Cancer coverage is inadequate
Cancer coverage in health-insurance plans across Asia remains patchy. Despite progress in rolling out national health-insurance programmes, far too many people rely on bare-bones policies when it comes to cancer, and premiums lag behind rapidly rising costs of care. Action from insurers and policymakers needs to match their tough talk on prevention and early detection.

New sources of capital are needed
In the race to fund cancer care and control, new sources of capital must be found to supplement health insurance. Impact investing is one option, but it must offer investors commercial-grade returns to be a viable, large-scale solution. Partnerships between banks, insurers and governments can reduce the risk of new financial products so they can draw in big institutional investors.

There is a lack of trust between the private and public sectors
What role the private sector should take in funding care is a thorny issue; lack of trust between the public and private sectors reins in collaboration. Still, some policymakers and businesses in Asia are experimenting with different ways to work together, from patient-assistance programmes to risk-sharing agreements. Across Asia, a dearth of data is a key challenge to expanding such efforts.

As a global problem, cancer needs global solutions
Given the global scale of the threat, governments need to pool data, resources and expertise to speed improvements in cancer care. Nascent attempts to leverage money and expertise from around the world will be hard to scale up, but optimists believe the lessons they yield will be reproducible around the world.

Fighting cancer is a marathon, not a sprint
Throughout the day, Asia’s cancer-care specialists stressed the need to look beyond treatment towards funding the whole continuum of care, from prevention to palliation. Vested interests have focused attention and funding on aggressive treatment options, but governments need a balanced portfolio of interventions.
INTRODUCTION

Cancer places a heavy burden on Asian countries. The challenge to deliver care is growing, with the region already accounting for just under half of all new cancer cases worldwide. As incidence rises and treatment costs spiral, everyone can agree that the situation is urgent. What remains in question is who will pay for it all—and what they should buy. In the latest edition of The Economist Events’ War on Cancer series, held at Singapore’s One Farrer Hotel on March 30th, policymakers, cancer-care specialists and companies from around the region gathered to assess the options.

Participants at the one-day event acknowledged there has been progress in expanding cancer care and control across Asia, partly funded by innovative financing mechanisms such as sin taxes—levies on products deemed harmful to the public, such as tobacco. But that progress is going neither far nor fast enough to move the needle on the world’s second-leading cause of death. Governments across Asia are experimenting with different ways to pull together funding from myriad public, private and philanthropic sources, but the jury is still out on what works best. Faced with more questions than answers, participants’ mood was cautious: when polled, more than half the audience thought affordable, quality care for cancer patients in Asia was an unattainable goal.

“We’ve been used to meagre budgets, but the sin tax has increased our budget fivefold since 2012.”

Paulyn Rossell Ubial
Secretary of health
The Philippines
CANCER COVER IS INADEQUATE

“...In Taiwan, cancer accounts for 28% of deaths, but only 10–11% of national health-insurance expenditure.”

Sen-Tien Tsai
Vice minister of health and welfare
Taiwan

Participants agreed that the key determinant of cancer survival is access to health insurance—but cancer coverage in health-insurance plans remains patchy across Asia. In recent years, the region has seen the roll-out of national health plans, many of which have been funded through sin taxes. Despite such progress, insurance coverage and revenue from premiums remain meagre in comparison to hefty costs for cancer treatment and care.

In the Philippines, for example, the introduction of a sin tax has enabled a fivefold increase in the health budget since 2012. As a result, the government has been able to enrol around 90% of citizens in the national health-insurance programme. 85% of sin-tax proceeds go towards universal health coverage, said Paulyn Rossell-Ubial, the Philippines’ secretary of health. Yet cancer coverage in that programme is limited to breast, prostate and children’s cancers, leaving patients with other cancers exposed. In China, the government subsidises insurance premiums for 95% of the population, but cancer costs can outstrip a plan’s payout, leaving a chaotic system of cross-subsidies to fill the funding gap. “Only a few commercial insurance companies have cancer products,” said Xiaojie Sun, an associate professor at the school of health-care management at Shandong University.

The problem affects developed countries, too. In Taiwan, cancer accounts for 28% of deaths, but only 10–11% of national health-insurance expenditure, said Sen-Tien Tsai, Taiwan’s vice minister of health and welfare. He acknowledged that the country will face a budget shortfall if premiums (which are currently capped) do not rise quickly and other sources of revenue are not found.

Insurers and policymakers are therefore eager to “delay the claim”, said Zia Zaman, the chief innovation officer at MetLife Asia. Both sides “have an incentive to increase early detection and preventive screening.” Still, action lags behind tough talk, and the proportion of cancer patients first presenting themselves for treatment in the disease’s late stages remains stubbornly high across the region.
NEW SOURCES OF CAPITAL ARE NEEDED

In the race to fund cancer care and control, new sources of capital must be found to supplement health insurance. Impact investing, where investors expect both financial and social returns on their money, is touted as one way to ensure long-term and predictable revenue for cancer care. While it is an option, such investments need to offer investors commercial-level returns if they are to attract capital and provide a viable, large-scale solution. Speakers observed that to date, experiments with impact investing have been geared towards philanthropic clients, offering returns of only around 5%.

The cancer-care ecosystem needs to attract big institutional investors with the clout to scale up efforts across Asia. James Gifford, a senior impact-investing strategist at UBS, was quick to cite his bank as an example. He said UBS had invested $500m in companies doing research on early-stage oncology medicines with “expectations of a 20% return or more”, with the “majority of the roughly half a billion dollars coming from Asian clients”. But financial institutions currently prefer tried and tested conventional products, he added; they are unwilling to do the research on impact-investment products. Banks must do more to get those new products in front of investors.

Panellists agreed that there is an opportunity for policymakers to step in here. Public–private partnerships between banks, insurers and governments could “de-risk” impact-investment products and smooth the path for commercial investors.

“There is a valley of death in terms of funding between basic research and human clinical trials. Impact investments can fill this gap.”

James Gifford
Senior impact investing strategist
UBS
While many speakers agreed that the private sector is a key player in the delivery of cancer treatment, its role in funding that care is more contentious. A lively discussion revealed that a lack of trust hampers better collaboration between the two. “One of the big problems is government advisors only have public-sector knowledge—they have no concept of what goes on in the private sector,” said B.S. Ajaikumar, chairman and chief executive of HCG, an Indian firm. “They don’t realise we reinvest profits.” Governments are also too slow at reimbursing agreed subsidies, he added.

That said, some policymakers and businesses are experimenting with different collaboration models, including ways to improve availability of medicines for poorer patients. Isabel Torres, global head of access to medicines at Takeda Pharmaceuticals, spoke of the firm’s patient-assistance programmes: it has tie-ups with ministries of health in Singapore, Malaysia and Taiwan to part-fund cancer drugs for patients who could not otherwise afford a full course of treatment. Takeda also employs such programmes in African countries, alongside NGOs and charities. Participants noted that the benefit for the private sector only exists if such schemes are executed at scale.

“To have impact you need to move all the pieces together. If you increase affordability but don’t invest in diagnostics, you won’t have much impact.”

Isabel Torres
Global head of access to medicines
Takeda Pharmaceuticals
Other public–private partnerships are starting to take shape across Asia. Three Indian states have just announced deals to buy the HPV vaccine at a discount for regional vaccination campaigns to help prevent cervical cancer, noted Sangita Reddy, joint managing director of Apollo Hospitals. Some 25% of radiotherapy machines in Indonesia are privately owned, according to Soehartati Gondhowiardjo, the chair of Indonesia’s National Cancer Control Committee. The government will eventually own the equipment, as long as they carry out a certain number of interventions, she added.

Risk-sharing is another model that is gaining traction, observed Raman Singh, president at Mundipharma for the Asia-Pacific, Latin America, Middle East and Africa. Australia has implemented this model since 2003, allowing the government to recoup part of the cost of highly priced medicines—or get a discount—from pharmaceutical manufacturers if annual spending on those drugs exceeds a predefined cap. “We can replicate this approach in the emerging world,” he said. The challenge in Asia is the “dearth of data” needed to inform risk-sharing agreements. “We don’t have the luxury to wait for data,” Mr Singh added. “As companies start working towards [patient-centred care], the data set will get richer and wider.”
AS A GLOBAL PROBLEM, CANCER NEEDS GLOBAL SOLUTIONS

Given the global scale of the threat, governments need to pool data, resources and expertise to speed improvements in cancer care. “Cancer is as global as climate change,” said Gregory Simon, director of the Biden Cancer Initiative and former executive director of the White House Cancer Moonshot Task Force. The international community’s efforts on climate change are also instructive for cancer.

The first challenge is in pooling medical records. Discussion highlighted wide disparities in data collection across Asia, with participants lamenting a lack of registries in many lower- and middle-income countries. Nearly 100% of cancer cases are registered in Taiwan, but in the Philippines, a national database of cancer-patient records is only slated to be in place by 2018.

Two initiatives highlighted at the event show the potential of global collaboration. For financing, cancer would benefit from a global fund like GAVI (the Global Alliance for Vaccinations against Infectious Diseases), said Smita Aggarwal, a member of the national managing committee for the Indian Cancer Society. A global fund would help alleviate the growing “cancer divide” between wealthy and poorer countries. The Indian Cancer Society funds treatment for patients living on less than $5 a day; its $25m pot supports 1,000 patients a year. Though this is a “drop in the ocean” of India’s cancer burden, the initiative demonstrates the benefits of having one fund that can pool investments from bigger institutions and ensure equitable distribution of funds, Ms Aggarwal said.
Drawing on world-class cancer expertise also offers a benefit. C/Can 2025: City Cancer Challenge, launched by the Union for International Cancer Control (UICC) at the World Economic Forum at the start of the year, aims to support five cities in 2017 by sending technical teams to assess and advise on cancer care. These teams will move from constructing a plan through to financing and implementing its strategy. “Technical support now is piecemeal,” said Cary Adams, the chief executive of the UICC. “C/Can 2025: City Cancer Challenge is a one-stop shop that lifts expertise from around the world.”

C/Can 2025: City Cancer Challenge and GAVI share the same problem—scale. But Mr Adams remains optimistic that other initiatives can learn from them and replicate their strengths globally.

“Urbanisation is happening fast. By focusing on cities, we’ll be building cancer infrastructure where the world’s population will be.”

Cary Adams
Chief executive
Union for International Cancer Control
FIGHTING CANCER IS A MARATHON, NOT A SPRINT

Throughout the day, Asia’s cancer-care specialists stressed the need to look beyond treatment towards funding the whole continuum of care, from prevention to palliation.

Due to vested interests, cancer care has thus far focused on “the attack option, not prevention” said Ms Reddy of Apollo Hospitals. Little attention has been paid to successful strategies such as vaccination, in part because the benefits—a lower incidence of cancer—take time to materialise, noted Karen Canfell, director of Cancer Council NSW. The HPV vaccine has been a success in Australia and Malaysia, speakers said, while Taiwan has felled the rate of liver cancer from 10–17% to 1%. Both of these achievements have come largely through vaccination. The fall in secondary diseases due to increased vaccination rates, and better education about the benefits of vaccines, would help boost such programmes’ appeal. “The key is for lower- and middle-income countries to think of a balanced portfolio of cancer intervention tactics,” added Ms Canfell.

“In the race to allocate dollars to cancer, the case is being won by higher cost treatments like chemotherapy - by the attack option, not prevent.”

Sangita Reddy Joint managing director Apollo Hospitals Group
At the other end of the care timeline, speakers agreed that in medical circles, the stigma around palliative care must be tackled. Palliation controls the symptoms of cancer, yet end-of-life-care in Asia is neglected or often an afterthought; policymakers do not fund it, and physicians rarely refer patients to it. Palliative care needs to be thought about much earlier in the process, said Richard Lim, a consultant palliative-medicine physician for the Malaysian ministry of health. One way to do that would be to include palliation in medical training curriculums and invest in palliative care as a formal discipline: “Palliative care shouldn’t be an orphan field; we need to make it conform to best-quality practices,” he said.

As the event chair summed up the day, even the war analogies employed in discussions came under attack. “Is the military terminology for cancer right?” asked Vivek Muthu, chair of health care for The Economist Intelligence Unit. “We need to place more emphasis on quality of patient care, not just on eradicating the cancer cell.”