International Cancer Patient Coalition

Sweden

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 a low-incidence cancer in men.
- Incidence rate: Approximately 5 per 100,000 men per year.
- Total new cases (2022): Around 800–900 men.
- Daily diagnoses: About 2–3 men per day.
- Deaths (2022): Roughly 700–800 men.
- 5-year survival rate: Around 30–40%.
- Most affected age group: Men aged 70 and above.
- Screening participation: No routine screening; detection occurs after symptom onset

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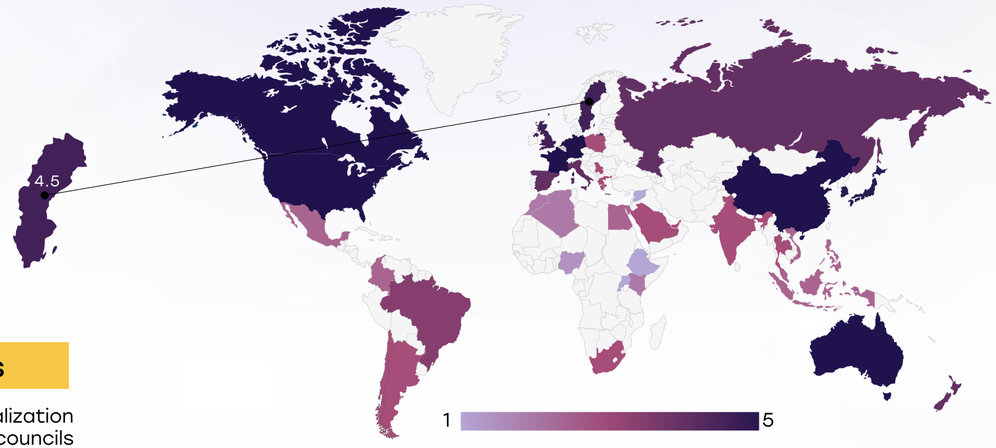
Infrastructure



Strengths

- Sweden has a centralized and well-organized cancer treatment framework with multidisciplinary teams, shorter referral-to-treatment timelines, and centralization of gastric cancer surgeries into high-volume specialist centers over the past decade.
- The Swedish Cancer Registry boasts nearly 98–100% completeness for gastric adenocarcinoma recording, enabling robust epidemiological tracking and quality assurance

Weakness

- Regional decentralization across 21 county councils causes variation in diagnostic and treatment capacity, including regional differences in staffing and equipment availability
- Shortages of medical personnel, including oncologists, pathologists, and specialized surgical staff, can strain care delivery, especially outside major urban centers

Opportunity

- Continued centralization and multidisciplinary coordination can further improve outcomes, as 1-year survival gains already illustrate
- Investment in digital interoperability and national data platforms (e.g. e-referrals, registry integration) can optimize case tracking and infrastructure planning

Threats

- Persistent regional inequality risks uneven access to state-of-the-art diagnostics and therapies.
- Workforce limitations could exacerbate delays or capacity gaps as aging population increases cancer burden.

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

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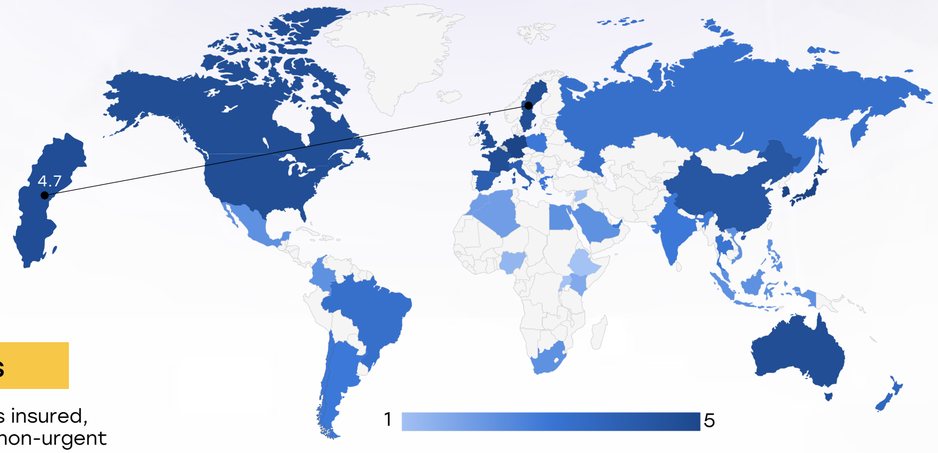
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Sweden's universal health care system provides tax-funded, largely free-of-charge cancer care, including surgery, chemotherapy, and hospitalization, with minimal out-of-pocket fees capped annually
- National cancer policy initiatives (e.g. All.Can Sweden) emphasize multidisciplinary care, prevention, and precision medicine, coordinating evidence-based research and community engagement

Weakness

- While treatment is insured, waiting times for non-urgent diagnostics or follow-up care can be long, varying by region and institution.
- Public prevention campaigns focus heavily on breast, cervical, colorectal cancer; gastric cancer awareness remains low, with minimal specific outreach.

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Opportunity

- Expanding precision oncology programs within the national strategy could build biomarker-based treatment, including HER2 and PD-L1 targeting.
- Enhanced public health messaging on gastric cancer could improve symptom awareness and early presentation.

Threats

- Competing funding priorities (e.g. aging care, mental health) may limit investment in gastric cancer–specific programs.
- Equity gaps may persist among ethnic or socioeconomic groups despite universal coverage

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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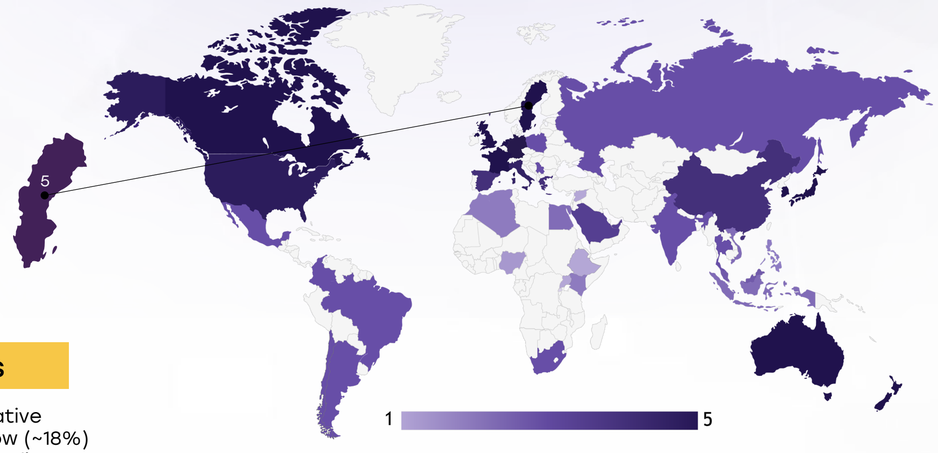
Survival Rates, Early Detection and Palliative Care



Strengths

- One-year survival rates for gastric cancer have improved significantly, reflecting better early diagnosis, centralization, and preoperative chemotherapy protocols.
- Five-year survival for surgically treated gastric adenocarcinoma rose sharply—from ~33% to ~44% for non-cardia tumors—indicating improvements in operative practices and postoperative care

Weakness

- Overall 5-year relative survival remains low (~18%) for gastric non-cardia cancers and only modestly better for cardia tumors (~18%).
- Survival declines significantly in patients aged ≥80 and those with comorbidities; older patients see minimal improvement in long-term survival

S W O T

Opportunity

- Improved screening (e.g. endoscopy for high-risk groups), earlier referral mechanisms, and geriatric oncology protocols could boost survival beyond year 1.
- Expansion of palliative care and supportive services can help those with advanced disease and improve quality of life.

Threats

- Without further improvements in survival beyond the first post-diagnosis year, gains remain limited.
- Gaps in care for older and comorbid patients may widen survival disparities over time.

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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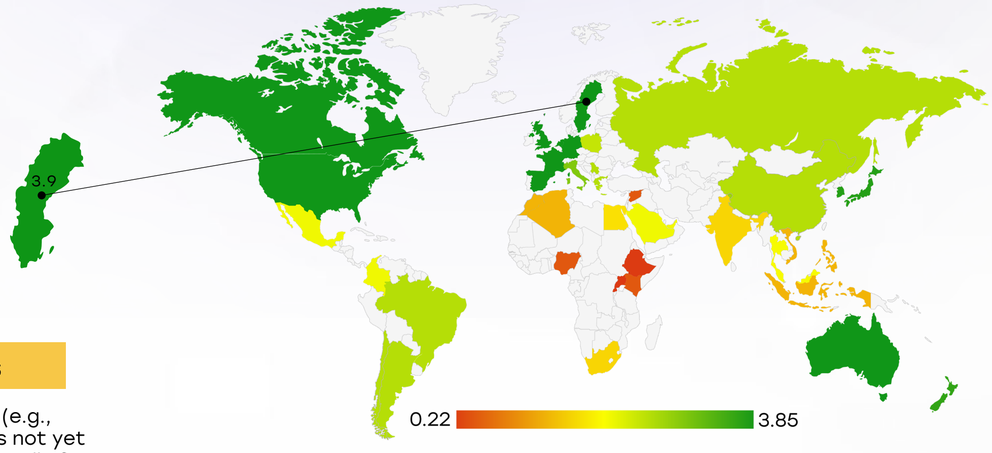
Utilization of Biomarkers



Strengths

- National policies include adoption of precision oncology, which lays groundwork for biomarker testing like HER2 and PD-L1 in metastatic gastric cancer settings
- Sweden's comprehensive registries and cancer data strategy support integration of biomarker-linked outcomes into evidence-based care pathways

Weakness

- Biomarker testing (e.g., HER2, MSI, PD-L1) is not yet standardized nationally for gastric cancer; access and use are inconsistent across centers.
- Novel biomarkers such as CLDN18.2 and FGFR2b are not routinely tested, nor are therapies widely available or reimbursed.

S W O T

Opportunity

- Regional HTA frameworks and cost-effectiveness analysis can support wider adoption of companion diagnostics and targeted therapies.
- Trial infrastructure and registry data enable biomarker-driven clinical studies and outcome tracking.

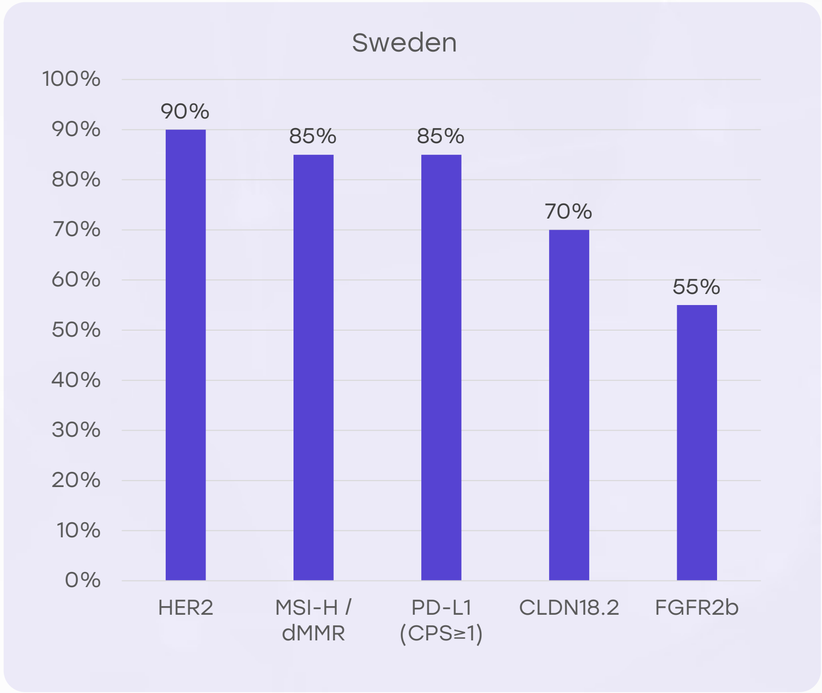
Threats

- Variability in biomarker availability and reimbursement across regions may delay equitable implementation.
- High drug costs and limited regional uptake could impede access to targeted agents.

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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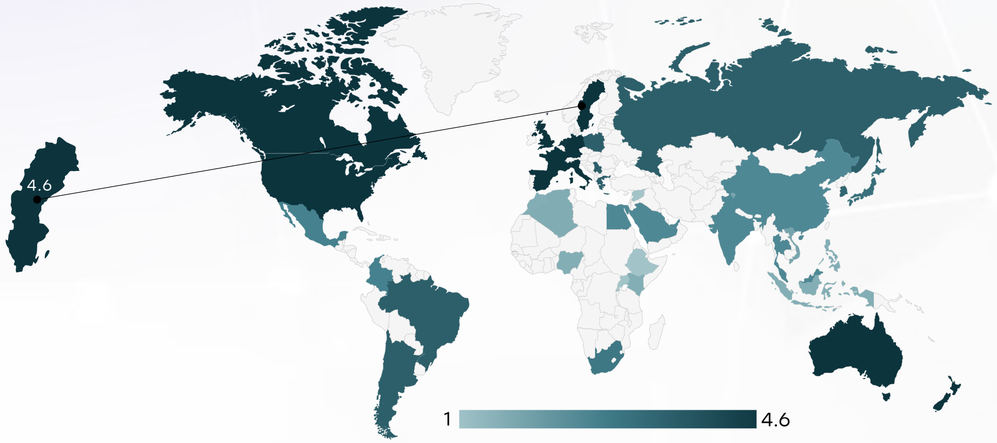
Clinical Guidelines



Strengths

- Swedish guidelines for gastric and oesophageal cancer—aligned with global protocols—recommend preoperative chemotherapy, surgery, and immunotherapy options for metastatic disease
- Guidelines emphasize multidisciplinary team (MDT) involvement and align with national cancer control strategies

Weakness

- Regional implementation varies; clinical guideline enforcement and consistency differ among counties, leading to inequities in care pathways

S W O T

Opportunity

- Digital dissemination via the national 1177.se portal and e-learning can drive uniform guideline adherence and broader clinician access.
- Updates to guidelines to include biomarker testing and newer targeted approaches could drive uptake nationally.

Threats

- Administrative decentralization and regional autonomy may slow adoption of guideline updates.
- Provider resistance or lack of training may limit guideline compliance at the local level.

	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

- Healthcare is publicly funded; virtually all cancer care (including diagnostics, surgery, hospitalization, chemotherapy) is covered, with patient cost capped each year (~1,100 SEK)
- Regions use health technology assessment (HTA) to determine value-based reimbursement strategies for new cancer drugs, considering societal costs and benefits

Weakness

- Regional variation means some areas may delay or deny reimbursement of high-cost drugs or companion diagnostics not yet evaluated nationally.
- Experimental or marginal-benefit treatments may be excluded under value-based thresholds.

S W O T

Opportunity

- National HTA and pricing agreements can facilitate equitable rollout of targeted therapies based on cost-effectiveness.
- Reimbursement expansion to cover biomarker tests (e.g., HER2, PD-L1, MSI) would improve precision oncology implementation.

Threats

- Budget constraints and stringent pricing frameworks may restrict access to novel agents in some regions.
- Patients in regions with restrictive formularies may face disparities in treatment options.

● 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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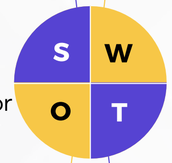
Colorectal Cancer Screening

Strengths

- Sweden operates well-established national screening programs for breast, cervical, and colorectal cancers with high uptake (coverage ~82–85%)
- Organized pilot studies for prostate and lung cancer screening demonstrate capacity to implement complex screening policy frameworks

Weakness

- There is no national population-based gastric cancer screening program; upper GI endoscopy is only performed reactively when symptoms arise.
- Preventive medical check-ups (like general bloodwork or early cancer screening) are regionally limited and not systematically available for gastric cancer



Opportunity

- Risk-based screening pilots (e.g. H. pylori testing in high-risk subgroups) could inform future organized protocols.
- Incorporating gastric symptom-awareness into primary care pathways or preventive check-up initiatives may aid early detection.

Threats

- Low incidence and cost-effectiveness concerns make Japan/Korea–style population screening unlikely in Sweden.
- Without targeted awareness or pilot programs, gastric cancer may remain under-detected until advanced stage.

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