
International Cancer Patient Coalition

# BRIDGING THE GAP

## Enhancing Equitable Access & Innovation in **Gastric Cancer Care** in Italy

## EXECUTIVE SUMMARY

**Italy** has strong clinical expertise and many high-quality tertiary centres, yet gastric cancer (GC) outcomes remain constrained by late diagnosis, regional variation in access to endoscopy and molecular diagnostics, and uneven availability of advanced systemic and supportive therapies across regions.

Financial protection under the National Health Service reduces catastrophic costs for many, but regional disparities (north vs south) and variability in pathway organization limit timely, equitable care. This brief outlines strategic reforms to standardize pathways, scale diagnostics (including HER2 testing), strengthen peri-operative and metastatic treatment access, and expand palliative and survivorship services nationwide.

## INTRODUCTION

### Building on Awareness Gains Amid Structural Gaps

Italy's universal healthcare system and strong oncology centres provide a solid foundation for GC care. However, fragmented pathway organisation between regions, inconsistent diagnostic capacity at lower-tier hospitals, and variable adoption of molecular-driven treatment mean that clinical strengths do not uniformly translate into equitable outcomes.

With a **Level 3 – Emerging** gastric cancer maturity, Italy can move decisively toward greater equity and system integration through targeted policy action and regional implementation support.

**Italy Ranks at Level 3 –** Gastric Cancer Care Maturity Framework


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# GASTRIC CANCER IN ITALY

## Current Landscape and Strategic Gaps

| Pillar | Current Status | Strength | Policy Action |
|---|---|---|---|
| Early Detection & Diagnosis | No national population screening for GC; diagnosis is largely symptom-driven and some patients present at advanced stages. Endoscopy access and waiting times vary by region and facility. | Strong tertiary endoscopy and diagnostic centres in major cities; experienced endoscopists and surgeons. | Define a national GC referral pathway with alarm-symptom triage and time-to-endoscopy targets; expand sessional endoscopy lists in underserved provinces and strengthen primary-care referral triggers. |
| Biomarker & Molecular Testing | HER2 testing and other molecular diagnostics are available in many centres but are not uniformly accessible across all hospitals; turnaround times vary. | Established molecular labs in regional cancer centres and academic hospitals. | Standardize HER2 testing as routine for advanced GC, set turnaround-time standards, and build hub-and-spoke lab networks to ensure equitable access and quality assurance. |
| Treatment Access | Curative gastrectomy and peri-operative chemotherapy are routinely available in tertiary centres; access to targeted agents and newer systemic therapies can vary by region and reimbursement pathways. | High surgical competence and oncology expertise concentrated in referral centres; NHS coverage reduces out-of-pocket costs for many essential treatments. | Clarify and harmonize reimbursement paths for HER2-targeted therapies and other guideline medicines across regions; ensure peri-operative chemo protocols are delivered equitably and support referral networks to surgical hubs. |
| Clinical Guidelines | National and regional clinical guidance exists but implementation and adherence vary between regions and hospitals. | Strong professional societies and MDT culture in major centres support guideline uptake. | Develop a nationally endorsed GC pathway and promote consistent MDT review across regions; link pathway adherence to regional quality monitoring and improvement programs. |
| Palliative & Survivorship Care | Palliative care services exist but their availability and integration into cancer pathways vary regionally; survivorship support (nutrition, psychosocial care) is inconsistent. | Well-established palliative medicine specialty and community care models in many areas. | Embed early palliative referral into the GC pathway, ensure opioid and symptom-control access, expand survivorship programs (nutrition, psychosocial support) and standardize community follow-up. |


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# CONCLUSION & Call to Action

Italy has clinical excellence and universal coverage but must close regional gaps to ensure all patients benefit from timely, guideline-based gastric cancer care. Priority actions include standardizing a national GC pathway, guaranteeing routine molecular diagnostics and fast turnaround, harmonizing funding/access for targeted therapies, scaling equitable diagnostic capacity, and strengthening palliative and survivorship services. Coordinated national-regional implementation, tied to measurable performance indicators, can deliver measurable improvements in survival and patient experience.

## KEY POLICY PRIORITIES

1. **National GC Pathway:** Define alarm-symptom criteria, referral SLAs, and targets to reduce diagnostic delays.
2. **Molecular Diagnostics:** Standardize HER2 testing with hub-and-spoke labs, QA, and guaranteed turnaround.
3. **Treatment Access:** Ensure consistent reimbursement and access to HER2 therapies and peri-operative chemotherapy nationwide.
4. **Endoscopy Capacity:** Expand sessional lists, maintenance, training, and mobile outreach for underserved areas.
5. **Palliative & Survivorship Care:** Integrate services into standard pathways, ensure opioid availability, and scale psychosocial and nutritional support.

# CONCLUSION

With targeted, coordinated action across national and regional health authorities, Italy can translate its clinical strengths into consistent, equitable gastric cancer outcomes. Prioritizing pathway standardization, diagnostic equity, and sustainable access to evidence-based therapies—paired with robust data and regional accountability—will be essential to raise national GC maturity and ensure every patient receives timely, high-quality care