International Cancer Patient Coalition

Netherlands

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 not among top male cancers, but incidence is higher in older adults.
- Incidence rate: Around 7–8 per 100,000 men per year.
- Total new cases (2022): Around 2,000 men.
- Daily diagnoses: About 5–6 men per day.
- Deaths (2022): Approximately 1,300 men.
- 5-year survival rate: Estimated 30–40%.
- Most affected age group: Mostly men aged 70+.
- Screening participation: No national screening; endoscopy is performed only when clinically indicated.

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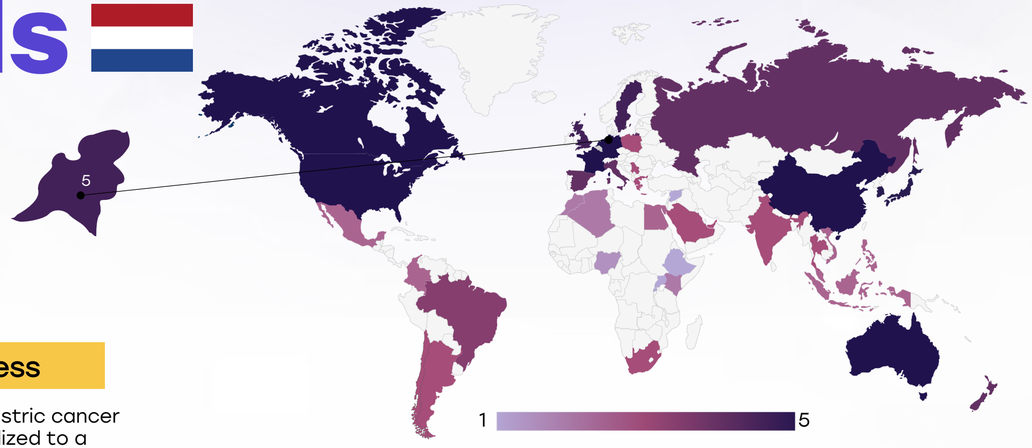
Infrastructure



Strengths

- The Netherlands has a highly organized healthcare system with advanced cancer centers like the Netherlands Cancer Institute (NKI) and University Medical Centers (e.g., UMC Utrecht, Erasmus MC).
- National electronic health records and integrated diagnostic pathways support streamlined referrals, diagnostics, and treatment planning.

Weakness

- Specialized gastric cancer care is centralized to a limited number of high-volume centers, which may delay treatment initiation for patients in peripheral regions.
- Limited endoscopy capacity in some areas causes delays in early diagnosis, especially post-COVID

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Opportunity

- Expand telepathology and remote tumor boards to enhance access for patients in non-academic hospitals.
- Increase training in gastrointestinal oncology and surgical specialization to reduce dependency on central hubs.

Threats

- Increasing pressure on hospital capacity due to an aging population and staff shortages, particularly in surgical and pathology departments.
- Delayed upgrades in regional hospitals due to budget caps and public-private funding constraints.

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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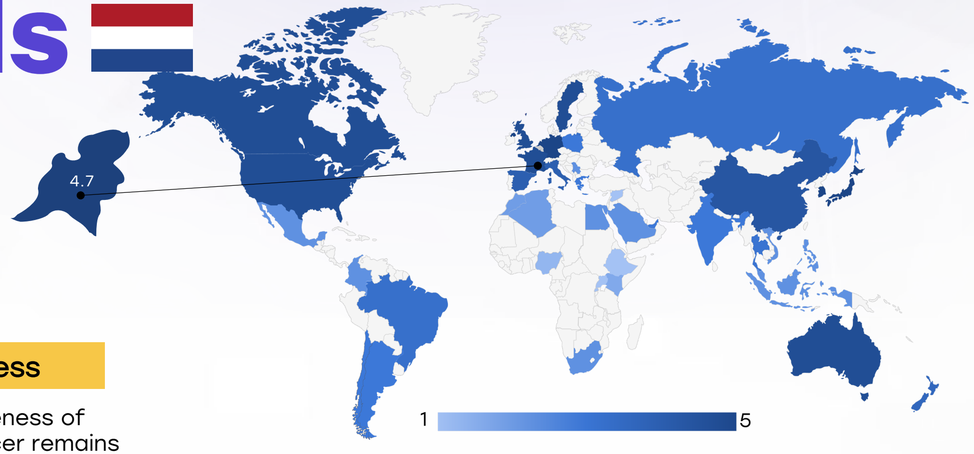
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Strong government and EU-level funding for cancer research (e.g., Dutch Cancer Society, Horizon Europe projects).
- Universal healthcare coverage ensures equitable access to chemotherapy, surgery, and radiotherapy.

Weakness

- Public awareness of gastric cancer remains low, especially in comparison to breast or colorectal cancer.
- Access to clinical trials is often limited to major academic hospitals, reducing opportunity for patients in community settings.

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Opportunity

- Boost funding for targeted awareness campaigns on H. pylori and gastric cancer risk factors.
- Leverage Dutch research strengths in precision medicine and AI-driven diagnostics to improve gastric cancer outcomes.

Threats

- Rising costs of oncology care and new drugs may strain reimbursement systems.
- Patient advocacy is weaker in gastric cancer compared to other cancer types, potentially affecting fundraising and policy influence.

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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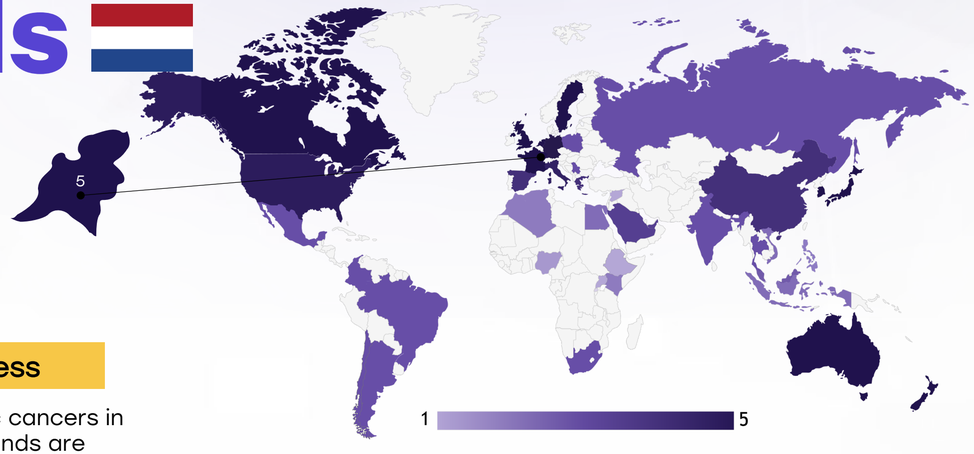
Survival Rates, Early Detection and Palliative Care



Strengths

- 5-year relative survival rates for localized gastric cancer can reach over 60% when detected early and treated in high-volume centers.
- Strong palliative care infrastructure, including home-based and hospice care integrated into the national health system.

Weakness

- Most gastric cancers in the Netherlands are diagnosed at an advanced stage, often stage III or IV.
- Early detection programs for gastric cancer are non-existent, and H. pylori testing is not routine.

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Opportunity

- Introduce risk-based screening pilots for high-risk populations (e.g., migrants from high-incidence regions).
- Expand non-invasive testing pathways, such as stool-based markers or serological risk panels.

Threats

- Continued absence of national gastric cancer screening may prevent significant survival improvement.
- Delayed symptom recognition among both GPs and patients, due to vague early signs and low awareness.

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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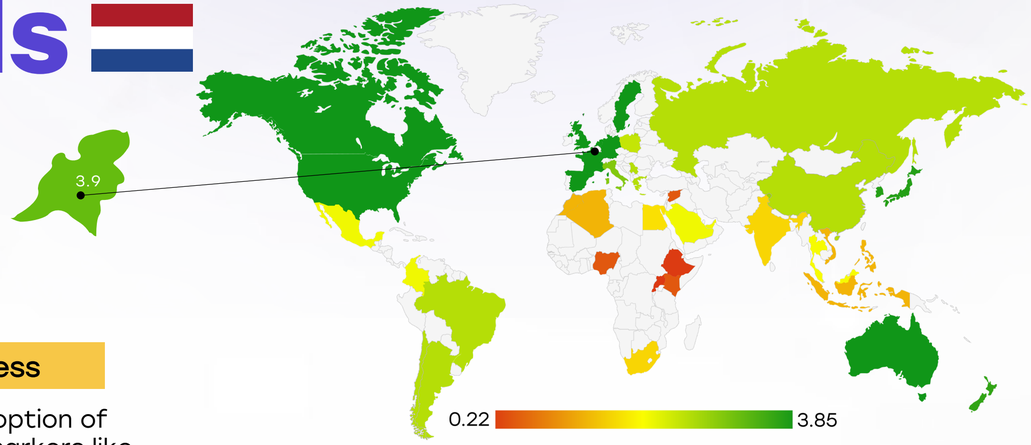
Utilization of Biomarkers



Strengths

- HER2 testing is routine in advanced gastric cancer, and trastuzumab is reimbursed for HER2+ patients.
- PD-L1 testing (CPS≥1) and MSI testing are increasingly implemented to guide immunotherapy use.

Weakness

- Limited adoption of newer biomarkers like CLDN18.2 and FGFR2b in standard clinical workflows.
- Variability in testing access across smaller or non-academic hospitals, especially for less common biomarkers.

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Opportunity

- Expand biomarker panels through national cancer genomics initiatives like the Hartwig Medical Foundation.
- Integrate comprehensive molecular profiling into routine advanced-stage gastric cancer workup.

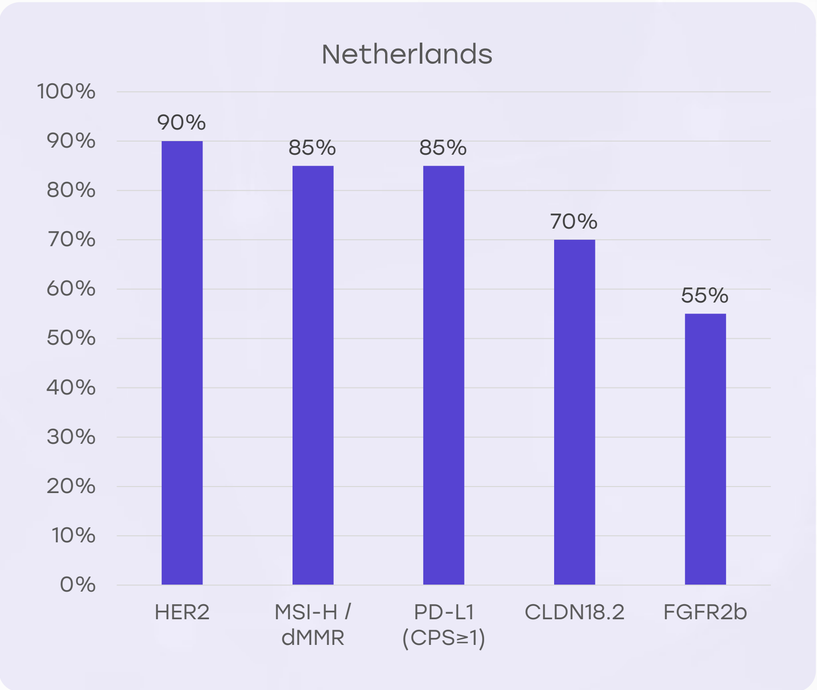
Threats

- Reimbursement delays for newer biomarker tests and therapies may limit their uptake.
- Risk of disparity in access between urban and rural hospitals or academic vs. community centers.

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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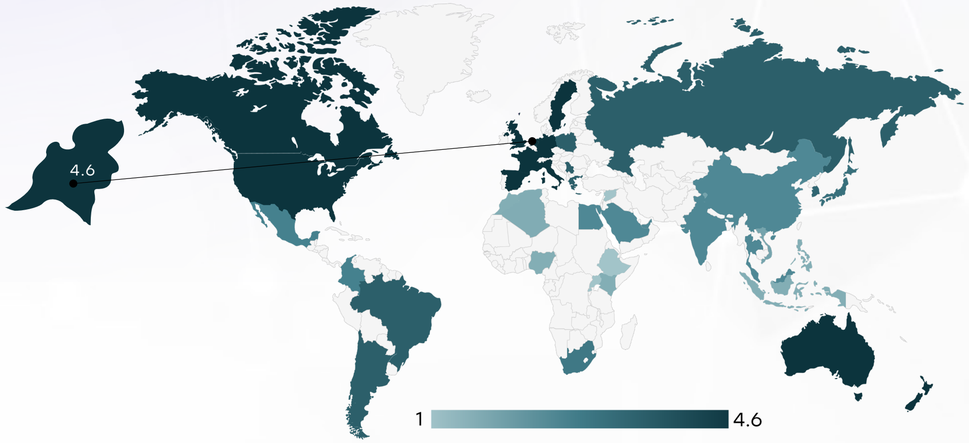
Clinical Guidelines



Strengths

- The Netherlands follows Dutch Society of Gastroenterology and ESMO/NCCN-adapted guidelines for gastric cancer management.
- Multidisciplinary Tumor Boards (MDT) are standard, ensuring personalized and consistent decision-making.

Weakness

- Guidelines are often complex and subject to interpretation, particularly for rare biomarker-driven subtypes.
- Updates may lag behind the pace of innovation in targeted therapies and diagnostics.

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Opportunity

- Regular integration of real-world evidence and clinical trial results into national guidelines.
- Enhance training modules for community oncologists and GPs to ensure guideline adherence

Threats

- Inconsistent application of advanced diagnostics and treatment due to variability in hospital resources.
- Potential guideline conflicts due to emerging therapies lacking EMA approval

	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

- The Dutch healthcare system provides universal coverage for approved gastric cancer treatments, including chemotherapy, surgery, and immunotherapy.
- Centralized reimbursement decisions through Zorginstituut Nederland help ensure cost-effectiveness.

Weakness

- Delays in approval and reimbursement of novel therapies post-EMA approval (e.g., zolbetuximab or FGFR2b inhibitors).
- Cost-effectiveness assessments may delay access to expensive biomarker-driven treatments.

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Opportunity

- Pilot value-based reimbursement models linking biomarker testing to therapeutic outcomes.
- Greater negotiation power for innovative pricing agreements for immunotherapies and biosimilars.

Threats

- Pilot value-based reimbursement models linking biomarker testing to therapeutic outcomes.
- Greater negotiation power for innovative pricing agreements for immunotherapies and biosimilars.

● 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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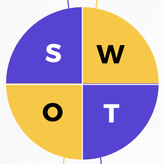
Gastric Cancer Screening

Strengths

- Strong national screening infrastructure for other cancers (e.g., breast, cervical, colorectal), which could be adapted for gastric cancer.
- Some academic pilot studies exploring H. pylori eradication and surveillance in high-risk groups.

Weakness

- No national screening program for gastric cancer or H. pylori testing.
- Limited focus on migrant populations who may carry higher gastric cancer risk.



Opportunity

- Implement targeted screening strategies for high-risk ethnic groups (e.g., East Asian, Turkish, North African descent).
- Use serology and urea breath tests as non-invasive methods to screen for H. pylori in primary care.

Threats

- Low gastric cancer incidence overall may prevent screening programs from being prioritized.
- Risk of over-medicalization and unnecessary interventions without proper risk stratification.

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