POLAND

International Cancer Patient Coalition

BRIDGING THE GAP

Enhancing Equitable Access & Innovation in **Gastric Cancer Care** in Poland

EXECUTIVE SUMMARY

Poland has strengthened oncology infrastructure in recent years, but gastric cancer (GC) outcomes are limited by late diagnosis, inconsistent access to molecular diagnostics, and regional disparities in treatment and survivorship services. Universal health coverage reduces catastrophic costs for many patients, yet variability in endoscopy access, reimbursement for targeted therapies, and integration of palliative care reduce equity and timely care.

This brief outlines priority reforms to raise Poland's gastric cancer maturity.

INTRODUCTION

Building on Oncology Strengths Amid Structural Gaps

Poland's healthcare system supports strong oncology centres in major cities, but many regions face long waits for diagnostic endoscopy, uneven molecular testing availability, and variable access to newer systemic therapies.

With a **Level 3 – Emerging** gastric cancer maturity, Poland should focus on standardizing pathways, expanding diagnostic capacity, ensuring equitable biomarker access, and embedding palliative and survivorship services into routine care.

Poland Ranks at Level 3 – Gastric Cancer Care Maturity Framework

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GASTRIC CANCER IN POLAND

Current Landscape and Strategic Gaps

Pillar	Current Status	Strength	Policy Action
Early Detection & Diagnosis	No national screening; many GC cases diagnosed at advanced stages. Endoscopy availability and wait times vary, especially outside major urban centres.	High-quality diagnostic capacity exists in oncology centres in Warsaw, Kraków, Gdańsk and other cities.	Define national referral criteria for alarm symptoms; set time-to-endoscopy targets; expand sessional endoscopy lists and mobile outreach in underserved regions; strengthen primary-care referral triggers.
Biomarker & Molecular Testing	HER2 and MSI testing are available in tertiary centres but not uniformly accessible; turnaround times vary.	Research hospitals and academic labs provide molecular testing capability that can act as hubs.	Make HER2 testing routine for advanced disease; set TAT standards (e.g., ≤10 working days); build hub-and-spoke lab networks and subsidize testing for public patients.
Treatment Access	Curative gastrectomy and peri-operative chemotherapy are available in tertiary centres; access to HER2-targeted therapy and immunotherapy is limited by reimbursement and regional policy variability.	High surgical and oncology expertise concentrated in referral centres.	Harmonize reimbursement rules for targeted therapies; adopt pooled procurement or negotiated pricing; ensure peri-operative chemo protocols are available across networks and support referral to high-volume surgical centres.
Clinical Guidelines	National guidelines exist but adherence and implementation vary across regions and hospitals.	Strong professional societies and MDT culture in major centres support guideline development.	Publish and disseminate a nationally endorsed GC pathway; require MDT reviews for complex cases; implement monitoring/audits tied to improvement support.
Palliative & Survivorship Care	Palliative care services are present but inconsistently integrated into GC care; survivorship support (nutrition, psychosocial rehabilitation) is limited in many regions.	Growing palliative networks and NGO partnerships provide foundations for scale-up.	Embed early palliative referral into the GC pathway; ensure opioid availability and prescriber training; scale survivorship programs including nutrition, psychosocial support and rehabilitation.

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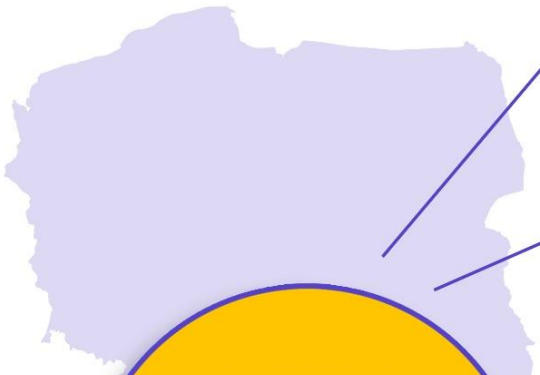
CONCLUSION & Call to Action

Poland's clinical expertise offers strong potential to improve gastric cancer outcomes, but regional fragmentation, diagnostic delays, and unequal access to molecular and novel therapies must be addressed. Key actions include standardizing the care pathway with clear time targets, ensuring routine funded molecular testing, aligning reimbursement and pricing for targeted therapies, expanding diagnostic capacity in underserved areas, integrating palliative and survivorship support, and strengthening data systems with public dashboards and performance-linked funding. Coordinated national and regional governance with time-bound milestones and transparent reporting will be essential to ensure equity and sustained progress.



KEY POLICY PRIORITIES

1. **Launch a National GC Pathway:** Standardize alarm-symptom criteria, referral SLAs, and time-to-endoscopy/treatment targets.
2. **Make Molecular Testing Routine:** Implement hub-and-spoke HER2/MSI testing with guaranteed turnaround and public funding.
3. **Scale Endoscopy & Diagnostics:** Invest in sessional lists, equipment maintenance, workforce training & mobile outreach for remote populations.
4. **Integrate Palliative & Survivorship Care:** Ensure early palliative referral, opioid access, nutrition and psychosocial programs within the pathway.
5. **Secure Equitable Treatment Access:** Harmonize reimbursement for HER2-targeted therapies and immunotherapies; negotiate prices and consider pooled procurement.

CONCLUSION

With targeted, coordinated action, Poland can translate its clinical strengths into uniformly high-quality, equitable gastric cancer care. Prioritizing pathway standardization, diagnostic equity, and sustainable access to evidence-based therapies—backed by transparent data and regional accountability—will enable Poland to raise its gastric cancer maturity and ensure better outcomes for all patients regardless of where they live.