Access to Cancer Medicines: The Question Beyond Headline Prices

Why in the News

The National Pharmaceutical Pricing Authority (NPPA) issued revised maximum retail prices (MRP) of **543 brands** on **28 October 2026**, which will take effect from **9 November 2026**. This step implements the central government's decision of **8 October 2026**, which approved capping the trade margin (the profit spread added in the distribution chain) on non-scheduled cancer medicines at **30%** of MRP; on **17 October 2026** the Ministry of Chemicals and Fertilizers announced the **137 medicines** coming under this scope. The government estimates that prices will fall by up to **70%** and patients will save **crores of rupees a year**. But an analysis of the list shows that the prices of many expensive medicines are unchanged, so the real question lies beyond the headline prices - will a margin cap really increase access to cancer treatment?

Trade Margin Rationalisation: Understand the Arrangement

Trade margin is the difference between the price at which a medicine is sold to the stockist (the first point of sale) and its MRP, that is, the share of the distribution chain (distributor, chemist, hospital pharmacy). **Trade margin rationalisation (TMR)** means capping the percentage of the margin instead of fixing the price of every medicine, dose and brand separately. The formula of calculation is the same as in the 2019 notification: retail price = price to stockist x {1 + (margin / (100 - margin))}.

In the world of drug price control there are two categories. **Scheduled medicines** are in the National List of Essential Medicines and the NPPA directly fixes their ceiling price. **Non-scheduled medicines** are not under direct control; the one binding is that MRP cannot be raised by more than 10% a year. The NPPA's market analysis found that the average markup on non-scheduled cancer medicines is about **170%** and in some cases **700%** or more. This difference puts the cost of treatment directly on the patient's pocket.

This step has been taken under **paragraph 19 of the Drugs (Prices Control) Order, 2013 (DPCO)**, which gives the power of price control in the public interest in extraordinary circumstances. It includes branded and generic, domestic and imported, and patented and unpatented medicines alike. Producers will have to maintain current production levels so that supply does not break.

From the 2019 Pilot to the 2026 Expansion

This is not the first experiment. In **February 2019** the government had similarly capped the margin on 42 selected non-scheduled cancer medicines. From that experiment, the MRP of 526 brands fell by up to **91%** and patients saved an estimated **984 crore rupees a year**. That list had chemotherapy medicines such as cytarabine and mitoxantrone and targeted-therapy medicines such as osimertinib for lung cancer and ribociclib for breast cancer.

The 2026 expansion stands on this experience. An expert committee of the Directorate General of Health Services (DGHS) prepared the list and the NPPA issued the notification. The new list has medicines for **20 types of cancer** - including breast, prostate, colon, ovary and cervix - including immunotherapy. The annual business of cancer medicines in India is about **12,500 crore rupees**, of which the scheduled (already price-controlled) part is only about 2,250 crore rupees; this large non-scheduled segment had so far been the centre of the margin explosion.

How Much Relief Came, and to Whom

The examples from the issued list draw attention. One brand of palbociclib for breast cancer fell from **40,421 rupees to 2,720 rupees** for 21 capsules (93%), a 100 mg vial of the chemotherapy medicine thiotepa fell from **80,072 rupees to 7,150 rupees** (91%), and 10 tablets of anastrozole for hormone-sensitive breast cancer fell from **696 rupees to 73 rupees**.

But the full picture is also this: the median cut in the list's 643 entries is about **43%** and **159 entries** - which include some of the most expensive medicines - saw no change. The immunotherapy medicine pembrolizumab (100 mg vial 2,16,500 rupees) and osimertinib for lung cancer (30 tablets 4,16,492 rupees) are unchanged. The reason lies in the mechanism itself: the cap is only on the margin of the distribution chain, so a brand whose margin was already within 30% did not become cheaper. There is no control on the manufacturer-level price (the price to the stockist).

Judicial Oversight and the Market's Effect

Behind this step is the pressure of the judiciary. The Supreme Court recently raised questions over an almost **tenfold markup** on some cancer medicines and asked the government to investigate the practice of hospitals in which patients buy the medicine only from the hospital's own or a designated pharmacy. Around the same time, in another matter, a patient petitioned the Kerala High Court that the government make an essential medicine cheaper through "non-commercial" government use of the patent. After the signal, hospital-sector shares fell, because medicine sales are a significant part of the income of large private hospitals - about 72% of the revenue of one major cancer-care chain is linked to oncology. The market estimate is that average medicine prices in the country could fall by about 50%.

Beyond the Headline Price: Why the Relief Is Incomplete

The first gap: the base price is open. A company can sell the medicine to the stockist at a high price and add "free vials", which lowers the average cost while the paper price stays; MRP can be inflated despite the 30% cap. Experts therefore advise tying the margin cap to the manufacturing cost or the import cost.

The second gap: the monopoly power of patents. Even after the 2019 cap, the monthly cost of ribociclib rose from 58,000 rupees in 2022 to 78,000 rupees in 2025. In patent-protected medicines there is no competition, so no price pressure either; the margin cap does not even touch the manufacturer's base price.

The third gap: the access divide. According to a real-world study of the Tata Memorial Hospital, only **1.6%** of the patients needing targeted and immunotherapy reach them, and cost is among the biggest barriers. For a HER2-positive breast-cancer patient, one dose of the targeted combination costs about 2.7 lakh rupees, while 18 doses are needed. Cancer is a leading cause of catastrophic health expenditure in India; patients pay **50-80%** of the direct treatment cost from their own pockets.

What the Structural Options Can Be

Experts treat the margin cap as a short-term step and suggest two big structural reforms. First, tying price-setting to the manufacturing or import cost, so that the game of the base price stops. Second, **large-scale government purchase (pooled procurement)**, so that bargaining power stands before the monopoly seller and prices stay stable. Along with this, the existing tools of the patent law such as government use and compulsory licensing, cheap generic routes such as Jan Aushadhi, and the expansion of cancer packages in an insurance arrangement such as Ayushman Bharat are the other pillars of access.

Mains Practice Question

"The 30% trade-margin cap on non-scheduled cancer medicines can bring prices down, but without resolving the manufacturer-level price and the patent monopoly it is not a complete solution of access." Examining this statement, analyse the structural measures necessary for the overall improvement of cancer-drug affordability in India. (Write the answer in 250 words. 15 marks)

Answer Outline

Introduction: the meaning of trade margin rationalisation and a reference to the revised MRP of 543 brands described in the article.

Main Body: after the relief from a lower distribution margin, explain the limit of having no control on the base price and the patent monopoly. Make this gap clear with the examples of unchanged entries and of ribociclib. Connect access to treatment and the burden of out-of-pocket expense. Evaluate options such as cost-based pricing, pooled government purchase, government use or compulsory licensing, cheap generics and insurance expansion.

Conclusion: treating the margin cap as a useful but incomplete remedy, state the need for a combination of price control, competition, purchasing power and insurance.

Way Forward

Attention will be on the 9 November implementation: chemists and hospitals will have to display the new prices and patients can check prices with the NPPA's "Pharma Sahi Daam" app. The real test will be three - whether the next step (cost-based pricing or government purchase) comes for the unchanged expensive medicines; whether the Supreme Court's investigation direction brings rules on hospital-pharmacy margins; and whether the supply of cheaper brands holds despite the condition of maintaining production.

Sources

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