

Costing & financing cancer control

Guiding principles & approach

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Outline

Making cancer care available to all



How do we spend it? (*economic factors*)

- To promote equitable, resource use?
- To manage disease & programmatic priorities?

Set priorities




Where does the money come from? (*financial factors*)

- To ensure sufficient and sustainable financing?

Priority-setting policy dialogue

Status quo: Lack of prioritization

Domain	Example and Outcome	Process
Cancer control plan	70% NCCPs include breast cancer screening YET.... Feasible & cost-effective in <20%	Political but should be based on: Data → Dialogue → Decision-making
Benefit package (UHC)	<20% of packages include palliative care YET...40+% of packages in LIC cover screening	
Treatment standards	20% of nEMLs include bevacizumab but not asparaginase	

Why prioritization is needed

Failure to include cancer in policies and programmes

Key Findings

<30% Core cancer services included in LMIC national benefit packages;

9% National cancer control plans are costed

Outcomes

>60% Families suffer financial hardship including selling of assets

Cancer control **doesn't need** to be expensive

But... it does need to be **prioritized**

Basic package implementable for
\$US 5-10 per capita

Intervention Category

AFRO AMRO EMRO EURO SEARO WPRO



Priority-setting policy dialogue

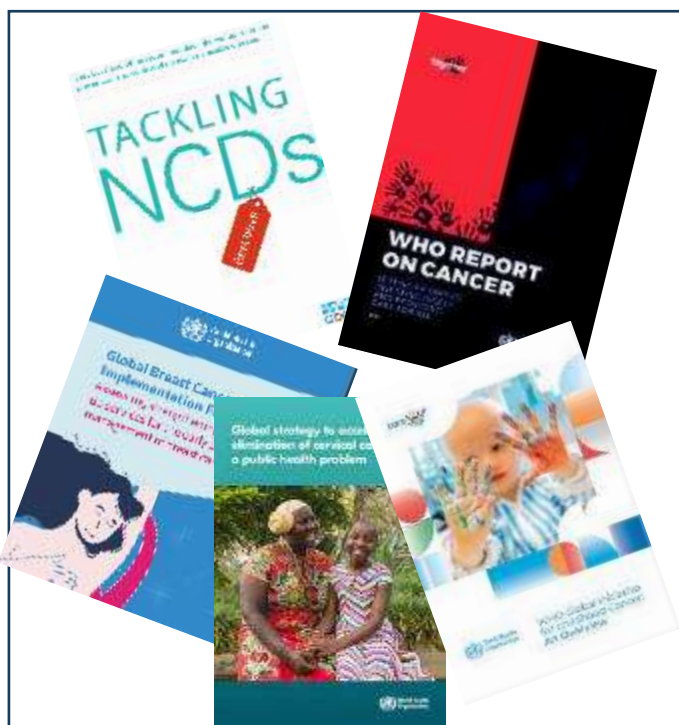
Status quo: Lack of prioritization

Domain

Example and Outcome

Process

Political but should be based on:
Data → Dialogue → Decision-making



(1) What interventions?

(2) What approach to increase coverage?

(3) What implementation strategy?



Best investment must reach scale & achieve value for money



WHA70.12
31 May 2017

**Cancer prevention and control in the context of
an integrated approach**

WHA70.12

Recalling also United Nations General Assembly Declaration of the High-level Meeting of the General Assembly on Non-communicable Diseases, which includes a road map for State and Government to address cancer and other noncommunicable diseases, and

Recalling further resolution WHA66.10 (2013) endorsing the prevention and control of noncommunicable diseases 2013-2020, and the commitment of Member States to realize the commitments they made in the Declaration of the General Assembly on the Prevention and Control of Non-communicable Diseases, including those related to addressing cancer;

Recalling in addition United Nations General Assembly Outcome document of the high-level meeting of the High-level Meeting of the General Assembly on Non-communicable Diseases, which sets out the progress to be made in the prevention and control of noncommunicable diseases, and the commitment of Member States to realize the commitments they made in the Declaration of the General Assembly on the Prevention and Control of Non-communicable Diseases, including those related to addressing cancer;

Recalling further resolution WHA66.10 (2013) and the Outcome document of the high-level meeting of the General Assembly and assessment of the progress achieved in the prevention and control of noncommunicable diseases 2013-2020, which sets out the continued and increased commitments that are essential for the High-level Meeting of the General Assembly on the prevention and control of noncommunicable diseases, including four time-bound national commitments of the existing monitoring tool that WHO is also implementing these four time-bound national commitments in EB130.13 (2015);

[illegible]

...the Sustainable Development Goals of the 2030 Agenda for Sustainable Development, in particular Goal 3 (Ensure healthy lives and promote well-being for all at all ages), premature mortality from non-communicable diseases and universal health coverage;

...the need for Member States' and international partners in regional and global strategies and plans of action on public health, innovation and digital health, and the need to address the digital divide in the development of digital health;

...the need to address the digital divide in the development of digital health;

[illegible]

OP1

- Develop **resource-stratified tool kits** to establish and implement comprehensive programmes... **leveraging work of other organizations**

OP2

- Collect, synthesize and disseminate evidence on the **most cost-effective interventions**...and to make an **investment case** for cancer

OP3

- Strengthen the capacity of the Secretariat to support implementation of cost-effective interventions and **country-adapted models...**

(1) Priority interventions define “best buys”

Priority setting: progressive realization

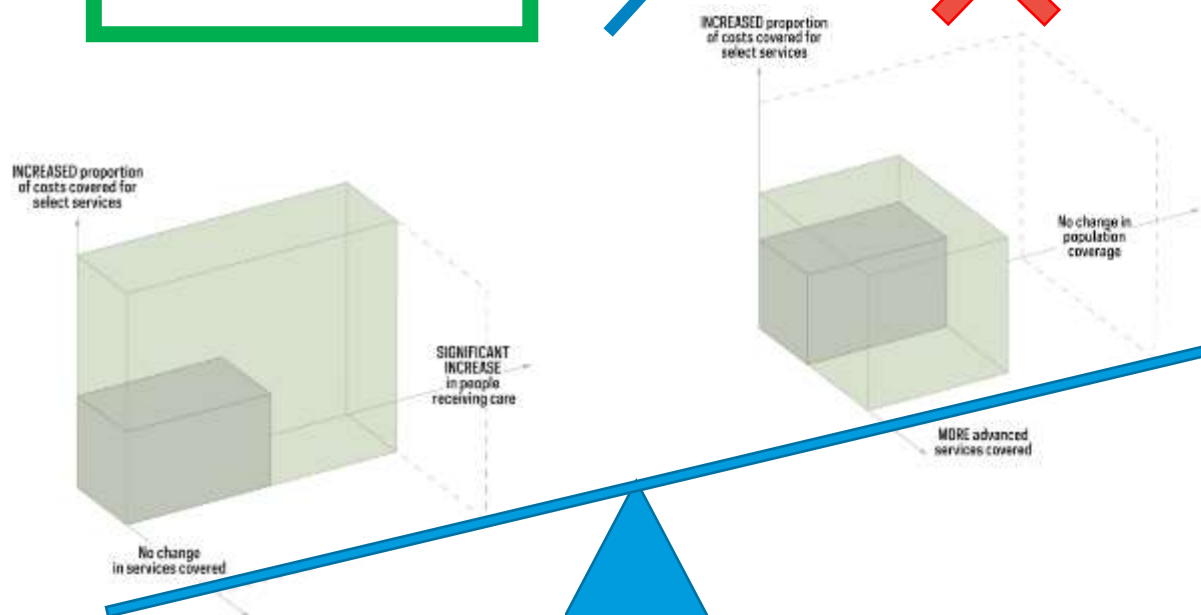
Best investment must reach scale & achieve value for money

↑funds

More people



More ~~goods~~



Two packages with
same price

Scenario A
Basic package for 75% population
Radiotherapy for high- impact, curative cancers
Select targeted therapy (eg, rituximab)
Cost: \$US 6.38 per capita
Lives saved: ~ 500 by 2040

Scenario B
High techn package for 40% population
Radiotherapy for all indications
10+ targeted therapy (including immunoRx)
Cost: \$US 6.38 per capita
Lives saved: ~ 200 by 2040

**(2) Focus on expanding coverage
before introducing new services**

Priority setting & system readiness

Coverage 1%
per yr:

Yes



~~Coverage 2%
per yr:~~



Additional salary (included in package):

\$US 7,000 per provider

Training (included in programme cost):

\$US 200,000 per year



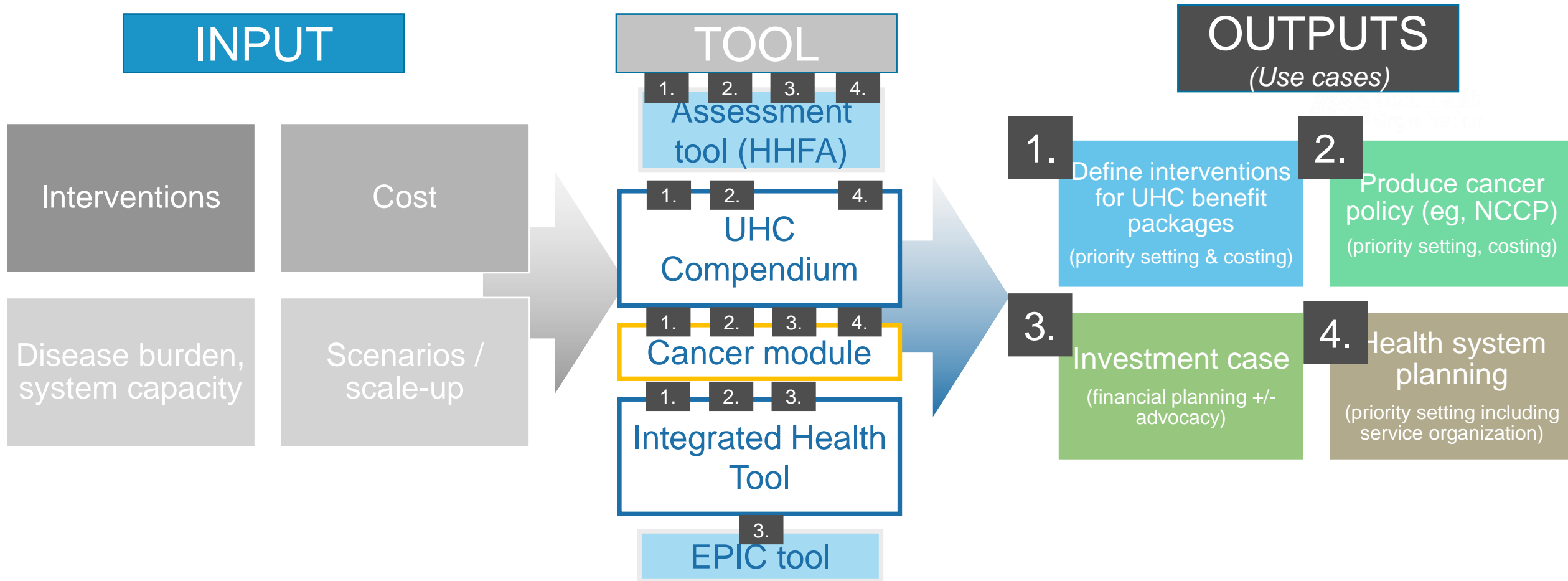
Not needed

Purchase ~~30~~ new
machines for breast
cancer screening
programme

***(3) Implementation approach must be
based on feasibility & system readiness***

Use cases

Matching tools to country-based stakeholder needs



Country Example

WHO, IARC, IAEA prioritization

1st Feasibility assessment, scenarios and priorities

Management Policies		
Cancer guidelines	yes	
Cancer guidelines incl drug-specific protocols	yes	
Cancer guidelines (utilized in >50% facilities)	yes	
Cancer guideline (last updated)	2019	
Cancer guidelines (include referral criteria)	yes	
Breast cancer early detection pgm/guidelines	yes	
Cervical cancer early detection pgm/guidelines	yes	
Colon cancer early detection pgm/guidelines	no	
Childhood cancer early detection pgm/guidelines	no	
Breast cancer defined referral		
Cervical cancer defined referral		
Colon cancer defined referral		
Childhood cancer defined referral	no	
Breast cancer screening pgm	yes	
Breast cancer screening pgm (type)	opportunistic	
Breast cancer screening pgm (method)	clinical breast exam	
Breast cancer screening pgm (coverage)	>50% and <70%	
Breast cancer screening pgm (target age start)		15
Breast cancer screening pgm (target age end)		60
Breast screening test performance (sens)		
Breast screening test performance (sens)		
Cervical cancer screening pgm	yes	
Cervical cancer screening pgm (type)	opportunistic	
Cervical cancer screening pgm (method)	visual inspection	
Cervical cancer screening pgm (coverage)	>50% and <70%	
Cervical cancer screening (STEPS)		
Cervical cancer screening pgm (target age start)		15
Cervical cancer screening pgm (target age end)		60

Goal: ↑coverage by 1% per yr, focusing on women + children

2nd Health system planning & capacity



EQUIPMENT

Pathology
Radiology
Cancer Diagnosis
Prostate Cancer
Diagnosis
Palliative care



CONSUMABLES

Records
Endoscopy
Radiology and Nuclear
Medicine Treatment
Palliative care.



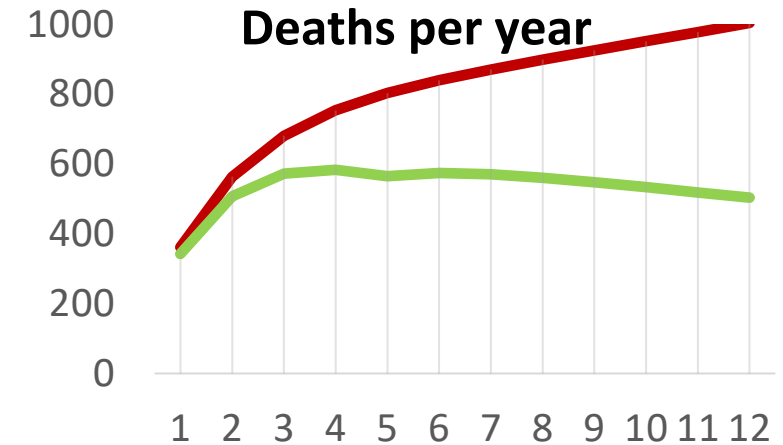
TRAINING

In service training
Quality control programs
Early Diagnosis Policies
Service Organization
Others

Capacity: workforce as bottleneck to reach goal

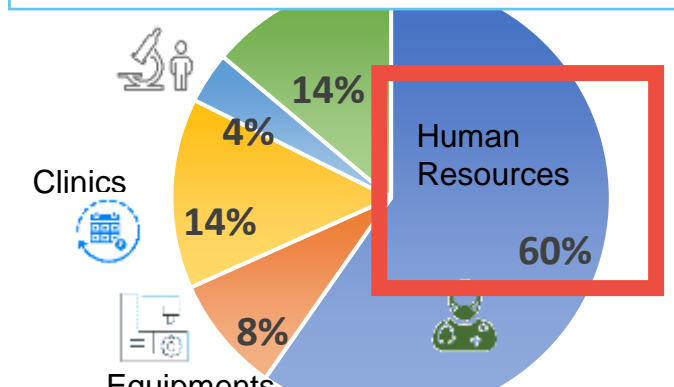


3rd Generate business model



— **Baseline (no further investment)**
— **Scale-up (1% ↑ coverage / year)**

Investment: ↑\$US 0.30 to save 100 lives per year (50% <60yo)

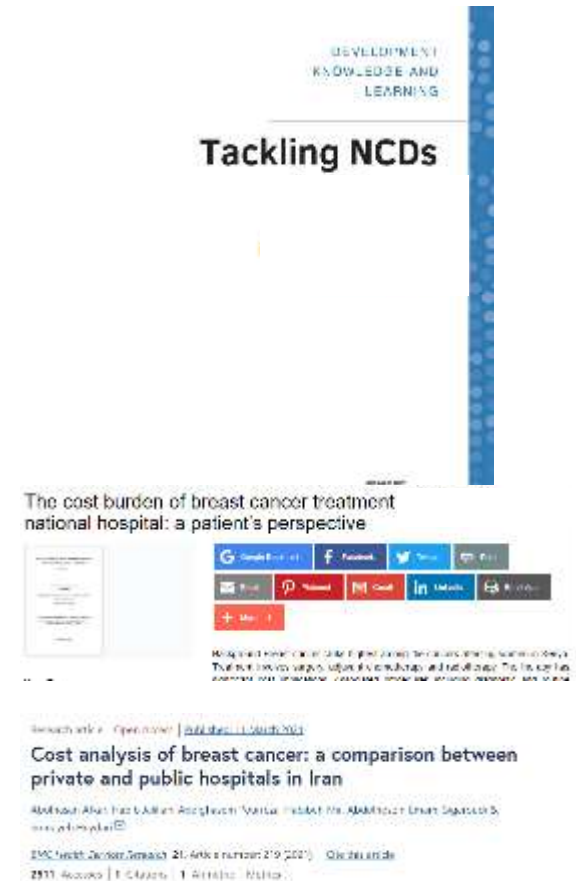


Effective cancer control planning in Country A

Review of costing & priority setting

Feb 2023





Key Assumptions & Scenarios

Inputs

- Estimated coverage for management of all cancers = 28%
(total number of cases per year estimated 42,000)
(number of cases treated per year - estimated 11,040)
- Disease burden and stage distribution
(obtained from national reports)

Cases per stage (number [row %])						
Cancer type	In Situ	Stage I	Stage II	Stage III	Stage IV	Total
Cervix uteri	1 (0.1)	139 (7.5)	709 (38.1)	774 (41.5)	240 (12.9)	1863
Breast	8 (0.9)	37 (4.2)	232 (26.3)	269 (30.5)	335 (38.0)	881
Colorectal	0 (0)	8 (2.6)	49 (16.0)	122 (39.7)	128 (41.7)	307
Esophagus	0 (0)	4 (1.7)	30 (12.4)	81 (33.5)	127 (52.5)	242
Stomach	2 (1.1)	6 (3.3)	28 (15.2)	43 (23.4)	105 (57.1)	184
Other sites	4 (0.2)	145 (8.1)	286 (16.1)	446 (25.1)	899 (50.5)	1780
Grand Total	15 (0.3)	339 (6.4)	1334 (25.4)	1735 (33.0)	1834 (34.9)	5257

Scenarios

- Anticipated scale-up of coverage = 3.5% per year (45% by 2028)
- Stage distribution shift *(obtained from literature)*:
Anticipated downstaging 2-3% per year
(range reflecting differences between cancer types)
- Anticipated improvements in diagnostic and treatment quality =
5-year survival (stage-specific) improved by 5-10%

Total costs

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total programme costs	997,452,083	1,181,368,285	1,342,971,780	1,491,805,500	1,614,133,551	6,627,731,200
Total clinical services	2,534,999,424	3,057,183,644	3,551,161,586	4,007,916,787	4,432,765,129	17,584,026,570
Screening programmes (cervix, colorectal-pilot, hepatitis B)	359,131,681	413,265,692	466,981,749	514,916,760	563,090,463	2,317,386,345
Adult cancers	1,882,802,595	2,323,355,843	2,744,917,931	3,136,491,566	3,494,937,730	13,582,505,665
Childhood cancers	293,065,148	320,562,109	339,261,906	356,508,461	374,736,937	1,684,134,560
Total capital costs	1,242,493,520	1,124,668,960	1,228,104,400	1,410,734,840	2,419,814,030	7,425,815,750
Total costs per year	7,309,944,450	8,420,404,534	9,673,399,352	10,918,373,914	12,899,477,840	49,221,600,090

Key findings

- (1) Programme costs 13% of total; **capital costs 15%**
- (2) Childhood cancer 10% of clinical service costs
- (3) Total costs nearly double over 5 yrs given scale-up rate

Total programme costs

Sub-activity (programme costs)	Activity	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total programme costs		997,500,000	1,181,400,000	1,343,000,000	1,491,800,000	1,614,100,000	6,627,800,000
NCCP activities	N/a	369,075,000	437,118,000	496,910,000	551,966,000	597,217,000	2,452,286,000
Training		69,825,000	82,698,000	94,010,000	104,426,000	112,987,000	463,946,000
Monitoring & evaluation		34,912,500	41,349,000	47,005,000	52,213,000	56,493,500	231,973,000
General programme management		105,598,000	124,294,000	140,760,000	155,946,000	168,482,000	695,080,000
Other (shared infrastructure costs)		418,089,500	495,941,000	564,315,000	627,249,000	678,920,500	2,784,515,000
HR Programme costs included in NCCP							
	4.3.1.1	3,400,000	3,400,000	3,400,000	3,400,000	3,400,000	17,000,000
NCCP staff	4.3.1.2	2,448,000	2,754,000	3,060,000	3,366,000	3,672,000	15,300,000

Key findings

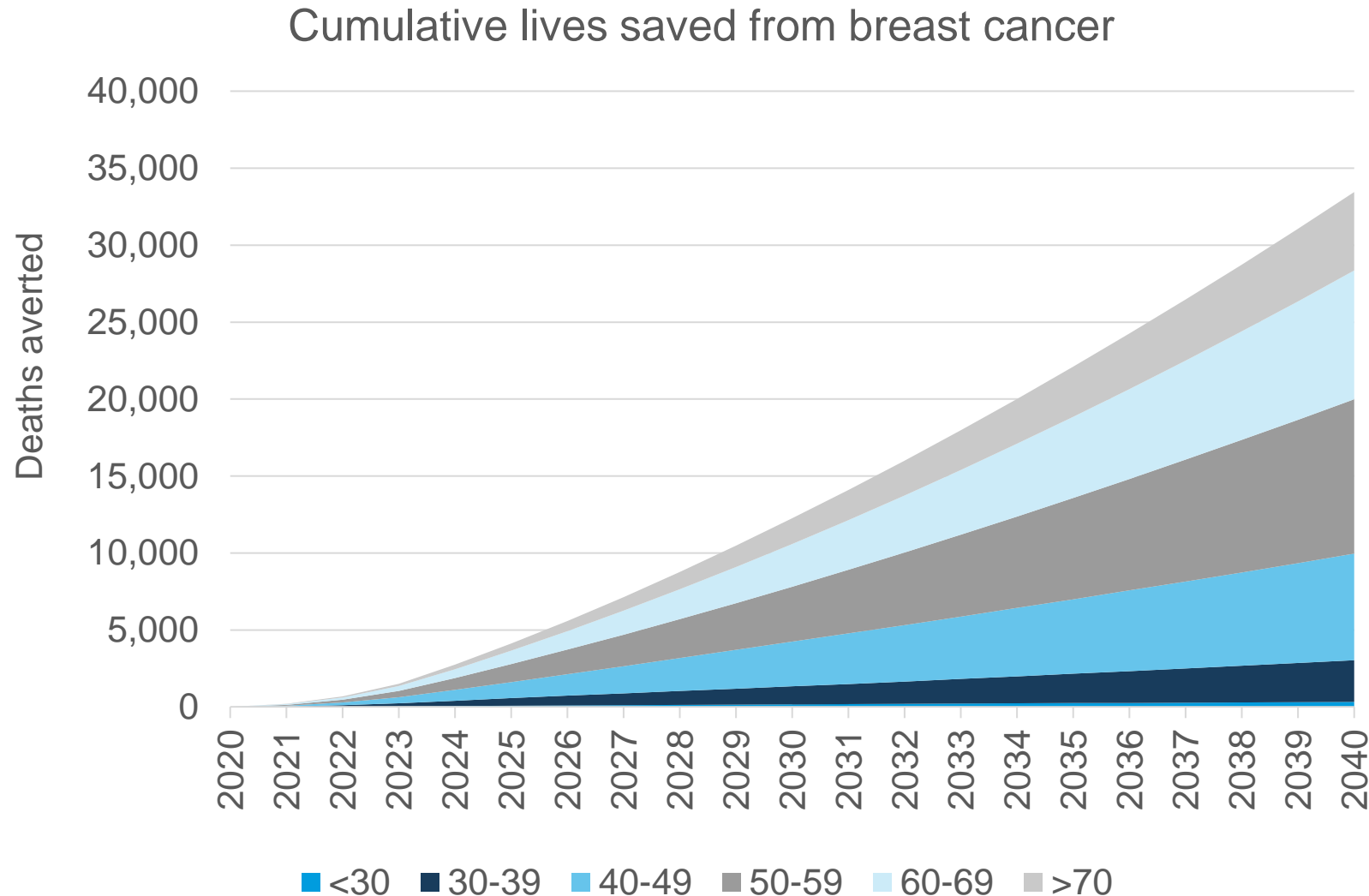
- (1) NCCP is 37% of programme costs (5% of total costs)
- (2) M&E 8% of programme costs
- (3) NCCP/NCI staff costs 1% of programme costs

Capital costs by group

CAPITAL COST PER NATIONAL CENTRE - National Centres (2)						
Sub-activity (specific clinical services)	Activity	Year 1	Year 2	Year 3	Year 4	Year 5
Ultrasound at level 4	2.1.2.1	420,000	420,000	420,000	420,000	
Acquire PT-CET in 2 national hospitals	2.1.2.3	145,000,000		145,000,000		
Acquire nuclear medicine + PET in 5 regional centres	2.1.2.3				165,000,000	
Development cloud-based radiology information system	2.1.2.3		20,000,000			
Establish immunohistochemical, flow cytometry, liquid biopsy	2.2.1.2	86,000,000				
Acquire cryostat equipment	2.2.2.4		2,400,000			
Aphersis equipment	2.2.2.6	12,000,000	12,000,000			
Establish and equip hostel facilities	3.1.2.2		80,000,000		80,000,000	

CAPITAL COST PER REGIONAL CENTRE - Regional Centres (5)						
Sub-activity (specific clinical services)	Activity	Year 1	Year 2	Year 3	Year 4	Year 5
Ultrasound at level 4	2.1.2.1	516,000	516,000	516,000	516,000	-
Establish interventional radiology services	2.1.2.2	84,900,000	57,400,000	84,900,000	57,400,000	84,900,000
Acquire PT-CET in 2 national hospitals	2.1.2.3	-	-	-	-	-
Acquire nuclear medicine + PET in 5 regional centres	2.1.2.3	33,000,000	33,000,000	33,000,000	-	33,000,000
Development cloud-based radiology information system	2.1.2.3	-	24,000,000	-	-	-
Establish immunohistochemical, flow cytometry, liquid biopsy	2.2.1.2	17,200,000	-	-	-	-
Establish pathology laboratory infrastructure	2.2.2.1	-	17,148,000	17,148,000	11,432,000	11,432,000
Mobile testing for telepathology	2.2.2.3	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000
Acquire cryostat equipment	2.2.2.4	-	480,000	-	-	-
Aphersis equipment	2.2.2.6	2,400,000	4,800,000	4,800,000	7,200,000	7,200,000

Anticipated impact (example of breast cancer)



Key findings (breast cancer)

- 31% of lives saved are women <50 years old
- Financial hardship avoided for >50% of families; 2.1 maternal orphans avoided per life saved
- Survival will increase to approx. 60%; bend curve of mortality rate

Example of investment case

Scenario: Coverage scale-up 29% per year All equipment, consumables and training included		Total cost over 5 years (2022- 2026)	Additional costs per year in 2026	Total cost per capita in 2026	2022
Intervention	Cancer				
Clinical management of cancer	Breast cancer	65,666,792	7,109,539.74	0.52	10,597,808
	Cervical cancer	59,060,941	5,925,143.07	0.47	9,442,131
	Kaposi's sarcoma	30,889,885	605,684.01	0.21	5,935,751
	Colorectal cancer	12,620,662	1,466,438.95	0.09	1,407,668
	Prostate cancer	26,367,966	2,361,487.31	0.21	4,294,929
	Gastric cancer	6,500,787	38,498.70	0.04	1,272,197
	Acute lymphoblastic leukemia	3,389,291	191,846.65	0.02	601,248
	Hodgkin's lymphoma	103,526	4,929.83	0.00	18,736
	Burkitt's lymphoma	701,410	51,956.31	0.01	119,560
	Retinoblastoma	881,163	146,860.47	0.01	118,410
	Wilms Tumour	1,201,174	277,193.98	0.01	132,828
	Low grade glioma	82,769	1,622.92	0.00	15,905
	Total (all cancers)				
Public health interventions	Cervical cancer screening	9,966,346	786,819.61	0.08	1678541.325
	Early diagnosis	1,210,000	242000	0.01	
	Breast cancer screening (pilot) (equipment and training only)	-	4,284,000.00	0.14	
Programme costs	Training	-	-	-	535,372.88
	Monitoring and Evaluation	-	-	-	1,018,288.40
	General Programme Management	-	-	-	320,489.47
Other		-	-	-	8,222,989.06
Total		54,369,214	1,941,757.66	0.38	10,097,139.81
Extra-budgetary	Patient housing		400,000.00		
TOTAL		273,011,926.32	25,835,779.22	2.20	45,732,851



Making cancer care available

Health financing system



How do we spend it? (*economic factors*)

- To promote equitable, resource use?
- To manage disease & programmatic priorities?



Where does the money come from? (*financial factors*)

- To ensure sufficient and sustainable financing?

...it depends...

National Health Accounts & financing function

Where does the money come from? And, where does it go?

How is money raised / organized?

Core Financing Functions

1

Raising
revenue

- Sustainable, predictable, progressive (ie, tax vs. insurance)
- Equitable and efficient revenue-raising

2

Pooling
risk

- Critical for financial risk protection
- Income and risk cross-subsidisation

3

Purchasing
services

- What services, from whom and at what price?
- Allocative and technical efficiency

How is money spent?

National Health Accounts

I. Ministry of Health budget (direct)

- (a) NCD or cancer programme
- (b) Research activities and/or special initiatives

II. Hospitals services

(unable to disaggregate by service type)

III. Medicines & technologies

(monitor expenditure by product type)

IV. Capital investments

(purchasing new equipment)

National Health Accounts & financing function

Where does the money come from? And, where does it go?

How

1

Portfolio Resources

Table 1.2: Department of Health 2017-18 Budget Measures (continued)

	Program	2016-17 \$'000	2017-18 \$'000	2018-19 \$'000	2019-20 \$'000	2020-21 \$'000
Healthy Heart Initiative - targeted activities						
Department of Health						
Administered expenses	2.4	-	7,670	4,634	1,271	1,445
Total expenses		-	7,670	4,634	1,271	1,445
National Cancer Screening Register - transition arrangements						
Department of Health						
Administered expenses	2.4	478	34,162	-	-	-
Department of Veterans' Affairs	4.1	2,207	(5,812)	157	(73)	9,654
Administered expenses		18	(49)	-	-	74
Total expenses		2,703	28,301	157	(73)	9,728
Australian Institute of Health and Welfare (AIHW)		28,076	-	-	33,030	61,108

The Government will invest \$10.8 million to fight childhood cancer through research and clinical trials. This includes providing Cancer Australia \$4.4 million aimed at increasing Australia's research capacity to advance diagnosis, treatment, management, analysis, and improve data and awareness of childhood cancer, as well as \$1.4 million to fast track international research collaborations of paediatric brain cancer in Australia. In addition, the Government will provide \$5 million under the Medical Research Future Fund to CanTeen to improve outcomes for children and young people fighting against cancer.

Independent Hospital Pricing

It is estimated that in 2017, breast cancer will become the most commonly diagnosed cancer. Funding of \$64.3 million will continue existing arrangements for women aged 70 to 74 years to participate in the BreastScreen Australia Program,

National Mental Health Commission	2,736	-	-	-	2,736
Professional Services Review	5,691	-	-	-	5,691

How is money spent? *National Health Accounts*

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National Health Accounts & financing function

Where does the money come from? And, where does it go?

Table 1.2: Department of Health 2017-18 Budget Measures (continued)

Program	2017-17 2017	2017-18 2017	2018-19 2018	2019-20 2019	2020-21 2020
Healthy Heart Initiative - targeted activities					
Cardiovascular disease					
Cardiovascular services					
Total program					

The Australian Government supports improvements to the health system through strategic investments in health infrastructure, which enable general practices to deliver increased health services and increased opportunities to provide teaching and training for health practitioners.

In the 2017-18 Budget, funding of \$68 million will be provided to the South Australian Government to purchase accelerator equipment and treatment rooms to support the establishment of Australia's first Proton Beam Therapy facility for advanced research and treatment of **cancer**.

Brain cancer in Australia: In addition, the Government will provide \$5 million under the Medical Research Future Fund to Cancer to improve outcomes for childhood brain cancer and adult glioma.

It is estimated that in 2017, breast cancer will become the most commonly diagnosed cancer. Funding of \$64.3 million will continue existing arrangements for women aged 70 to 74 years to participate in the BreastScreen Australia Program.

How is money spent? *National Health Accounts*

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(unable to disaggregate by service type)

III. Medicines & technologies

(monitor expenditure by product type)

IV. Capital investments

(purchasing new equipment)

National Health Accounts & financing function

Where does the money come from? And, where does it go?

Supporting our hospitals

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Administered expenses	2.4	478	34,162	-	-
	4.1	2,207	15,812	157	173
					9,654

Supporting our hospitals

The Government will deliver an additional \$2.8 billion to public hospitals in this Budget. Since the signing of the Council of Australian Governments (COAG)

The Government will spend \$1.2 billion on new and amended listings for the PBS.

well as \$1.4 million to fast track international research collaborations of paediatric brain cancer in Australia. In addition, the Government will provide \$5 million under the Medical Research Future Fund to CanTeen to improve outcomes for children and young people fighting against cancer.

Supporting our hospitals

How is money spent? *National Health Accounts*

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(monitor expenditure by product type)

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National Breast Health Commission	2,730			2,730
Medicare Services Commission	5,000			5,000

National Health Accounts & financing function

Where does the money come from? And, where does it go?

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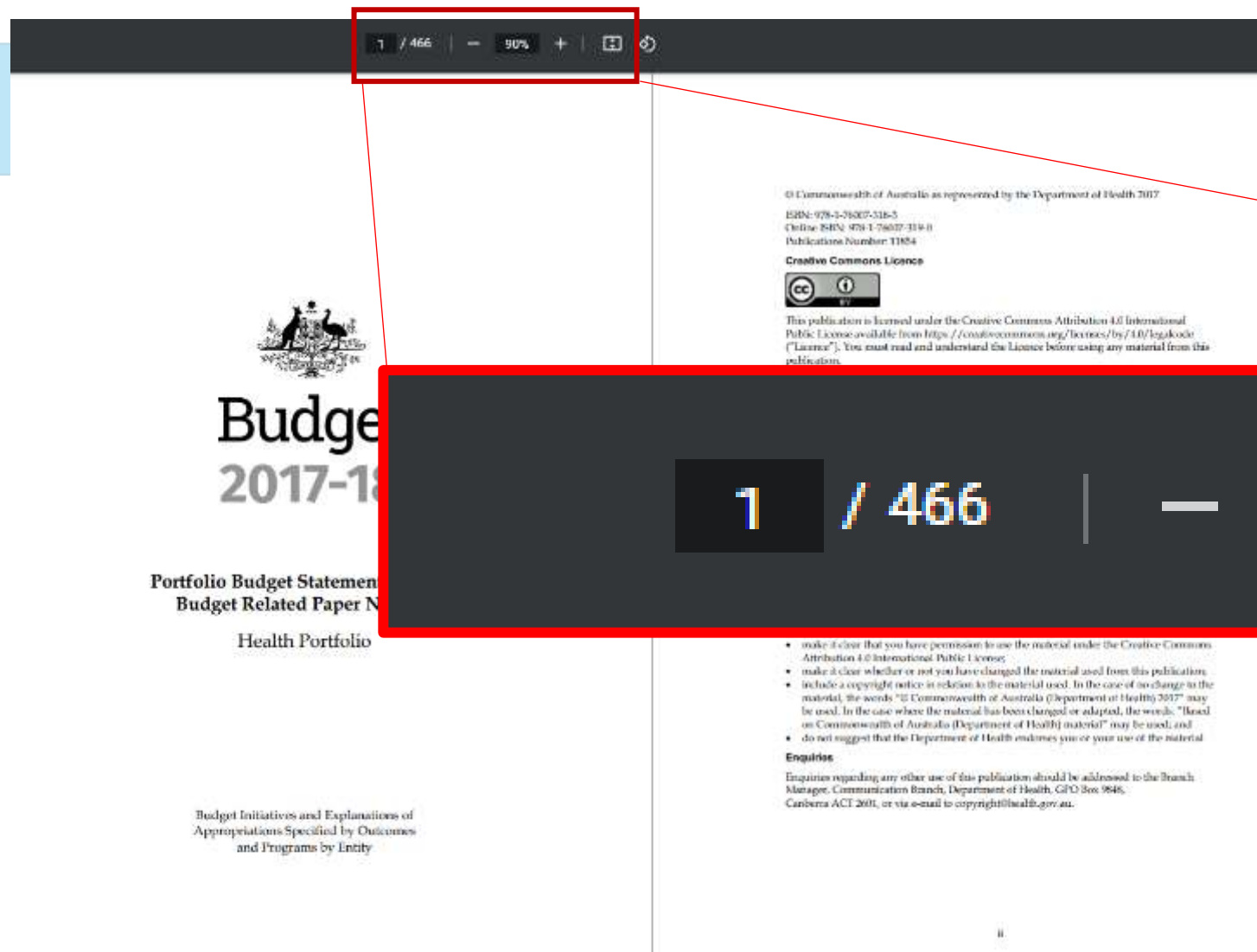
(monitor expenditure by product type)

IV. Capital investments

(purchasing new equipment)

National Health Accounts & financing function

Where does the money come from? And, where does it go?



How is money spent?
National Health Accounts

Ministry of Health budget (direct)
NCD or cancer programme
Research activities and/or special initiatives

Monitor expenditure by product type)

Capital investments
(purchasing new equipment)

Sources of funding

Who is providing the financing?

Revenue raising

Domestic

(1) Prefinancing:

(a) **Mandatory** (general govern't expenditure)

(b) **Voluntary** (eg, private insurer, community-based)

(2) Out-of-pocket payment

External

(1) Loans for national/international banks

(2) Grants from donors, development assistance

(3) In-kind support (minor)

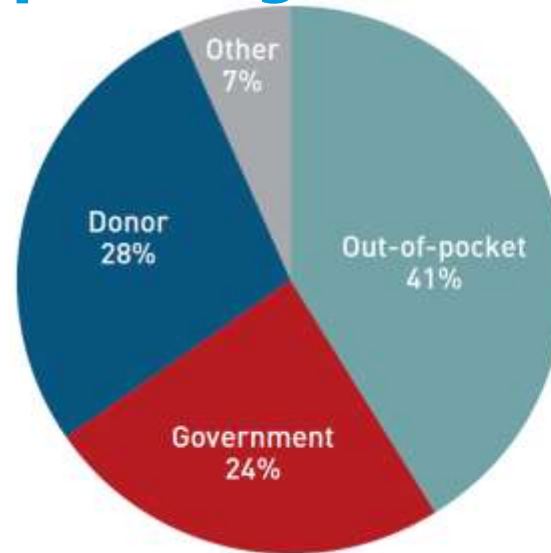
Innovative

e.g. Innovative financing instruments

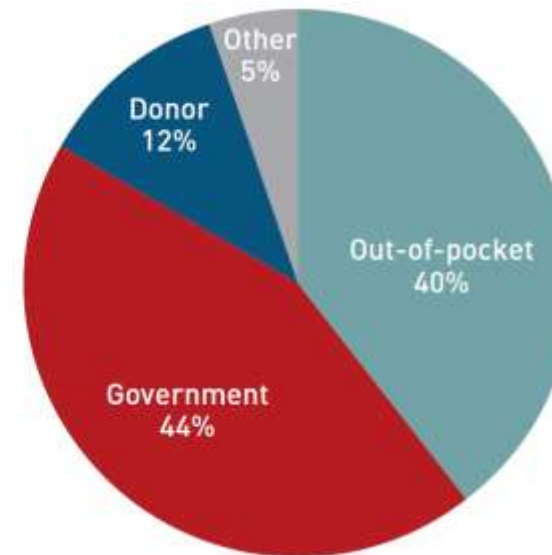
Share of health spending

Burden of OOP

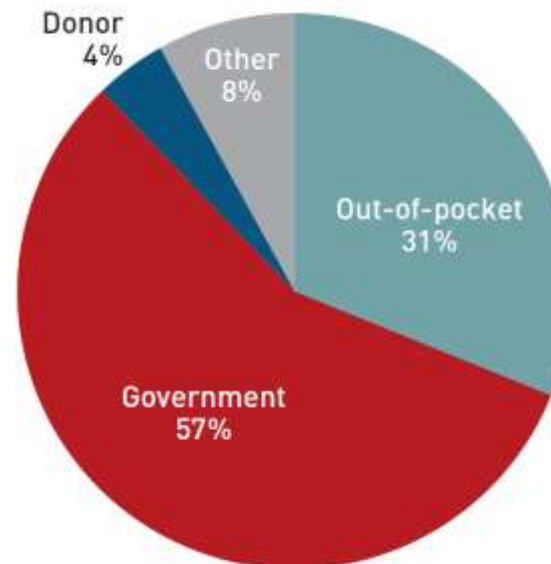
Low income



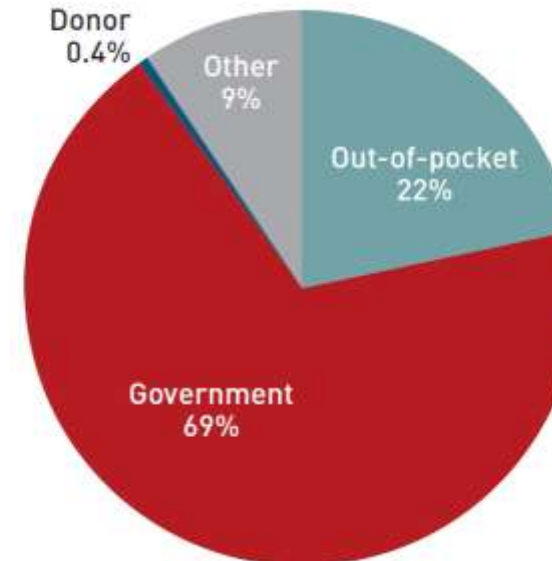
Lower middle
income



Upper middle
income

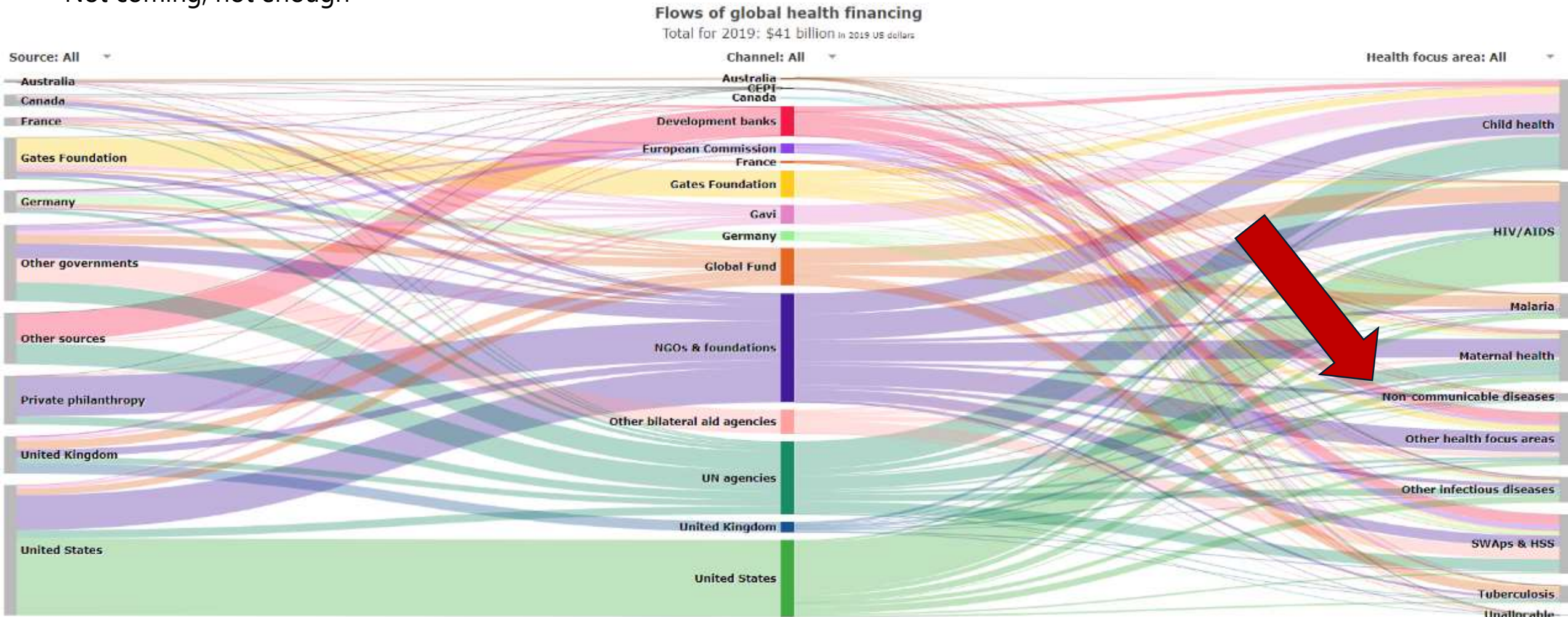


High income



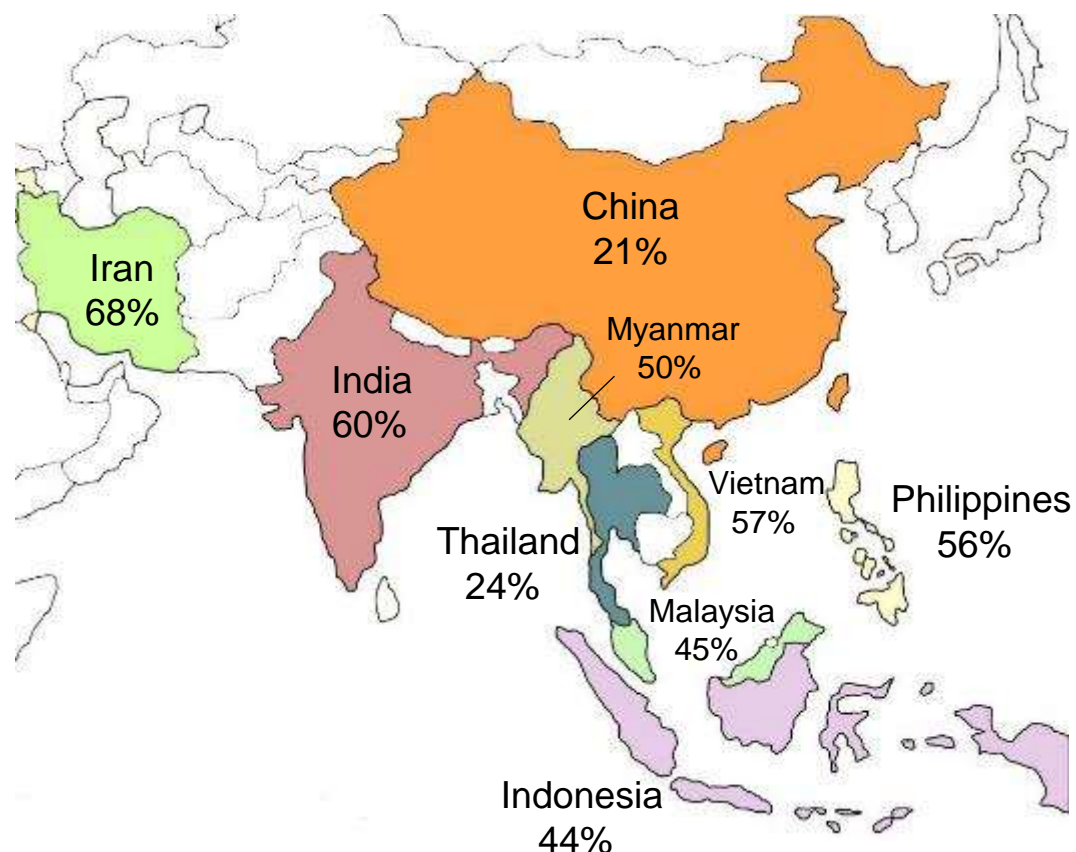
Development assistance (grants)

Not coming, not enough



In 2019, \$730 million DAH for NCDs

Financial burden of cancer to households



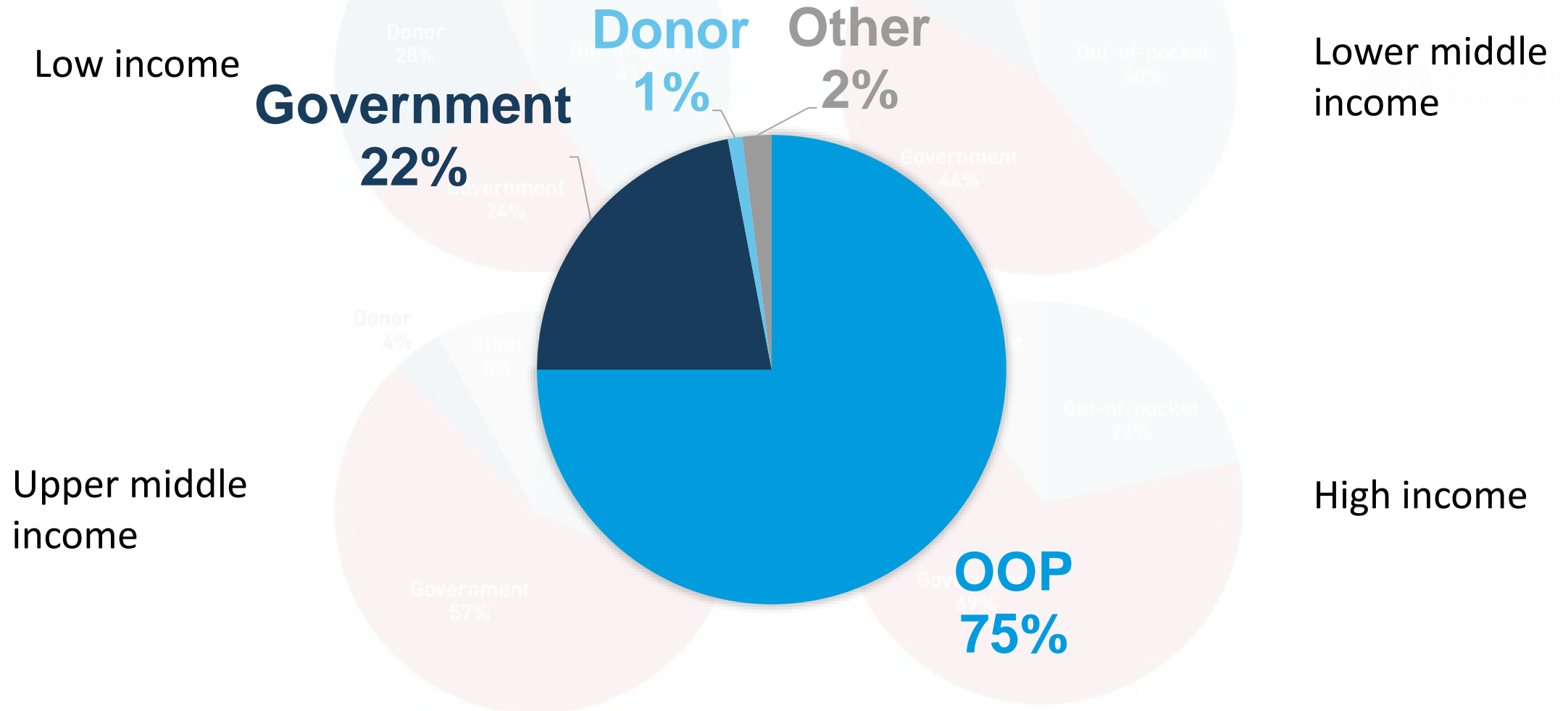
Financial catastrophe due to the costs of cancer treatment

- In many countries, families bear cost of cancer care
- Large out-of-pocket spending puts a heavy burden on families, especially poor
- **50-90% risk** of impoverishment due to catastrophic health spending → generational impoverishment.
- **30-80% risk** of abandonment

Share of health spending

Burden of OOP

SAMPLE EXPENDITURE (CANCER)



Social and economic impact of cancer

Cancer negatively affects economies & imposes heavy economic burden

Economy impact: premature mortality, absence from work and lost productivity.

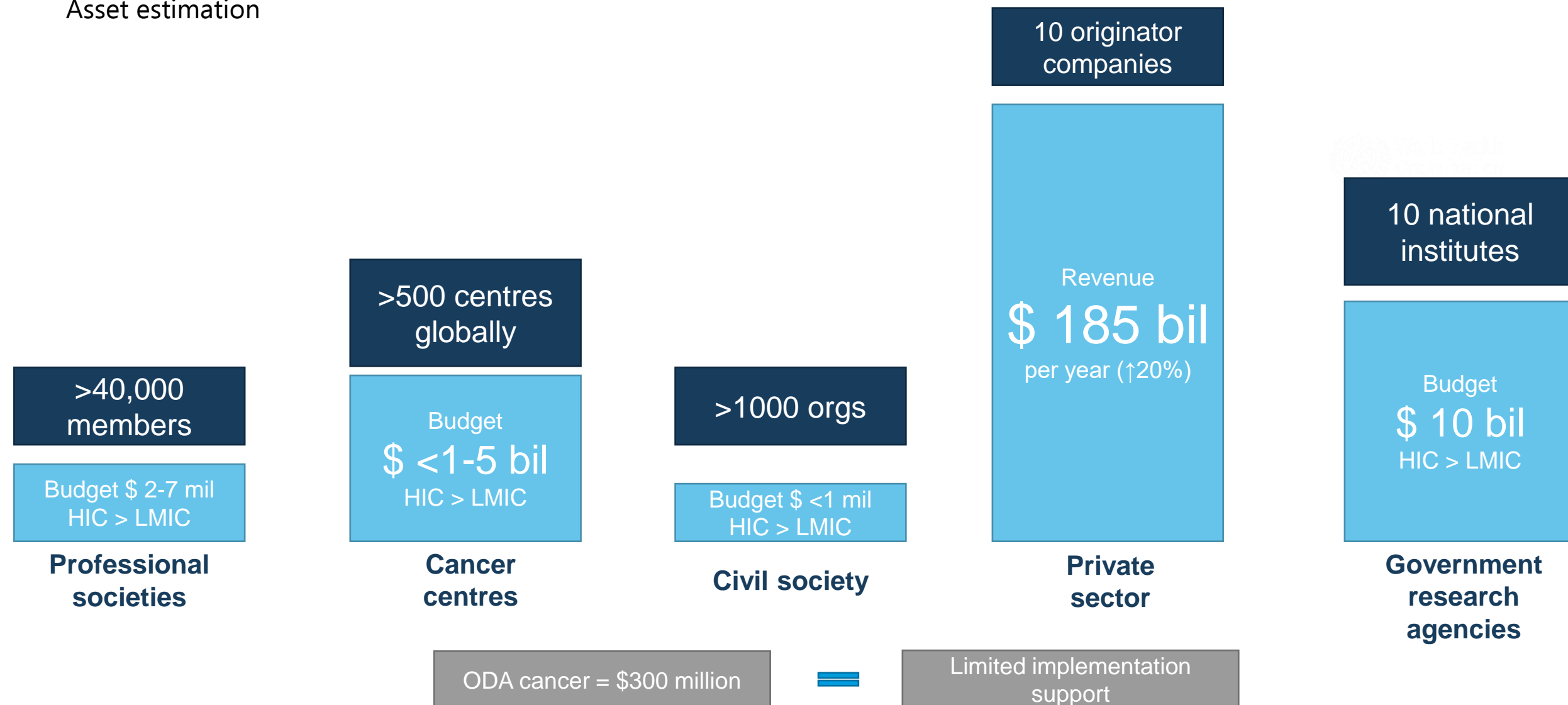
Social impact: psychological and subjective financial distress; >70% experience emotional distress (impact on marriage, child-raising)

But, limited evidence on the macro –and microeconomic impact of cancer. WHO activities:

- Several systematic reviews on economic burden of cancer ongoing
- Update estimates on global economic cost of cancer and investment case (2020 ROI is US\$ 2.30)
- Update EPIC tool to estimate the burden of ill-health (e.g. loss of employment to caregivers)

Who will prioritize implementation science?

Asset estimation



Making cancer care available

Health financing system



How do we spend it? (*economic factors*)

- To promote equitable, resource use?

So, where do we go
from here?



Where does the money come from? (*financial factors*)

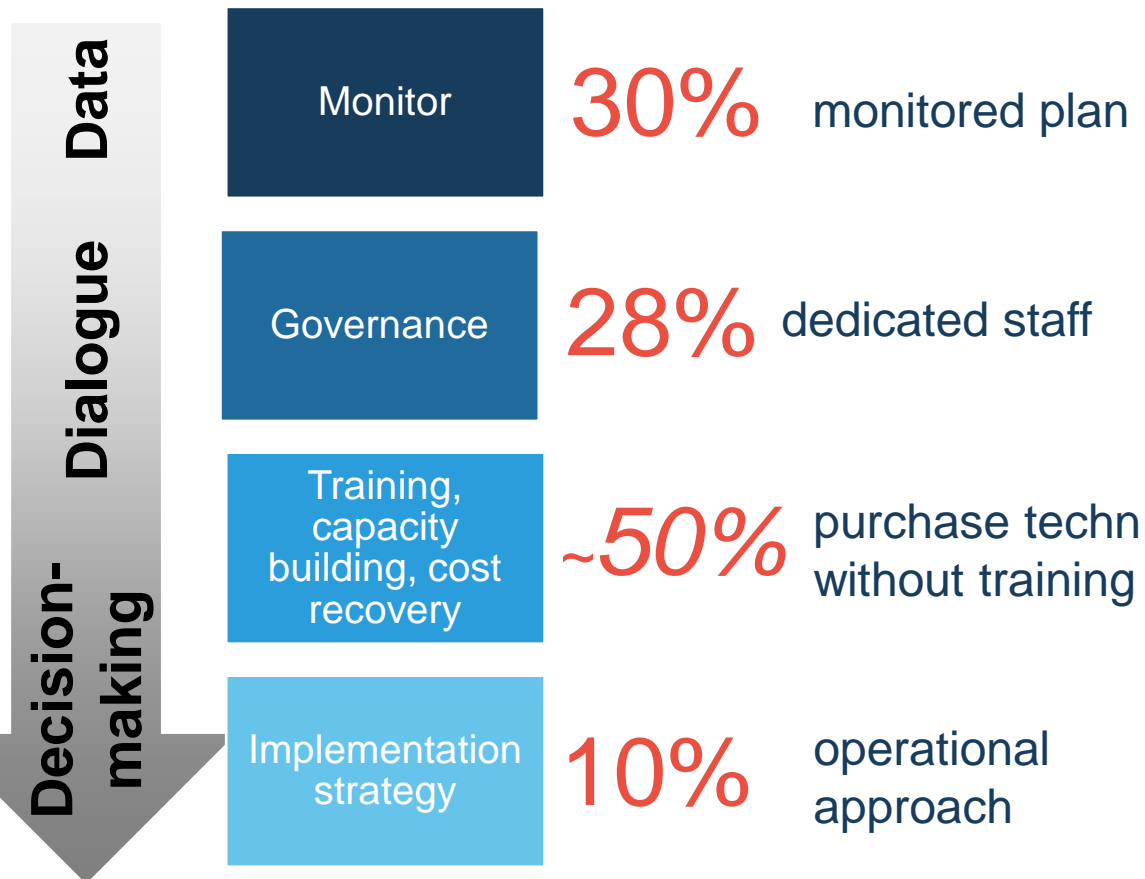
- To ensure sufficient and sustainable financing?

Guiding principles: *governance, capacity building & accountability*



Strategies for impact

Foundations for success



Threats to impact

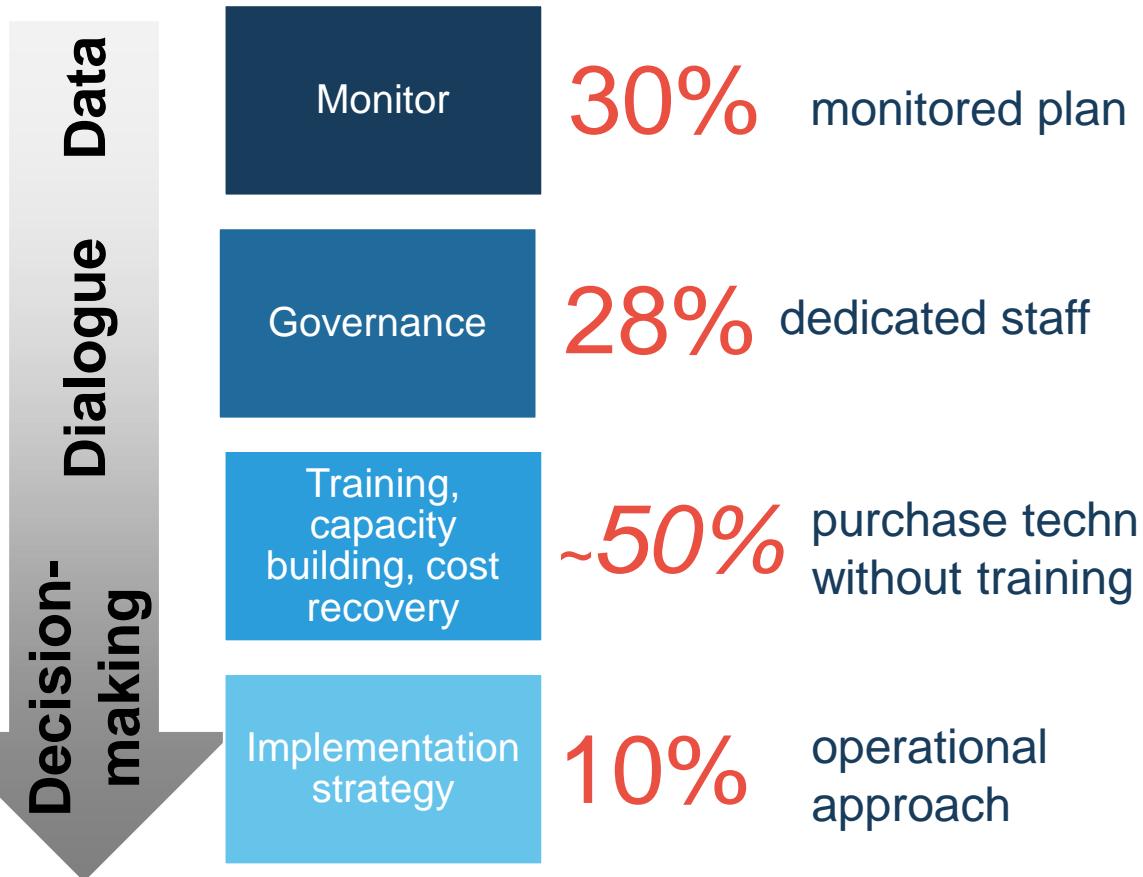
	Before plan implementation*	After plan implementation†	p value‡
Absolute change in prevalence of smoking in men, 2000–15§ 24			
All countries (n=59)	-2.1% (4.2)	-1.4% (4.0)	0.17
Tobacco strategy specified (n=53)	-2.0% (4.4)	-1.2% (4.2)	0.07
Tobacco strategy not specified (n=6)	-3.8% (1.4)	-3.3% (1.2)	0.10
Availability of breast cancer screening programme, 2010–15§			
All countries (n=48)	42 (88%)	36 (75%)	0.10
Breast cancer screening strategy specified (n=43)	38 (88%)	34 (79%)	0.70
Breast cancer screening strategy not specified (n=5)	4 (80%)	2 (40%)	0.07
New radiotherapy units acquired per year, 1965–2018§			
All countries (n=60)	1.9 (2.9)	3.7 (4.8)	0.01
Radiotherapy mentioned (n=33)	2.4 (3.7)	4.9 (5.9)	0.01
Radiotherapy not mentioned (n=27)	1.8 (2.2)	3.9 (4.1)	0.05
Annual change in per person opioid consumption, 1985–2015§			
All countries (n=61)	2.0 (3.1)	4.0 (7.8)	0.05
Strategy for pain management specified (n=38)	1.5 (2.5)	3.1 (5.5)	0.05
Strategy for pain management not specified (n=23)	2.1 (4.1)	4.3 (12.3)	0.20

Guiding principles: *governance, capacity building & accountability*



Strategies for impact

Foundations for success



Threats to impact

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Effective cancer strategy requires

- ✓ Resources to operationalize
- ✓ MoH focal point
- ✓ Infrastructure investment & dedicated workforce

Financing Opportunities

Development bank interest

IsDB البنك الإسلامي للتنمية
Islamic Development Bank

Search  

ENGLISH 

NEWS

IsDB launches call for innovation to save women's lives from cancer

The Islamic Development Bank (IsDB) and the International Atomic Energy Agency (IAEA) have partnered to launch an urgent call for innovation to find and reward solutions for strengthening national health systems in the area of breast and cervical cancer prevention.

5 February 2020

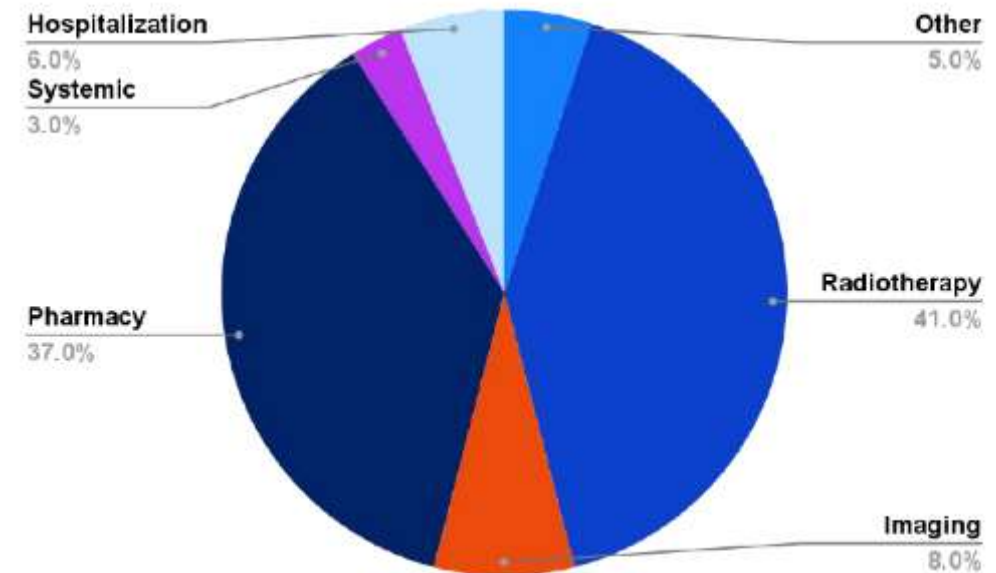


THE VALUE OF INNOVATION IN ONCOLOGY

Revenue Distribution by Service



Additional revenue from R&D and education activities can be generated

Conclusions

Where to go from here

✓ **Costing is essential.**

Approach should focus on **process**, not outcome: **ownership is important**

- Priority-setting, stakeholder-led “**dialogues**” foundational to success, founded on “**data**”
- “Decision”: **align timing** with broader policy discussions (eg, national health plans)

✓ Priority setting **can be** done by cancer type and intervention type

✓ WHO – working with IARC, IAEA, ICCP and others – have tools to support

- **Data-driven** decisions are best, based on **health systems investments**

✓ Financing cancer control: requires **multi-dimensional dialogues**

Based on need and financing streams (eg, governmental agencies, development banks)

Must focus on **domestic financing** for services (external support for equipment)

Investment cases must show the **full social and economic impact of cancer**

Thank you

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