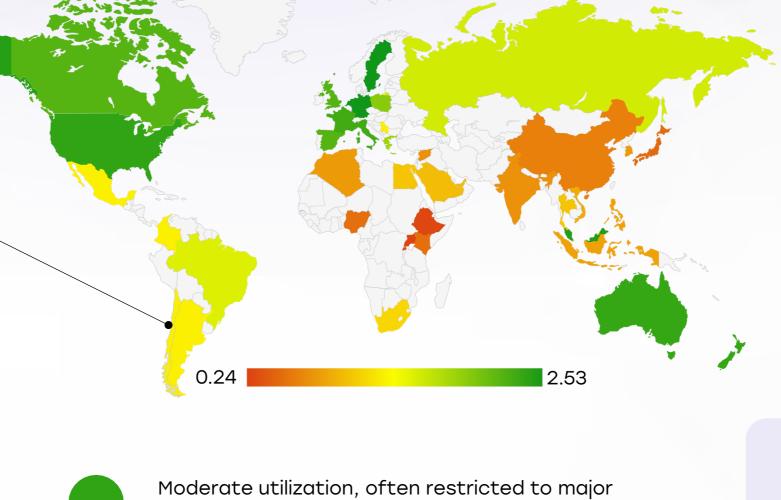
Threats

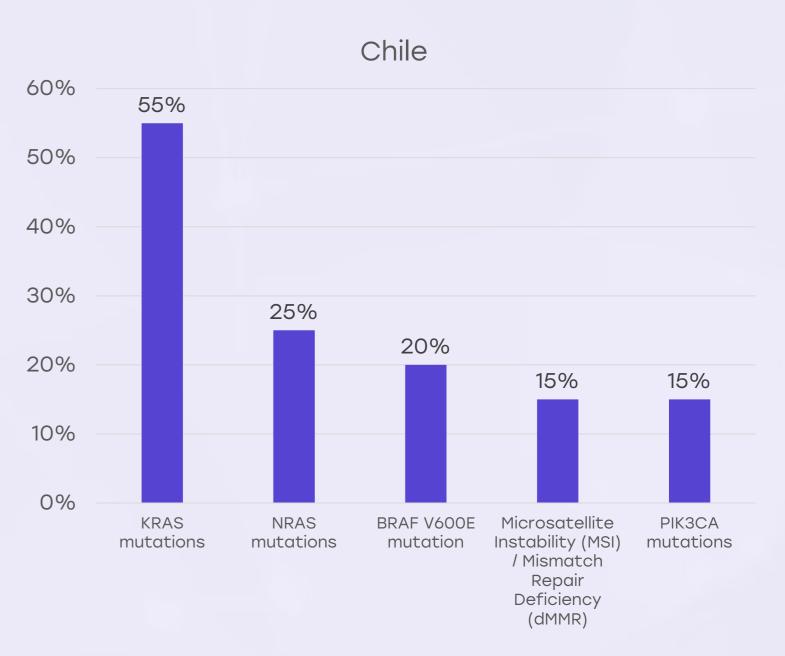
- High testing costs and absence of reimbursement limit patient access.
- Diagnostic delays or variability undermine personalized care.

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.









- Chilean oncologists refer informally to international CRC guidelines (NCCN/ESMO).
- GES program
 standardizes access
 to diagnosis and
 therapy once a case
 is identified.

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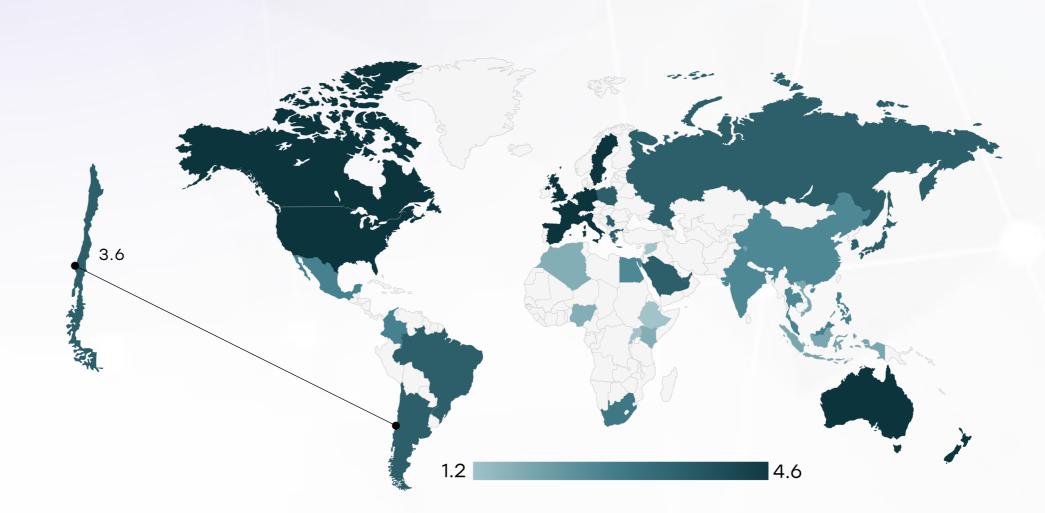
Opportunity

- Develop Chile-specific CRC clinical protocols, embedding molecular stratification and screening criteria.
- Provide national training to clinicians on biomarker use and guideline implementation.

Weakness

- Absence of national guidelines incorporating biomarker thresholds (e.g. KRAS, MSI) and molecularly tailored therapies.
- Significant gaps in guideline compliance between public and private institutions.

- Fragmented system and resource variability hinder unified guideline adoption.
- Resistance to change in lowresource contexts slows integration.



	Very High	High	Medium	Low	Very Low
Clinical Guideline Implementation	*	0	*	*	*
Feasibility of Integration	*	0	*	*	*
Adoption of International Guidelines	*	0	*	*	*
Engagement with Updates	*	*	0	*	*
ESMO Guidelines Implementation	*	0	*	×	*





 Under GES, core treatment services (surgery, chemo, radiotherapy) are guaranteed and publicly reimbursed.

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 Colonoscopy and basic diagnostics provided free within public hospitals once enrolled.

Opportunity

- Advocate for inclusion of essential biomarker tests (e.g. KRAS, MSI) in GES coverage.
- Pilot public reimbursement of molecular diagnostics in high-risk or metastatic cases.

Weakness

- Biomarker testing and targeted therapies are not reimbursed under GES and remain costly for patients.
- Inequality in insurance coverage leads to survival disparity based on patient insurer type.

- Budget limitations may delay reimbursement expansion.
- Out-of-pocket costs continue to create barriers to individualized care.



- 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	0	0
United Kingdom		
Canada		
Australia		
Germany		
France		
Netherlands		
Sweden		
Italy		
Spain		
Poland		
Japan		
South Korea		
China		
India	0	0
Singapore		
Thailand		
South Africa	0	0
Kenya	0	0
Nigeria	0	0
Egypt	0	0
Morocco	0	0
Algeria		
Ethiopia	0	0
Mexico		
Brazil		
Argentina		
Chile		
Colombia		
New Zealand		
Greece		
Rwanda	0	
Uganda	0	0
Serbia		
Saudi Arabia		
UAE		
Syria	0	0
Indonesia		0
Vietnam		O
Philippines	0	0
Russia		
Malaysia	0	
	•	•





- Pilot programs using FIT (iFOBT) achieved high compliance (~77-94%) and colonoscopy followup rates (~58-94%)
- Cancer detection rates reached ~1.0-1.5% in asymptomatic populations aged 50-75, with many early-stage detections

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Weakness

- Chile currently lacks a national, organized CRC screening program.
- Public awareness and physician-driven screening remain low.

Opportunity

- Scale up provincial FITbased screening programs nationwide under GES.
- Integrate educational outreach via primary care and media campaigns.

- Insufficient endoscopy capacity may limit follow-up after positive FIT.
- Sociocultural barriers and lack of awareness may suppress participation.

Country	Colorectal Cancer Screening
Courtery	Color Cotal Carloci Col Colling
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