# FICCI-EY compendium of recommendations on 'Roadmap for making cancer care affordable and accessible in India'

**November 2024**



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# Preface

FICCI had constituted a multi-stakeholder task force on cancer care in 2022, which had representation from cancer care providers, senior clinicians, medtech and pharma companies as well as civil society organizations, with EY as a knowledge partner. With their contributions we developed a **report titled, "Call for Action: Making quality cancer care more accessible and affordable in India"**, (FICCI-EY Report 2022), which highlighted the need for more effective measures aimed at proactive cancer prevention and treatments.

The task force, with an aim to present this report and garner further suggestions from stakeholders across the country, has been organizing **Regional Roundtables under the aegis of Ministry of Health & Family Welfare, Government of India**. Five roundtables have been held till September 2024.

The first regional roundtable was held in Gujarat for the western region, under the Chairmanship **of Shri Vishal Chauhan**, Joint Secretary, Ministry of Health & Family Welfare, Government of India. The second roundtable was organized for southern region at the Vidhana Soudha, Bengaluru, which was graced by **Shri Dinesh Gundu Rao**, Hon'ble Minister for Health and Family Welfare, Government of Karnataka. The third one was held for the eastern region in Bhubaneshwar, Odisha, under the Chairmanship of **Smt. Indrani Kaushal**, Joint Secretary, Ministry of Health & Family Welfare, Government of India. The fourth roundtable was held in Jaipur under the Chairmanship of **Smt. Shubhra Singh**, Additional Chief Secretary, Medical & Health and Family Welfare Department, Government of Rajasthan. The fifth Roundtable for the north-eastern region was held in Shillong under the Chairmanship of **Smt. Mazel Ampareen Lyngdoh,** Hon'ble Minister for Health & Family Welfare, Government of Meghalaya.

This document is a comprehensive assimilation of recommendations from all the round tables as a compendium to guide policy decision making on cancer control and care for the country.

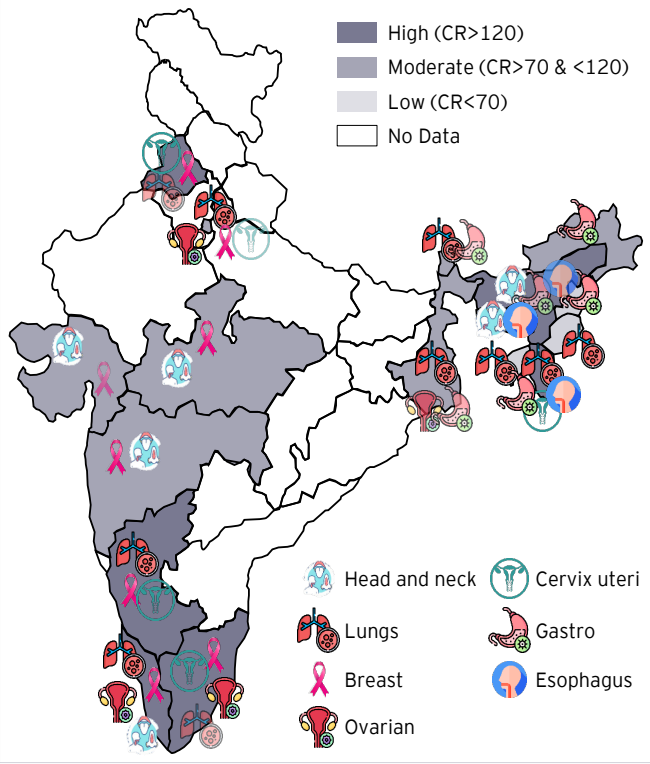
# Context



India faces a significant challenge of a sizeable cancer incidence burden, which continues to grow further. Estimates indicate India's reported cancer incidence in 2022 to be 19 to 20 lakh, whereas real incidence may be 1.5 to 3 times higher than the reported cases. It is crucial that the society, governments, and the healthcare ecosystem prioritize cancer prevention and early diagnosis as the disease causes physical, emotional, financial, and social distress that affects not just an individual but the entire family.

- Rate of cancer incidence has grown at a CAGR of 6.8% from 2015-2020[1]. States in Southern India have the highest overall incidence rate. Cancer incidence is expected to further intensify over the next five to six years with new cases estimated to reach > 45 lakh.
- The challenge of growing incidence is further intensified due to sub-optimal outcomes in terms of mortality compared to global counterparts across all major organ types.

**Map of India with top organ cancer types and crude rate**

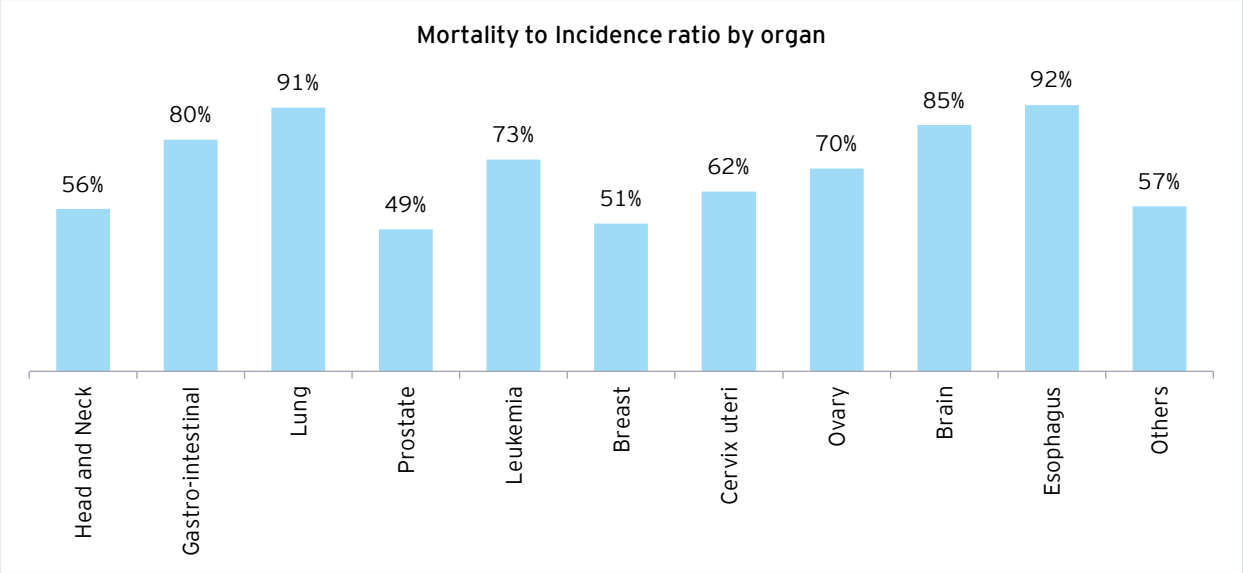



**Key state-wise projected crude incidence per lakh population (2020) and CAGR trend**

| State/UT (no. of registries) | Crude rate per lakh population | | |
|---|---|---|---|
| | Overall | Male | Female |
| Kerala (2) | ↑ 181.6 | ↑ 188.7 | ↑ 175.4 |
| Karnataka (1) | ↑ 151.7 | ↑ 132.3 | ↑ 172.6 |
| Tamil Nadu (1) | ↑ 148.6 | ↑ 135.4 | ↑ 161.5 |
| Punjab (1) | ↑ 144.0 | ↑ 126.4 | ↑ 163.7 |
| Mizoram (1) | ↑ 141.7 | ↓ 143.5 | ↑ 139.9 |
| Assam (3) | ↑ 138.6 | ↑ 151.6 | ↑ 125.8 |
| Delhi (1) | ↓ 113.5 | ↓ 111.7 | ↓ 115.5 |
| Maharashtra (6) | ↑ 97.2 | ↑ 88.8 | ↑ 106.2 |
| Arunachal Pradesh (2) | ↓ 94.1 | ↓ 91.0 | ↓ 97.1 |
| West Bengal (1) | ↓ 87.9 | ↓ 94.1 | ↓ 81.4 |
| Madhya Pradesh (1) | ↑ 87.8 | ↑ 85.3 | ↑ 90.4 |
| Gujarat (1) | ↑ 85.8 | ↑ 92.6 | ↑ 78.2 |
| Meghalaya (1) | ↑ 79.5 | ↑ 100.7 | ↑ 58.4 |
| Sikkim (1) | ↓ 70.5 | ↓ 67.8 | ↓ 73.5 |
| Tripura (1) | ↑ 68.5 | ↑ 76.7 | ↑ 60.0 |
| Nagaland (1) | ↑ 68.2 | ↓ 74.1 | ↑ 61.9 |
| Manipur (1) | ↑ 56.2 | ↑ 50.8 | ↑ 61.6 |

Source: NCRP annual reports, EY analysis

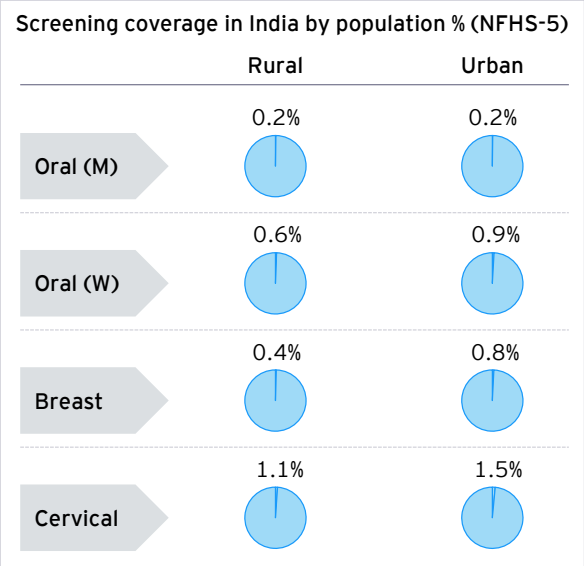
[1] NCRP annual reports




Source: NCRP Annual report 2020

The cancer control landscape in India is sub-optimal with challenges across stages ranging from awareness and prevention to screening, detection and access to treatment. Key challenges include the following:

- Awareness landscape is still dominated by tobacco-related cancers. Knowledge of other common cancers such as cervical cancer and gastro-related cancers and their associated risk factors is low. Additionally, India is still to add the HPV vaccine to its national immunization program.
- Despite the proven benefits of early identification in downstaging the disease as well as in achieving a reduction in mortality and morbidity, screening penetration of key cancers in India is very low. Across focus cancers being screened under the NPCDCS program, screening coverage is less than 5% of population which is negligible when compared with global peers. Oral cancer has the lowest screening coverage at 0.2% of the population.
- There is significant geographic skew in the presence of comprehensive cancer centres in the country. Only ~175 districts in the country covering 40%-45% of the population have Comprehensive Cancer Centres (CCCs). Of the 470 to 480 CCCs available in the country, ~40% are concentrated in metros and state capitals.[2]




Source: NFHS-5

- Treatment cost for cancer care is financially prohibitive and is almost 3x that of other non-communicable diseases (NCD). Additionally, treatment cost continues to increase. The cost of a single cancer hospitalization (in public or private facility) exceeded the average annual expenditure of 80% population in 2017 vis-à-vis 60% population in 2014. In addition, significant variations exist in the coverage of different treatment options such as PET-CT, biopsies, immunotherapy and targeted therapy across various state government health schemes, resulting in variations in access to latest treatment options.

[2] Making quality cancer care more accessible and affordable in India – FICCI report '22



# Recommendations

## for enhancing cancer care in the country and making it more accessible and affordable



# Awareness generation

Awareness generation is regarded as the most effective tool in early detection and prevention of cancer. Across all round table discussions, focus on awareness creation for cancer is rated as the most important factor supported by clear recommendations to expedite the awareness campaigns.

- **Drive a differentiating awareness agenda focusing on cancer prevention lifestyle:** The country is witnessing a growing trend of alcohol consumption, tobacco consumption, obesity and female physical inactivity. It is imperative to educate students in schools and colleges regarding various cancers and their probable causes along with the need for early detection and promoting cancer preventive lifestyle. Cancer education can be included as a part of school curriculum.
- **Drive awareness of cervical cancer and improve access to HPV vaccine:** Despite cervical cancer being the second largest cancer, impacting 0.2 per 1,000[3] women every year, awareness regarding cervical cancer stands at <40%. Women should be fortified with knowledge to encourage the vaccination of young girls against cervical cancer.
- **Design prevention programs keeping in mind the social and cultural aspect of the region** as certain topics are sensitive. For example, cervical cancer has high prevalence in Mizoram, Karnataka, Tamil Nadu, Punjab and Delhi. It also has some level of stigma attached to it since the culture of India does not encourage open conversations about sexual practices.
- **Collaborate with NGOs** to widen the reach of cancer awareness initiatives and to conduct screening camps with them.
- There is need for showing urgency in creating awareness. An approach similar to "Arogya Setu" can be taken for creating awareness.



[3] Source: WHO website



> We recognize the unique healthcare challenges faced by the north-eastern region, especially concerning cancer care. High tobacco consumption, inadequate healthcare infrastructure, and delayed diagnosis fuel the alarming rise. Tobacco accounts for 57% of cancers in men and 28% in women. To combat this, there is a pressing need for comprehensive prevention strategies, early detection initiatives, and improved access to treatment, especially in underserved and remote regions.
>
> **Mr. Raj Gore**
> Chair, FICCI Task Force on Cancer Care and CEO,
> Healthcare Global Enterprises Limited (HCG)

**FICCI Roundtable – Western Region** was held under the Chairmanship of **Shri Vishal Chauhan**, Joint Secretary, Ministry of Health & Family Welfare, Government of India




Addressing the roundtable, Mr. Chauhan highlighted the profound burden of cancer on the society and shared that recently, **post-screening continuum of care has emerged as a significant challenge**, which necessitates urgent action. He also expressed that while the government has launched programs for infrastructure creation and treatment provisioning, there is a **huge scope for collaborative efforts** towards affordability and accessibility of cancer care in the country.



# Screening
## and prevention

- **Cancer screening and early detection is the key.** A 2020 report from the Indian National Cancer Registry Programme highlighted that **North-east India** had a higher cancer burden relative to the rest of the country. Compared with the average cancer incidence rate in India (122 per 100,000), Aizawl district of Mizoram had the highest incidence rate for males (269.4) and Papumpare district of Arunachal Pradesh had the highest incidence rate for females (219.8). This means that one in four males in Aizawl district and females in Papumpare district could likely develop cancer before age 74. Aizawl district was also reported to have a cancer mortality rate of 152.7 per 100,000 males which is greater than the average cancer mortality rate in India (62.7) and the US (85.7). The high cancer burden in North-east India – where the populations are largely rural – is likely multifactorial, caused by greater exposure to cancer risk factors (such as tobacco use), low health prevention measures, and limited access to medical facilities. Socio-economic status has also been associated with the risk and outcomes of various cancers.
- **Include screening packages under PMJAY scheme.** Some of the state governments are **actively** considering introduction of cancer screening packages in their respective state schemes. Day care packages for diagnostics under the PMJAY scheme should be explored.
- Adoption of **low-cost point of care screening** devices, specially at primary healthcare centre level, will help improve screening pool and drive early detection.
- **Mobile screening programs:** Mobile screening units should be available in all districts to make it accessible for people in remote localities to be screened easily for various types of cancer. Training for nurses to conduct screening activities in camps and mobile screening facilities should be provided.

> “Innovations in oncology have come a long way and today our experts are utilizing AI to detect lung cancer. However, it is important to recognize that screening and detection of cancers will help only when there is follow through with appropriate diagnosis, treatment and care. Further, insurance schemes, including government health insurance, should provide additional coverage for specific disease areas under cancer.”
>
> **Mr. Praveen Akkinepally**
> Business Unit Head, Oncology,
> AstraZeneca India



- **Encourage use of telemedicine:** Telemedicine should be encouraged at primary healthcare centres and medical colleges for screening. This would be beneficial for the North-east states, considering a larger rural population and logistics issues. Teleconsultation centres would help in early detection and right diagnosis and in-time referral to advanced centre for further treatment.
- **HPV screening to be universalized** in the community for early detection of cervical cancer in women.
- **Mammography equipment must be made available at all district hospitals.** Diagnosis should be made accessible through at-home or at-centre facilities, especially for breast cancer. Combination of digital and physical efforts will be required to build an **integrated system from screening to treatment**. Use of AI tools to enhance screening efficiencies for breast and lung cancer should be leveraged.
- **Screening coverage can be expanded** by the government by mandating screening for all government employees as well as all vendors working with the government.
- **Hub and spoke model should be used to penetrate tier II and tier III cities and other remote areas,** leveraging medical colleges as the focal point or hubs and diagnostic centres, traditional practitioners and private doctors as spokes for screening.
- Counselling of suspects identified in screening programs to undertake advanced diagnostics and thereafter treatment, will be critical in this regard. Robust referral pathways should be developed and managed through automation to ensure dropouts are reduced. **A PPP model between private tertiary care hospitals and district hospitals** should be explored to provide advanced screening facilities across states. The cancer care infrastructure in North-east India is especially poor, as more than 75% population is rural while 95% of cancer care facilities are in urban areas leading to huge burden on tertiary care centres, especially in handling late-stage cancer patients who tend to have poor outcomes. Therefore, need exists for setting up facilities to conduct district level cancer screening, diagnosis and for setting up comprehensive cancer care centres in rural areas.
- Comprehensive state-wise data on number of screenings, diagnosed cases, and patients put on treatment needs to be captured and published. A comprehensive cancer care management approach needs to be taken instead of looking at the data at different stages of cancer independently.
- **Prevention strategy for cervical, lung and oral cancer** – Consider inclusion of cervical cancer vaccination in national immunization program, which will act as a huge boost to prevention. Provide support programs for children to quit tobacco to prevent oral and lung cancers.

# Treatment
## and care

### Enhancing diagnosis

- Advanced diagnostic facilities should also be improved at the district level such that patients can undergo accurate diagnosis before being referred for treatment. It is essential to provide access to diagnostics facilities for enabling early diagnosis such that we can improve the ratio of stage 1-2 detection.
- With the help of government, advanced diagnostic centres including molecular diagnostics and genomic sequencing, for personalized and tailored treatment can be set up across states/districts.
- Steps to minimize histopathology assessment variation should be undertaken. Also, registration of histopathology data and creating biorepository of samples should be ensured to generate data for predictive analytics leveraging AI in the future.
- **Access to bio marker testing and NGS in states** – Cancer care is becoming increasingly personalized as treatments become specific to cancer sub-types. For a medical oncologist to choose the best available therapy for a specific cancer type, it is imperative to ensure access to cancer bio marker tests and NGS facilities in states. Depending on the patient load a hub-spoke model can be deployed keeping the ICMR DIAMOND labs as hub.

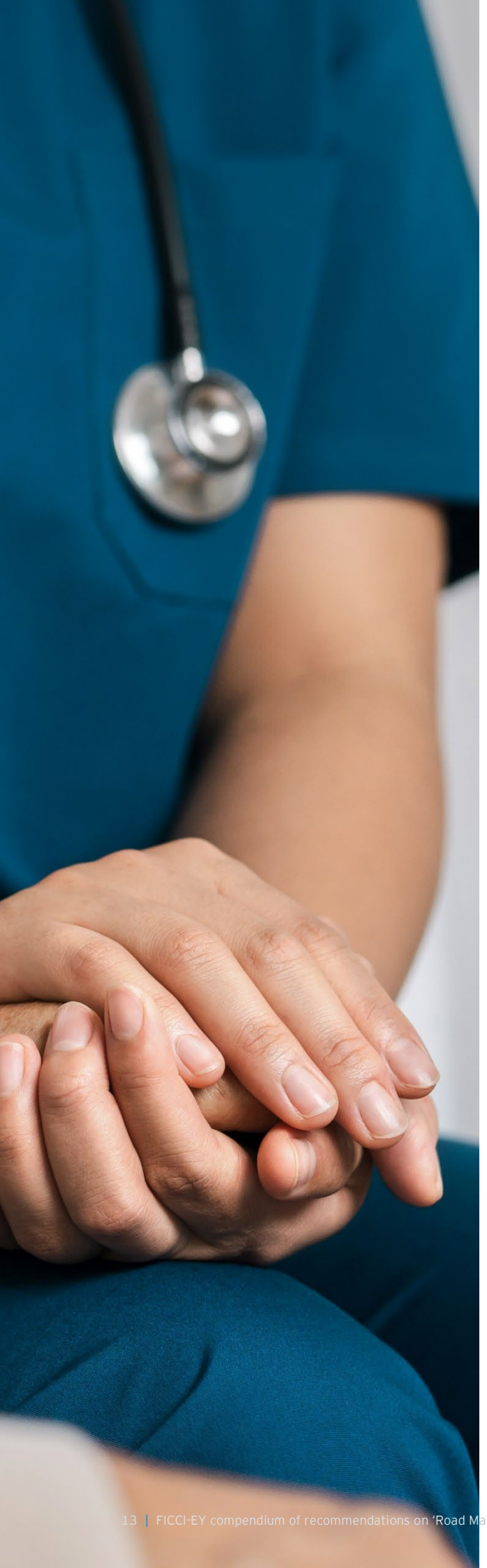
### Enhancing treatment

#### Supporting skill building and enhancement

**Early exposure to oncology subjects**

- Oncology should be introduced as subject in MBBS course, and all medical colleges should have oncology departments. Radiotherapy is a subject that is recommended but is still optional at U/G level. Recommendation is to make it a compulsory subject and introduce this program across all medical colleges. Also, cancer should be introduced as a subject under Ayush programs. Ayush doctors should be made aware about symptoms, screening and early detection to ensure timely referral to cancer centre.
- Molecular oncology/genomics curriculum should be introduced to improve trained skill availability.





## Focus on improving superspecialists availability

- Shortfall in oncologists is likely to worsen over the next two decades given the rising disease burden specifically as the population starts ageing. Surgical oncologists treat 80% of solid tumours. The duration required for a surgical oncologist to be qualified is as long as 11 years (MBBS+ PG in general surgery + PG in surgical oncology + organ-specific fellowship). Efforts need to be undertaken by bodies such as NMC to streamline the same and optimize the timelines for surgical oncologist to be qualified. Two separate degrees of MD and DNB can be integrated into one with the same curriculum and training.
- **Focus on medical and surgical oncology specialty**: There is a need for 2,500-3,000 more medical oncologists and 700-800 more surgical oncologists to take care of the current incidence rates. Thoughts towards having more seats for medical and surgical oncology in the medical colleges can be debated upon.[4]
- **MD radiotherapy program must be made mandatory in medical colleges.** This would ensure that there is a regular pool of doctors who are trained and who pass out every year. This will also ensure supply of oncologists in tier II and tier III cities.
- Private medical college fee for obtaining super specialized degrees such as in oncology is very high. Mechanisms should be put in place to cap such fee. Also, efforts to be made to add more DNB seats in government training centres and private teaching hospitals. Incentivize students to study oncology especially in north-eastern regions where supply of surgical oncologists is severely constrained.
- **Medical colleges at the district level should have surgical oncology department** to perform limited complex surgeries which do not need to be referred to apex tertiary care centres. PPP can be evaluated for setting up surgical oncology department in medical colleges.
- Availability of oncologists in tier II / tier III markets is low. Efforts need to be taken collectively by private sector and the government to upskill doctors available (in primary care and secondary care settings) in these cities through knowledge transfer programs such that at least accurate detection and timely referral can be enhanced. Focus on leveraging telemedicine facilities to improve access to specialized care in remote areas.
- Private sector and oncology associations can also come forward to impart training to general surgeons for treating common cancers.

[4] Source: Making quality cancer care more accessible and affordable in India – FICCI report '22

### Develop new subspecialties in oncology

- **Develop newer skillsets to address evolving nature of cancer patients:** With cancer patients surviving for more than 20 years, newer skill sets need to be developed like onco-cardiologists.
- **Develop new sub-specialities**: Focus on development of new sub-specialities like onco-pathology, palliative medicines, interventional radiology, nuclear medicine and particularly isotope therapy, specially in government hospitals and private set-ups in tier I and II cities.
- **Train the workforce and make them technology-ready:** Clinicians and surgeons need to be technology-ready. Hence, more endeavours and industry support for training are required so that technologies such as robotics surgery can be put into practice by a greater number of surgeons.

### Addressing the shortage of trained paramedics and nursing workforce

- There is a shortage of trained nurses and technicians. Even with advancement in technology, there is a requirement of trained staff to run the machines in the diagnostic centres. There is a need for a pyramid model where the base is equipped with strong infrastructure, preventing the overburdening of tertiary care cancer centres.
- **Train and create oncology-focussed nursing team:** Oncology nurses will form the backbone of the treatment. There is need to train our nurses in a focused manner for providing care to cancer patients.
- **Train and motivate ASHA workers for cancer screening and early detection:** Role models from government hospitals (e.g., Silchar hospital), can be looked upon to train and motivate ASHA workers for initial cancer screening and early detection.

### Empowering doctors through research

- **Empower doctors to provide services across larger patient base:** Rules and regulations on how and where doctors can practice need to be re-evaluated so that their services can be available to a larger patient base.
- **Encourage regional research:** There is a need to do local and regional research for cancer, focusing on local needs and problems. We generally follow research from western countries, which may not be applicable to us.
- Reporting of outcomes such as 5-year survival data through peer review process is a good measure to evaluate effectiveness of the resources deployed in cancer care.

**FICCI Roundtable – Southern Region** was chaired by **Mr. Dinesh Gundu Rao**, Minister for Health and Family Welfare, Government of Karnataka who addressed the meeting and unveiled a comprehensive Nine-Target strategy as part of the Bengaluru-Declaration of FICCI Cancer Care Task Force. This initiative is dedicated to significantly reducing premature deaths caused by cancer, improving the quality of life as well as elevating cancer survival rates in the State.



## Strengthening oncology infrastructure

### Availability of infrastructure:

- **Reusing cobalt bunkers:** Bunker infrastructure for cobalt equipment is available across many locations in the country. Many of these cobalt equipment have been decommissioned. Capabilities exist today to upgrade old equipment with modern technology with limited effort. Creation of modular bunkers takes about 50% of the construction time as compared to traditional bunkers with all the regulations as needed in place. An exercise can be carried out to evaluate mechanisms for replacement of cobalt equipment with modern LINACs. For example, of the eight cobalt bunkers in Rajasthan, one is working. With little modifications and the latest medical technology available, these bunkers can be modified and made functional.
- Medical colleges in India follow the approved norm of 2:1 Cobalt to LINAC ratio and dual photon energy equipment, both of which are outdated technologies. These norms need to be reviewed and updated.
- **Evaluate hub and spoke model for radiation oncology**: Hub and spoke model should be considered for radiation therapy, as it may not be currently possible to have a radiation machine at every hospital. This will help channelize patients from a particular area to one common centre.
- **Ramp up PET CT infrastructure**: Currently, the penetration of PET CT in the country is only ~0.26 per million population. We have ~360 PET CTs available, while the requirement is ~480. There is a need to expand local manufacturing of PET CT machines in the country. Utilizing government schemes such as the PLI scheme will be beneficial in this regard. Greater awareness and drive are required at the industry level as well as from the government to promote local manufacturing using the PLI scheme. Also focused investment needs to be undertaken to increase the number of cyclotrons in the country.
- **Improving availability of radiotherapy facility:** Radiotherapy is the third pillar of treatment for cancer patients. Currently, only 120 out of the 740 districts in India have radiotherapy facility. A target can be set to expand coverage of radiotherapy facilities to 300 districts over the next five years with a vision of pan-India availability by 2035. NMC does not suggest radiation therapy as a compulsory department for all medical colleges. Regulatory change needs to be brought about in this regard such that each medical college is mandated to set up radiation oncology department.
- **Increase number of comprehensive cancer care centres**: Less than 30% of the districts in the country have comprehensive cancer centres (inclusive of both public and private centres). There is a need to increase the number of comprehensive care centres which have all the facilities under one roof for the patients.

> "Usually 50-60% of cancer patients need radiotherapy during treatment. However, in India less than 20% are able to access it due to various infrastructural gaps, which need to be filled through partnerships. Entire cancer management should be seen comprehensively, with an end-to-end approach from treatment to follow-ups."
>
> **Ms. Malti Sachdev**
> Sr. Managing Director, Varian

### Financing for cancer care infrastructure:

- **Viability gap funding** should be considered for setting up radiotherapy centres in tier II and III cities.
- Mechanism/policy to consolidate requirement of radiotherapy equipment at central level can be evaluated to standardize the procurement process and ensure purchase commitment from the government.
- **Inverted duty structure,** whereby import of raw materials has higher taxes compared to import of finished goods, should be corrected along with provision of incentives for exports to enable **local manufacturing of medical equipment** required for cancer diagnosis and treatment. Efforts should be made to add more indigenous radiotherapy machines. Also, the service support/maintenance management by local companies/government-run organizations needs to be improved substantially.
- **Import duty on medical equipment** can be considered for rationalization. **Customs duty on radiotherapy equipment is high to the tune of ~30% including cess**. This high duty is also a deterrent for expansion and is eventually passed on to the patient. The customs duty rates for radiotherapy equipment should be reconsidered.

- **Timelines and guidelines** should be defined for the release and utilization of schemes announced by the government for increasing capacity/addition of new state cancer institutes and other tertiary care government cancer set-ups.
- Consider the **hub and spoke model for optimal utilization** of resources. The hub should be a comprehensive cancer care facility including radiology, medical, surgical, and diagnostic oncology. Therefore, they need to have high-end diagnostic equipment like PET CT, Mammogram, GAMMA camera, LINAC etc. Spokes can be daycare centres that can be spread across the districts for screening, lab test, biopsy facilities and referral base. They should be equipped with MRI, CT, Ultrasound etc.
- **Improve the facilities in secondary cities using hub and spoke model through Public Private Partnership:** Setting up various levels of cancer care centres in all the districts with availability of medical and radiation oncology treatments will reduce the dependency of patients on the major/capital cities.

**FICCI organized its third Regional Roundtable** on Cancer Care on March 1, 2024, at KIIT campus, Bhubaneswar for the eastern region. It witnessed about 40 participants including senior officials from the Government of Odisha, clinicians and industry experts in the area of oncology and was Chaired by **Ms. Indrani Kaushal**, Joint Secretary, MoHFW, Government of India.

Ms. Kaushal emphasized the need for early diagnosis and stated that our focus must shift towards detecting cancer in its preliminary stages. She also highlighted the need for data assimilation, overcoming the inertia due to a lack of manpower and promoting incubation for technicians as critical areas requiring attention.



## Enhancing accessibility to treatment

### Accessibility to latest drugs for cancer treatment

- **Targeted therapy needs to be made accessible to patients as it** increases chance of survival by another 5%-10% over and above the 10%-15% provided by chemotherapy.
- Government schemes should be updated to include the coverage of innovative cancer care therapies in the existing package (e.g., Rajasthan offers a coverage of INR25 lakhs, however, none of the innovative cancer care is being covered in this package). Targeted therapies need to be comprehensively included across all state schemes.
- Public and private sectors should work towards making the latest molecules and therapies accessible to the population at large.
- **State governments can be open to innovative pricing mechanisms in tenders:** Considering the cost of innovative therapies and limited resources, state governments should open up differential pricing agreements with pharma companies to allow better access to innovative therapies.

### Treatment guidelines and clinical protocols

- **Implementation of cancer treatment guidelines** need to be made mandatory so that facilities which are not able to implement even the "optimal" guidelines are not treating patients but are referring them to the right treatment facility. This step will be critical to ensure that there is no compromise on outcomes. Also, mechanisms should be put in place to report what percentage of guidelines are being followed by different treatment centres.
- **Clinical protocols need to be of three kinds- ideal, optimal and essential.** Depending on resource availability the guideline needs to be put in place. However, there should be acceptance that cancer treatment is multi-modal and 70%-80% cancers treated require multi-disciplinary team review to decide ideal treatment. The same should be considered while designing protocols and ensuring that skilled oncologists are available for treatment. Based on learnings from Tata Medical's day care centre operations at Muzaffarpur, to ensure delivery of clinical care in remote locations where skilled oncologists may not be available, steps can be taken to **stratify treatment protocols based on complexity of clinical care delivery.** For lower risk/lower complexity clinical care such as giving oral medications etc. training of local resources can be considered.

> "Improving cancer care infrastructure in western India and particularly in Rajasthan is fundamental. We need to ensure that both urban and rural areas have the necessary facilities and equipment to provide high-quality cancer treatment. Additionally, private-public partnerships can bring in much-needed investment and innovation, helping to create a more efficient and accessible healthcare system. With concerted effort and strategic planning, we can pave the way for a future where comprehensive cancer care is accessible to all."
>
> **Ms. Srimayee Chakraborty**
> Partner, Healthcare Services,
> EY Parthenon

- **Advisory board to the government** should be set up for deciding treatment recommendation specially for high-cost innovative treatment.
- **ANC registration card like diagnosis cards** can be provided to every patient based on which referral pathway and continuum of care can be managed.
- **Minimal usage of drugs** must be encouraged. There are no real-world trials that justify too many rounds of therapies; hence research needs to be done in this direction to minimize drug dosages for the patients.
- **Track patients and ensure follow-up** by providing impetus on creation of ABHA Id for patients, for easy tracking from the beneficiaries and provider aspect. Long-term follow-up is required, specially when the patients are undergoing new forms of treatment.
- **Providing palliative care from the initial stages of diagnosis** is important. Patients must receive palliative care from the initial stages of diagnosis and not just by stage 3 and 4. Hence, more effort need to be made in this direction to develop palliative care delivery capabilities at cancer treatment centres.

The **fourth Roundtable** was organized in Jaipur, jointly with the Department of Medical, Health and Family Welfare, Government of Rajasthan, and Ministry of Health & Family Welfare, GoI.

**Ms. Shubhra Singh**, Additional Chief Secretary, Medical & Health and Family Welfare Department, Government of Rajasthan addressed the Roundtable and said that Rajasthan government is dedicated towards "swasthya" with 7.4% of public spend on healthcare.




## Affordability of treatment

- **Evaluate the increase in coverage under government schemes:** Government schemes should be updated such that in addition to the basic coverage provided, topping up could be done for specific disease groups like cancer after screening. A top-up cancer coverage increasing the benefit amount to 3x-4x of basic coverage (e.g., from INR5 lakh to INR15-20 lakh) will significantly increase access to innovative cancer treatments and improve patient outcomes. Health insurance programs such as the *Biju Swastya Kalyan Yojana*[5], where top-up coverage of INR5 lakh beyond the basic coverage of INR5 lakh is available to women, provide a model for implementing top-up coverage. A similar approach for cancer care will be a significant step forward in addressing this public health priority. **Government schemes should cover for the appropriate and complete treatment** of cancer applicable for a patient and **be flexible** to cover higher reimbursements on a case-to-case basis.
- **Evaluate revision of reimbursement rates and increase in coverage under state schemes:** Though various schemes are there in place, revision of reimbursement rates for surgical and radiation therapy needs to be looked at along with the extent of coverage under these schemes. Integration of high-end treatment modalities in the schemes should also be pondered upon. All these steps will encourage smaller private players to provide their services to the needy while being commercially viable. Rethinking of the reimbursement costs basis different tiers/set-ups of hospitals belonging to different cities should be taken up as this is hindering bigger hospitals from providing treatment to the poor and needy.
- Different healthcare schemes by state/central governments which focus on specific segments of people needs to be rolled out and **brought into a single platform.**
- Cancer cannot be cured through episodic treatment. There is need for comprehensive multi-disciplinary care being delivered which is

> "We need to ensure that the entire continuum of care of the patients is covered. All aspects including efficacy- people living longer, as well quality of life of patients is important. Cancer treatment has high out of pocket expenditure. Hence, new treatment modules should be covered under health insurance to make them affordable for the patients."
>
> **Dr. Ishan Patel**
> Category Medical Lead, Oncology,
> Pfizer India

[5] https://www.myscheme.gov.in/schemes/bsky-chcsgh

personalized to the patient's disease profile. If this approach is not followed and only partial treatment is provided to patients, there is risk of sub-optimal outcomes and wastage of resources. Schemes need to be evaluated to ensure comprehensiveness such as inclusion of diagnostics etc. for offering the right treatment options to patients.

- Include presidents of key oncology bodies in India such as IASO (Indian Association of Surgical Oncology), ISO (Indian Society of Oncology), AROI (Association of Radiation Oncologists of India), ISMPO (Indian Society of Medical and Paediatric Oncology) etc. in the Cancer Task Force which can investigate design of clinical protocols, health benefit packages for schemes and more.
- **Redesign PPP model for radiotherapy:** Though PPP models have worked well for other areas like nephrology and diagnostics, they have not picked up well for radiotherapy. A change in design of the PPP model should be thought of to make it lucrative for all the stakeholders.
- **Design innovative funding programs:** Industry can think about innovative funding programs for patient assistance.
- Health beneficiary packages should be developed in consensus with doctors, payors and providers. Robust, inclusive and predictable frameworks for **health technology assessment** can be instituted for inclusion of treatment options under health beneficiary packages of government schemes.
- **New treatment options** should be evaluated based on "value delivered" and not "pricing". Scope exists to consider outcome-based agreements and special managed entry agreements for evaluating the value of a treatment with reference to the outcome delivered by the treatment.
- It is important to allow access/referral mechanism to all patients reimbursed under any central or state government scheme including ESI to get biomarker testing done at DIAMOND labs free of cost.
- Two out of three advanced medical oncology therapies are oral. These therapies have proven outcomes based on research. There is merit in providing OPD coverage under schemes and private insurance policies to ensure access of patients to these modern convenient therapies.
- **PPPs** are required to solve for the challenges in including affordable and appropriate packages for treatment.
- **PPPs** for diagnostic services face a key challenge in terms of **reimbursement** to the private provider. The reimbursements should be robust enough to ensure viability for private providers.

The **fifth Roundtable** was organized in Shillong, jointly with the Department of Medical, Health and Family Welfare, Government of Meghalaya, and Ministry of Health & Family Welfare, GoI, in association with AstraZeneca, HCG Cancer Hospitals, and Varian, supported by EY & IMPF.




Dr. Mazel Ampareen Lyngdoh, Minister of Health & Family Welfare, Government of Meghalaya highlighted the grave incidence of cancer in the country, especially in the North-Eastern region during the roundtable. Dr Lyngdoh said, "Our vision is a cancer-free future generation, where everyone has access to accurate tests and affordable cancer treatment." She also appreciated the efforts of FICCI as this roundtable will help in formulating a policy that is achievable.

# Other recommendations

- **Creation of a nodal agency for cancer care** with defined objective is pertinent to enhance cancer care and control in the country. The objectives can be awareness and prevention, with a strong focus on linkage to care to ensure sustained and equitable access to diagnosis and treatment facilities for cancer patients.
  - The nodal agency can be responsible for strengthening the cancer information system and surveillance to monitor the program and evaluate the outcome of cancer control actions. It should be responsible for promoting the professional education of doctors, nurses, technicians, and health workers to augment human resources. It can promote research and utilization of its findings for prevention and control of cancer.
  - Significant success and impact were seen in HIV control through the establishment of a nodal body viz. NACO. The role of this agency should be to consolidate all efforts/schemes of the government related to cancer control onto a single platform. A detailed region-wise mapping of the disease burden and treatment facilities for cancer care can be a starting point for the nodal agency.
  - Several regulations are there in place for pharma and device companies which develop products and devices for cancer control. A nodal agency for cancer control can consolidate and simplify the regulations applicable to these companies.

> "There is an urgent need for a shift in the approach to cancer screening and treatment in India. The time has come to make cancer a notifiable disease, given its impact on society and the economy."
>
> **Dr. Bishnu Panigrahi**
> Chair of the FICCI Task Force

- **Policy prioritization for cancer care at Ministry of Health** – Cancer care in India is currently grouped under the NPCDCS program under the National Health Mission and focusses primarily on three types – Breast, Oral and Cervix. Under the current structure, cancer care is not getting its due policy focus and funding prioritization for key aspects in patient journey – early detection/screening, access to diagnosis and Innovative therapies for care etc. Systematic execution in a programmatic structure is key for cancer similar to other programs in communicable diseases (TB, AIDS, etc.). Hence, it is strongly recommended that the Government of India roll out a Comprehensive National Cancer Care Policy/Program with funding outlay for top six high burden cancers and provide an umbrella cover (similar to National Sickle Cell Mission) through all stages/modalities of patient care including diagnostics, medical, surgical and radiation treatment. Focused efforts can be made to develop policies/mechanisms for top-up cover, outcome-based funding/contracting, patient assistance programs, differential pricing for organ specific treatment with referencing option.



- **Creation and utilization of high-quality cancer registries**: Cancer should be made a notifiable disease. All state governments should mandatorily set up Population-Based Cancer Registries for accurate data capture with greater representation of all states. Capturing region-wise variations in cancers by organ will be critical for developing a customized action plan for different regions. Hence, better representation of population-based cancer registries is critical for decision making regarding cancer control. Reporting of outcomes such as 5-year survival data through peer review process is a critical measure to evaluate effectiveness of the resources deployed in cancer care. A detailed study of data from the cancer registry is necessary to define our strategy for addressing this issue. Connecting the data from the cancer registry to patient outcomes is crucial, as we currently lack insight into the patients' experiences and results. Each north-eastern state has prevalent cancer types; for instance, Meghalaya has a higher incidence of GI/BTC and oral cancers. Therefore, the state should develop a customized plan focusing on GI cancers rather than Head and Neck or Cervix cancers.
- **Enhance clinical trials**: India's participation in global clinical trials is currently 4% despite accounting for 20% of global disease burden. The country must have more participation in global clinical trials for performing genomic profiling and identifying new therapies for the Asian population. India needs to be better represented in global clinical trials for oncology, given that there is a significant increase (80%) in the number of principal investigators available in the country.
  - Upgrade of clinical trials facilities, specially in government set-ups, is required through clinical trials excellence programs.
  - Clinical trials should be included in the curriculum of post graduate medical programs in the country so that student doctors and medical colleges have a platform to take up clinical trials.
  - Focus on clinical trials will help introduce low-cost therapies faster.
- Evaluate integration of AI for oncology treatment.
- Integrated technology and teams for cancer are required at grass root level.
- Make anonymized data available on a single website from different sources for research and development of new technologies.
- Focus on simplification of procurement guidelines, enhancing ease of doing business and streamlining of processes for proprietary medicines.
- Bring uniformity in all the efforts that are being practiced at a central level. Currently, all efforts are sporadic in nature.
- Provide subsidies to promote use of telemedicine, AI and other digital tools. This will act as counterbalance to constraints in availability of skilled human resources across the length and breadth of the country.

Adequate forum and process to be set-up to learn from progress in solving problems in cancer care by different stakeholders. This will lead to overall efficiency in improving cancer care in the quickest time frame possible. A lot of states have taken small steps and piloted initiatives and implemented some. It is important for all stakeholders to learn from the broader knowledge and develop initiatives which can be leveraged for design of a national cancer control policy to enable cancer prevention, cancer control and cancer care in the country.





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Established in 1927, FICCI is the largest and oldest apex business organisation in India. Its history is closely interwoven with India's struggle for independence, its industrialization, and its emergence as one of the most rapidly growing global economies.

A non-government, not-for-profit organisation, FICCI is the voice of India's business and industry. From influencing policy to encouraging debate, engaging with policy makers and civil society, FICCI articulates the views and concerns of industry. It serves its members from the Indian private and public corporate sectors and multinational companies, drawing its strength from diverse regional chambers of commerce and industry across states, reaching out to over 2,50,000 companies.

FICCI provides a platform for networking and consensus building within and across sectors and is the first port of call for Indian industry, policy makers and the international business community.