International Cancer Patient Coalition

China

Gastric Cancer Factsheet: Insights & Key Developments

Key Insights on Gastric 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. Gastric Cancer Screening

Gastric 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 Gastric cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Gastric cancer is among the top 5 cancers in men and is a leading cause of cancer death.
- Incidence rate: Approximately 13.7 per 100,000 men per year.
- Total new cases (2022): Around 246,600 men.
- Daily diagnoses (2022): Roughly 676 men per day.
- Deaths (2022): About 181,600 men.
- 5-year survival rate: Estimated around 44–45%, higher with early detection.
- Most affected age group: Peak incidence in men aged 80–84; increases notably from age 55.
- Screening participation: No universal program; screening is targeted in rural high-risk regions, often via endoscopy and serum markers.

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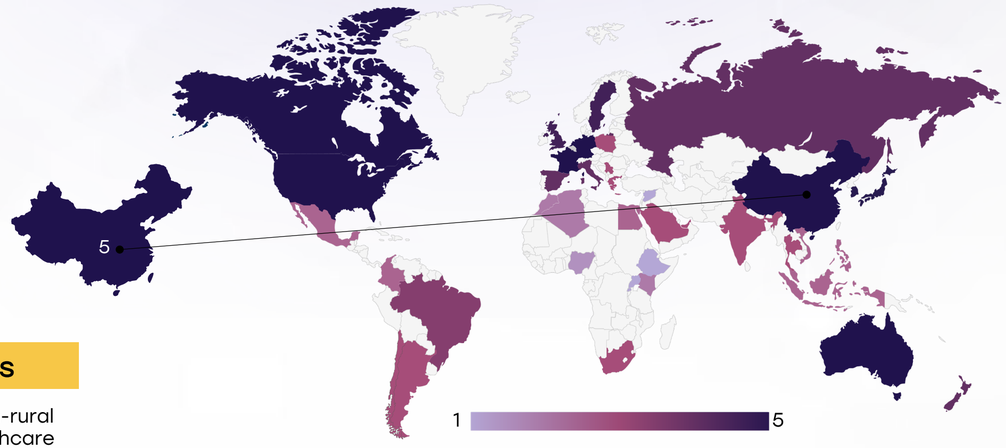
Infrastructure



Strengths

- China has world-class cancer centers in Tier 1 cities (e.g., Peking Union Medical College Hospital, Fudan University Shanghai Cancer Center) equipped with endoscopy, pathology, molecular testing, and robotic surgery.
- Rapid deployment of medical AI in urban hospitals to aid early GC detection through endoscopic image interpretation.

Weakness

- Significant urban-rural disparity in healthcare infrastructure; smaller city and rural hospitals lack advanced diagnostic tools and surgical expertise.
- Underdeveloped referral pathways delay diagnosis and appropriate treatment in lower-tier cities.

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Opportunity

- “Healthy China 2030” invests in expanding regional cancer centers and reducing healthcare disparities.
- Bolster tele-medicine and mobile GI screening units to reach remote populations.

Threats

- Overcrowded urban centers strain diagnostic and treatment capacity.
- Migration of skilled specialists to big cities leaves rural areas understaffed.

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	2	2
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	2	2
Uganda	2	2
Serbia	3	3
Saudi Arabia	4	4
UAE	4	4
Syria	2	2
Indonesia	2	2
Vietnam	3	3
Philippines	2	2
Russia	4	3
Malaysia	4	4

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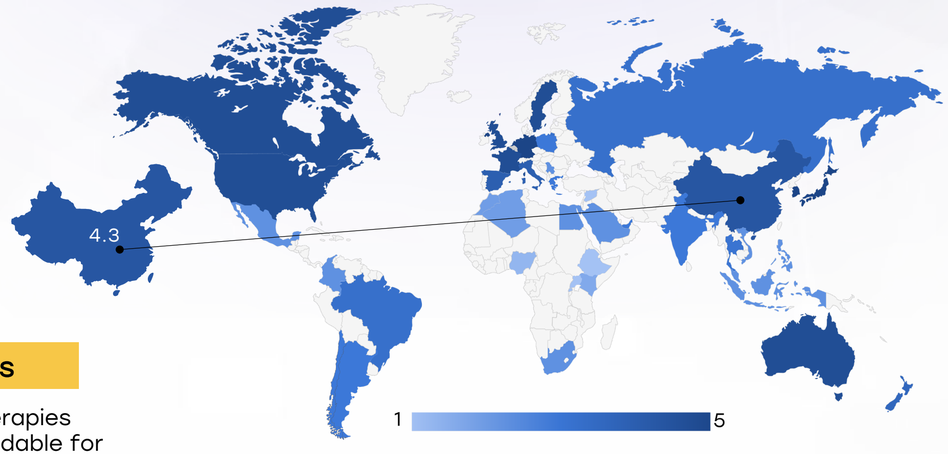
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- China leads in GC clinical trials and drug development, including trials focused on HER2, CLDN18.2, and PD-L1 biomarkers.
- Access to targeted therapies such as trastuzumab and PD-1 inhibitors is provided in major public hospitals.

Weakness

- Many novel therapies remain unaffordable for patients outside of urban centers without supplemental insurance.
- Public knowledge of early GC symptoms and risk factors (e.g. H. pylori, high-salt diet) is low, particularly in aging rural populations.

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Opportunity

- Leverage digital platforms (WeChat, short-video apps) for large-scale public health campaigns.
- Partner with global pharma and public institutions to expand access to biomarker-driven treatment in provincial hospitals.

Threats

- Economic inequality limits equal access to advanced therapies across regions.
- Possible reductions in healthcare funding post-COVID could slow expansion of treatment programs.

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

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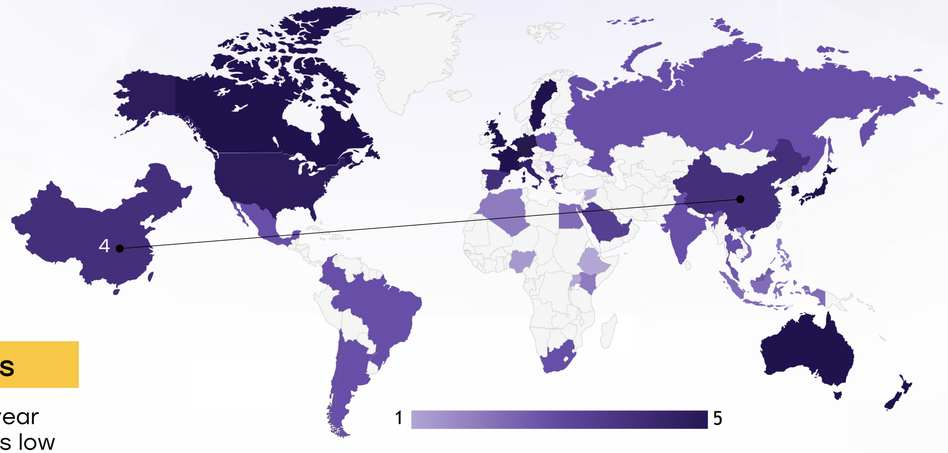
Survival Rates, Early Detection and Palliative Care



Strengths

- Pilot urban early screening programs led to 5-year survival of >60% for early-stage GC in some regions.
- Integration of palliative care in major centers, often combined with traditional Chinese medicine, enhances patient comfort.

Weakness

- Nationwide 5-year survival remains low (~35%), mostly due to late-stage diagnosis.
- Palliative care is limited outside major hospitals, lacking availability in many regions.

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Opportunity

- Expand early detection programs to medium-to-low tier cities and rural populations.
- Train primary care providers in identifying GC symptoms and appropriate referral pathways.

Threats

- High prevalence of H. pylori, tobacco use, and processed diets perpetuates high incidence.
- Social stigma and fear of cancer diagnosis deter early care-seeking behavior.

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

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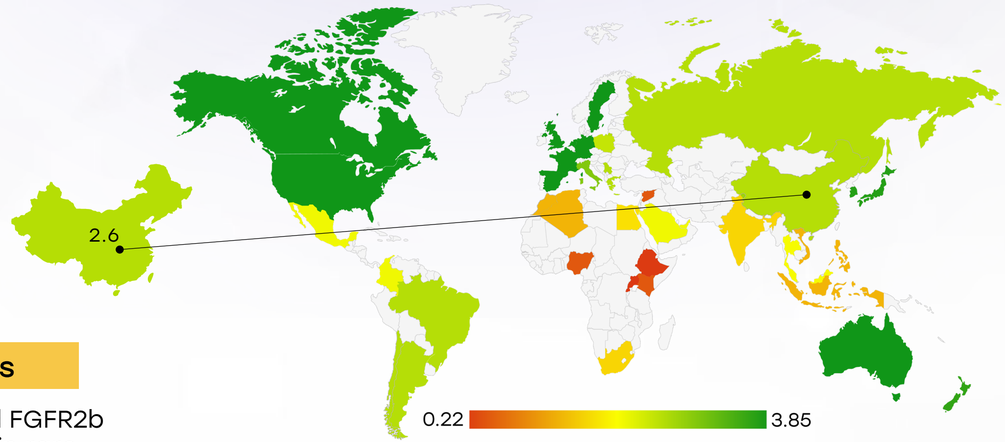
Utilization of Biomarkers



Strengths

- HER2 and PD-L1 testing are standard for advanced GC in leading hospitals.
- Domestic biotech companies are actively advancing CLDN18.2 and FGFR2b diagnostics/therapies for local markets.

Weakness

- CLDN18.2 and FGFR2b testing remain rare outside premier centers; MSI/dMMR is underused despite clinical utility.
- Limited molecular pathology infrastructure in rural hospitals delays timely genomic testing.

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Opportunity

- Develop regional molecular testing hubs to expand access to all biomarkers.
- Require broader biomarker panels in national clinical guidelines to standardize care.

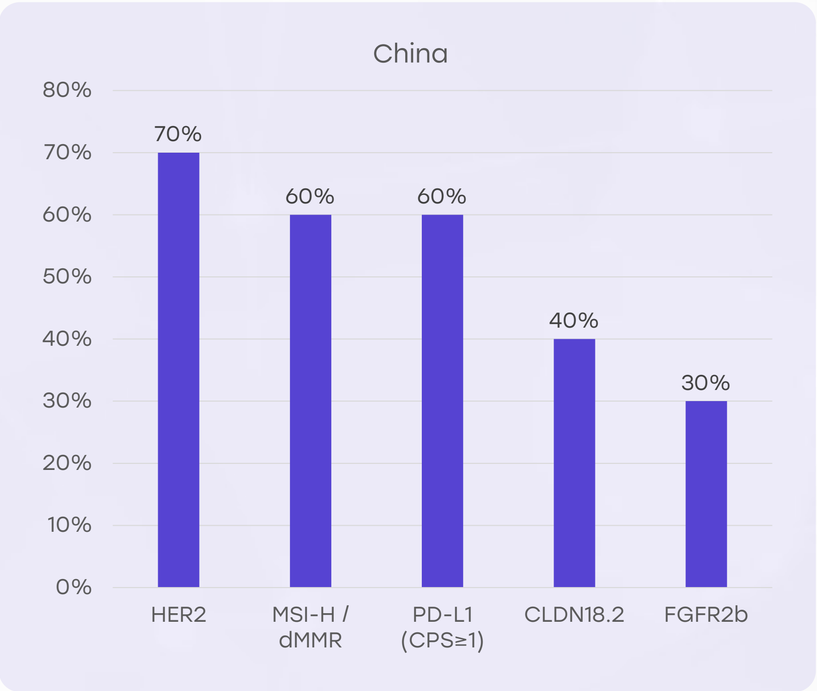
Threats

- High cost of import or licensing of tests and therapies limits widespread adoption.
- Insurance coverage gaps and reimbursement delays reduce real-world application of biomarker-based 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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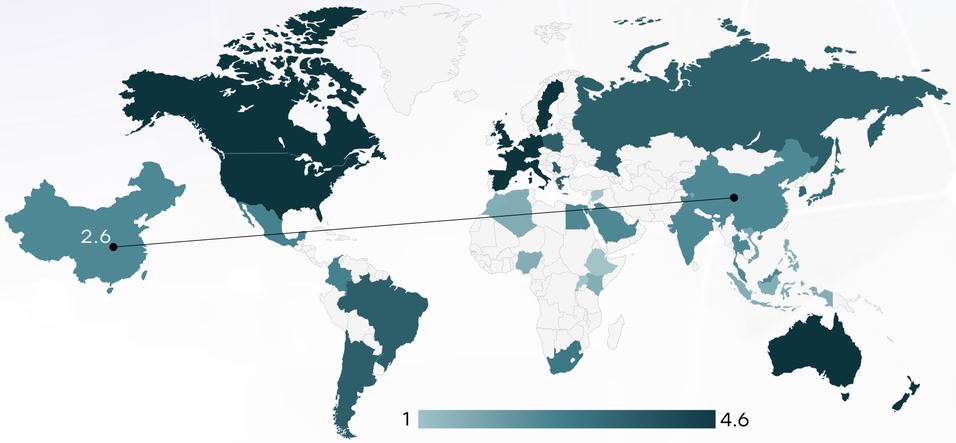
Clinical Guidelines



Strengths

- National guidelines (Chinese Anti-Cancer Association) align with international standards and include HER2/PD-L1 guidance.
- Progressive. integration of biomarker-based therapy sequencing into evidence-based protocols.

Weakness

- Delayed dissemination of updated guidelines to lower-tier hospitals.
- Lack of patient-friendly guideline summaries leads to low awareness and compliance.

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Opportunity

- Use real-world evidence from registries to adapt and refine guidelines for Chinese populations.
- Conduct periodic CME programs to ensure guideline adoption in all provinces.

Threats

- Regional administrative differences slow guideline rollout.
- Fragmented care across public/private hospitals prevents consistent application

	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

- National Reimbursement Drug List (NRDL) now includes HER2-targeted agents and some PD-1 inhibitors.
- Annual price negotiations reduce medication costs significantly, making advanced therapy more affordable.

Weakness

- Newer therapies targeting CLDN18.2 or FGFR2b are not yet covered.
- Public insurance schemes vary by province, leading to gaps in patient access across regions.

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Opportunity

- Expand NRDL to include additional biomarker-based therapies and companion diagnostics.
- Use outcome-based pricing models to accelerate access to high-cost treatments.

Threats

- Rising demands from an aging population may strain healthcare budgets.
- Delays in regulatory processes may slow reimbursement timelines.

● 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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Philippines

Gastric Cancer Screening

Strengths

- Pilot endoscopy + H. pylori screening programs in provinces like Jiangsu and Shandong significantly boost early detection.
- National Cancer Early Detection programs target urban residents aged 40–69.

Weakness

- Absence of a nationwide, mandatory GC screening program; rural and low-income populations often excluded.
- Low compliance with follow-up in high-risk individuals due to limited awareness.

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Opportunity

- Integrate AI-driven risk stratification and gastro screening in primary care across provinces.
- Scale-up community-based H. pylori eradication campaigns to reduce GP precancerous lesions.

Threats

- Cultural fear or confusion about invasive procedures like gastroscopy may deter participation.
- Health literacy disparities and minority language barriers reduce screening uptake among ethnic groups.

Country	Gastric 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	Gastric 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