International Cancer Patient Coalition

South Korea

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 the most common cancer in men for several decades.
- Incidence rate: Around 41–42 per 100,000 men per year.
- Total new cases (2022): Approximately 22,000–23,000 men.
- Daily diagnoses: About 60–65 men per day.
- Deaths (2022): Roughly 6,000 men.
- 5-year survival rate: Very high—around 75%, due to extensive national screening.
- Most affected age group: Men aged 60–79 years.
- Screening participation: Strong national screening program; endoscopy offered every 2 years from age 40.

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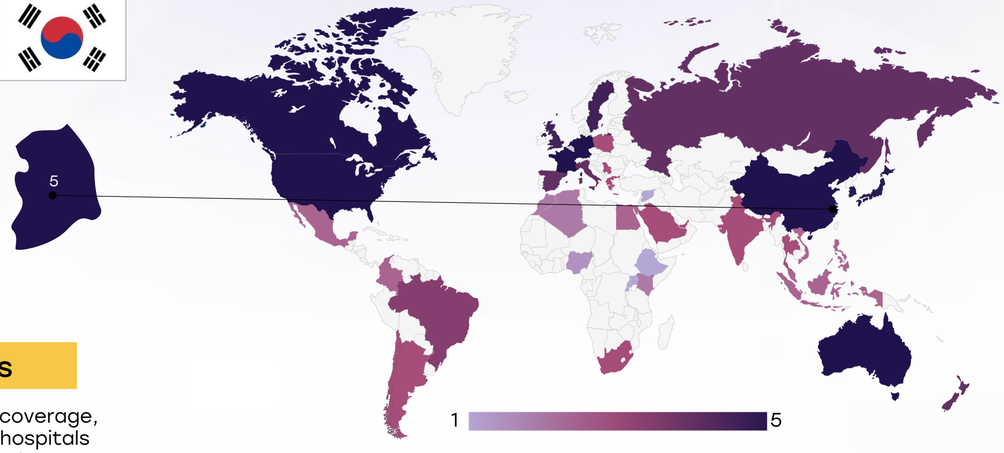
Infrastructure



Strengths

- South Korea offers a well-integrated universal healthcare system with high-volume, specialized cancer centers (e.g. Seoul National University, Gospel Hospital in Busan performing 400+ gastric cancer surgeries/year) .
- The Korea Central Cancer Registry has high-quality data covering virtually all gastric cancer cases, enabling precise epidemiological analysis and infrastructure planning.

Weakness

- Despite national coverage, rural and smaller hospitals may lack advanced endoscopic units or multidisciplinary teams, resulting in uneven service delivery.
- Workforce pressure persists in pathology and surgical specialization, especially in peripheral regions.

S W O T

Opportunity

- Further centralization of gastric cancer surgery in high-volume centers could enhance surgical outcomes and training.
- Expansion of digital health platforms and national e-referral systems may better coordinate infrastructure across regions.

Threats

- Aging population and increasing cancer volume may strain existing hospital capacity and surgical services.
- Regional disparities in diagnostic infrastructure may persist without targeted resource allocation

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	3
Spain	4	3
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	3
Greece	4	3
Rwanda	1	1
Uganda	1	1
Serbia	3	3
Saudi Arabia	4	4
UAE	4	3
Syria	1	1
Indonesia	2	2
Vietnam	3	3
Philippines	2	2
Russia	3	3
Malaysia	3	3

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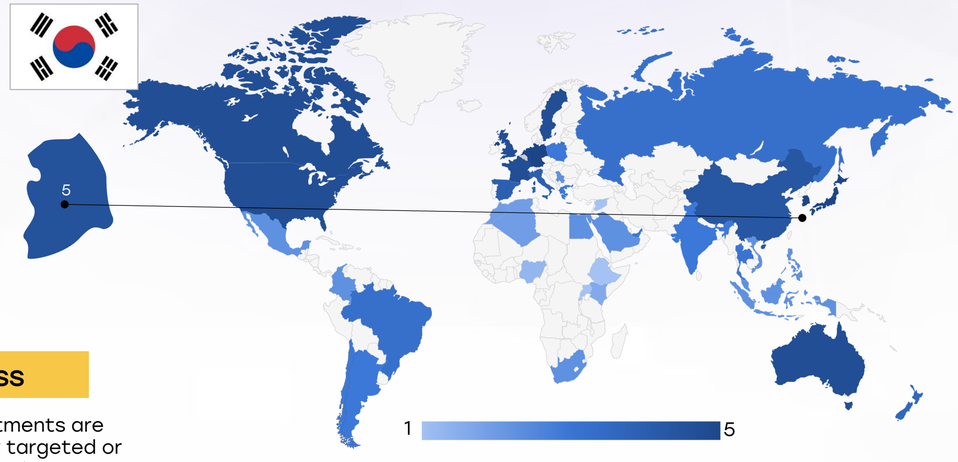
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- South Korea's National Health Insurance (NHI) categorizes cancer as a serious disease: patients pay only ~5% of treatment costs including drugs, diagnostics, and hospitalization.
- Government-led research funding and cancer clinical trials are robust, and public awareness campaigns have steadily promoted participation in screening programs

Weakness

- While core treatments are affordable, new targeted or immunotherapies (e.g. T-DXd, later-line nivolumab) may not be fully reimbursed, limiting access.
- Public awareness is strong for screening but gastric cancer symptom recognition and prevention messaging are still less emphasized compared to breast or colorectal cancer.

S W O T

Opportunity

- Increasing outreach around symptom awareness and prevention (e.g. H. pylori eradication) could boost early detection.
- Grants and public-private partnerships can promote translational biomarker research focused on topics like CLDN18.2 and FGFR2b.

Threats

- Rising costs of targeted treatments could shift financial burdens to patients not covered by private insurance.
- Persistent income or education-based disparities in awareness and screening uptake might undermine equity efforts

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	4	4	4
South Korea	4	4	4
China	4	4	4
Thailand	3	3	3
Singapore	4	4	4
United Kingdom	4	4	4
Germany	4	4	5
France	4	4	4
Netherlands	4	4	4
Sweden	4	4	4
Italy	4	4	4
Spain	4	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	4	4	4
Canada	4	4	4
Australia	4	4	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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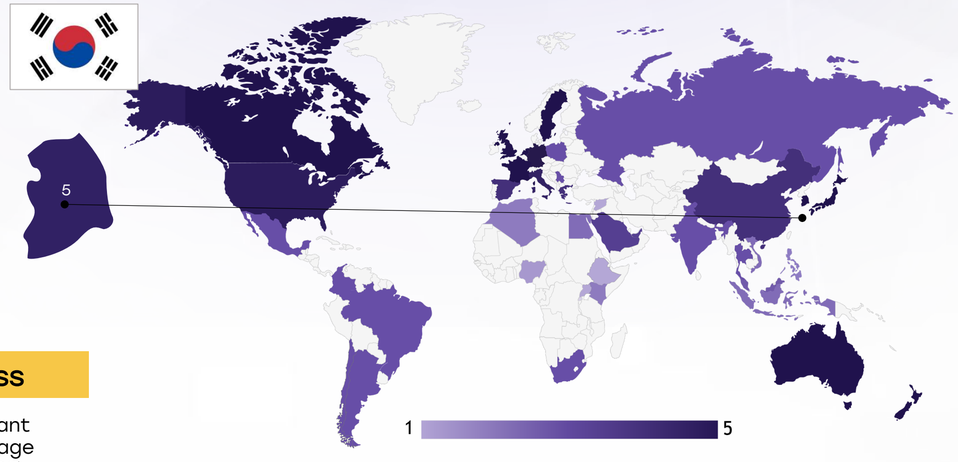
Survival Rates, Early Detection and Palliative Care



Strengths

- Thanks to systematic screening, localized-stage gastric cancer accounts for ~64% of cases, with 5-year survival for localized disease approaching 97%
- National 5-year relative survival improved from ~56% in 1999–2005 to 77% during 2013–2019, among the highest globally

Weakness

- Survival for distant (metastatic) stage remains low (~6%), consistent with global trends.
- Palliative care integration is not uniformly standardized; services vary across institutions, particularly for advanced gastric cancer.

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Opportunity

- Earlier surveillance of premalignant conditions and tertiary prevention strategies (e.g. H. pylori eradication programs) could shift stage distribution further.
- Expansion of palliative care and supportive oncology programs (pain relief, psychosocial services) could raise quality of life for late-stage patients.

Threats

- Without further advances in treatment or detection, mortality in metastatic disease may remain stagnant.
- Aging cohorts and comorbidities may challenge survival gains among elderly patients.

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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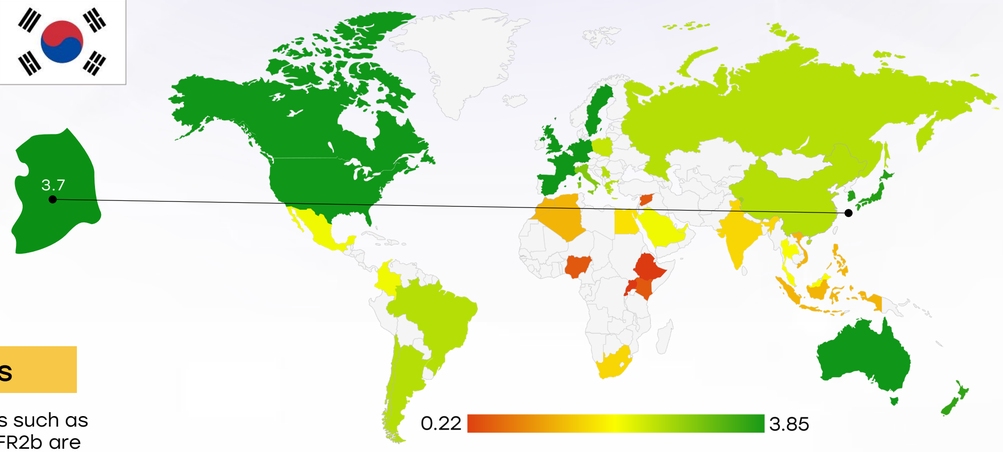
Utilization of Biomarkers



Strengths

- Korean treatment guidelines strongly integrate HER2, MSI/dMMR, and PD-L1 (CPS) testing, with reimbursement for trastuzumab and checkpoint inhibitors in earlier lines.
- CLDN18.2 expression has been explored in Korean cohorts: ~34% prevalence in stage II–IV tumors, paving the way for targeted therapies in later trials

Weakness

- Emerging markers such as CLDN18.2 and FGFR2b are not yet standardly tested, and companion diagnostics infrastructure remains uneven across centers.
- Access to new biomarker-driven treatments (e.g. Zolbetuximab for CLDN18.2) depends on reimbursement policy and drug approvals.

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Opportunity

- Broader integration of biomarker panels in standard clinical practice and companion diagnostic capacity-building could extend precision therapy.
- Korea's strong clinical trial networks provide a platform for evaluating FGFR2b or CLDN18.2–targeted agents locally.

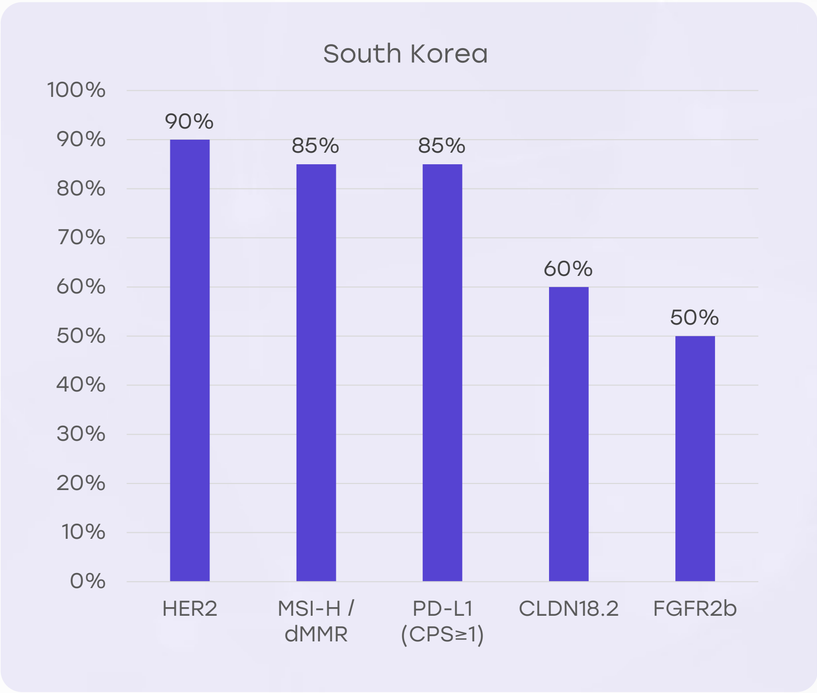
Threats

- Costs and reimbursement delays still limit access to later-line immunotherapy or antibody-drug conjugates.
- Variability in testing quality and standardization across labs can threaten comparability and reliability of results.

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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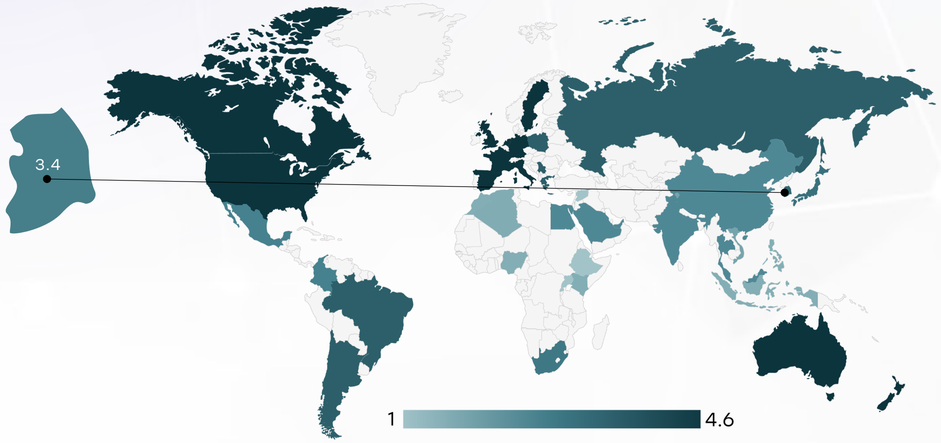
Clinical Guidelines



Strengths

- Korean Practice Guidelines (2024) are evidence-based and multidisciplinary, recommending use of preoperative chemotherapy, HER2-based therapy, and immunotherapy combinations based on PD-L1 CPS stratification (e.g. nivolumab for CPS ≥5, pembrolizumab for CPS ≥1).
- Guidelines align with major global trials such as CheckMate-649 and KEYNOTE-859 and are regularly updated.

Weakness

- Implementation may vary by center; not all hospitals uniformly apply updated guidelines, particularly regarding biomarker thresholds and drug sequencing.
- Adoption of guidelines for emerging markets (e.g. CLDN18.2, FGFR2b) lags behind research evidence.

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Opportunity

- Continuing medical education and standardized training could ensure uniform adoption of the latest protocols.
- Digital dissemination tools, centralized registries, and audits can support guideline adherence nationwide.

Threats

- Delayed guideline incorporation into reimbursement frameworks may slow access to recommended drugs or tests.
- Variation across regional providers could perpetuate inequities in guideline-based care.

	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 Health Insurance covers nearly all Koreans and defined cancer treatments at just ~5% patient cost-share, making cancer care affordable.
- Core chemotherapies, HER2-targeted therapy, and certain immunotherapy regimens are reimbursed for eligible patients.

Weakness

- Some later-line or newer agents (e.g. T-DXd, nivolumab beyond first line) are not reimbursed, forcing out-of-pocket spending or costs via private insurance.
- Companion diagnostics for newer biomarkers require expensive machines and are not widely reimbursed, limiting access.

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Opportunity

- Incorporating newer agents and diagnostics into value-based reimbursement decisions could improve equity.
- Encouraging private insurance products to bridge gaps for non-reimbursed treatments may help.

Threats

- Rising drug costs and constrained NHI budget may delay full inclusion of cutting-edge therapies.
- Cost disparities could widen between NHI-covered care and supplementary private provisions.

● 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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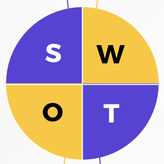
Colorectal Cancer Screening

Strengths

- Korea's National Cancer Screening Program (KNCSP) mandates biennial endoscopy for individuals aged 40–74. Participation surged: ~7% in early 2000s to ~63% by 2019; organized screening reaches ~70–73% by 2022, reducing socioeconomic disparities
- Endoscopy-based screening yields high early cancer detection (~46–67% early-stage), outperforming upper GI series and consistently showing cost-effectiveness (≈₩8.8–9.8 million per life-year saved)

Weakness

- Opportunistic screening still exists though declining; rural or low-education groups may have lower adherence historically but improved now.
- Rare adverse events from endoscopy, though very low, still require procedural oversight and quality assurance.



Opportunity

- Continued expansion of organized screening and awareness can further drive down incidence and mortality.
- Integration of H. pylori screen-and-treat with endoscopic programs could offer dual prevention benefits.

Threats

- For individuals >75 or >85, screening benefits decrease and guidelines advise against routine screening.
- Budgetary pressure to sustain high screening uptake may increase strain on NHI funding.

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