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Assessing the Impact of GST2.0 Reforms on Cancer Treatment Cost Affordability in India: A Policy Analysis

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1. Introduction

India's cancer burden is substantial and growing due to population aging, lifestyle changes, and improved detection. According to various estimates, the country sees around 1.4 million new cases each year, with projections indicating further increases. Cancer care is resource-intensive, involving surgery, chemotherapy, radiotherapy, immunotherapy, targeted therapies, and supportive care. In a mixed healthcare system where, private providers dominate advanced oncology services, patients frequently bear a large share of costs directly. Pre-reform OOPE for cancer treatment has been documented as high. A comprehensive multi-centre study by Prinja et al. (2023) estimated mean annual direct OOPE per cancer patient at approximately ₹3,31,177 (about US$4,171 at contemporary exchange rates). Medicines accounted for 45% of costs in hospitalization episodes, while diagnostics contributed 36.4% in outpatient settings. Mean OOPE per outpatient consultation was around ₹8,053, and per hospitalization episode ₹39,085. CHE prevalence reached 80.4% in outpatient care and 29.8% in hospitalization when considering direct costs alone; these figures rise sharply when indirect costs (travel, lost wages, caregiver expenses) are included. Poorer households and those seeking private care face disproportionately higher risks of impoverishment. Public insurance schemes like PM-JAY offer protection, but coverage gaps persist for many middle-income families and for outpatient or high-cost targeted therapies.

Prior to GST 2.0, the multi-slab GST structure (5%, 12%, 18%, 28%) applied to healthcare inputs. Many oncology drugs, including patented monoclonal antibodies and targeted agents, attracted 12% GST. Medical devices and diagnostic kits often faced 12-18% rates. Health and life insurance premiums carried 18% GST, inflating costs and

deterring uptake in a market with overall health insurance penetration below 30-40% for comprehensive coverage. These taxes compounded the already high base prices of imported or innovator drugs, limiting affordability.

The GST 2.0 reforms emerged as part of "Next-Gen" GST changes announced by the government, aiming to simplify compliance, reduce the tax burden on essentials, and support key sectors including health. The 56th GST Council meeting on September 3, 2025, under the chairpersonship of the Union Finance Minister, recommended sweeping rationalization while providing explicit relief for lifesaving medicines, devices, and insurance. These changes took effect on September 22, 2025. By zero-rating key oncology and rare-disease drugs, lowering rates on broader pharmaceuticals and devices, and exempting individual insurance premiums, the reforms directly target major cost drivers in cancer care.

This paper provides a detailed policy analysis of the reforms' implications for cancer treatment affordability. It expands on direct price effects, indirect benefits through insurance and hospital operations, equity considerations across income groups and regions, implementation challenges, and forward-looking recommendations. The analysis is timely, as early 2026 commentaries from AIIMS researchers and industry reports begin to assess initial impacts while highlighting the need for monitoring.

2. Objectives of the Study

The analysis is guided by the following four objectives:

3 To document the key provisions of GST 2.0 reforms relevant to healthcare, particularly oncology drugs, medical devices, diagnostics, and insurance.

4 To assess the direct and indirect impact of these reforms on cancer treatment costs and OOPE using pre- and post-reform tax rate comparisons and available price data.

5 To evaluate the potential effects on affordability, equity, and CHE risk, especially for low- and middle-income households, incorporating stakeholder perspectives.

6 To provide policy recommendations for maximizing benefits, addressing implementation gaps, and ensuring sustained improvements in cancer care access.

3. Literature Review and Pre-Reform Context

Financial toxicity in cancer care has been extensively studied in India. Prinja et al. (2023), based on primary data from over 12,000 patients across seven cancer centres, provides robust evidence: direct OOPE is dominated by medicines and diagnostics, with CHE and impoverishment risks significantly higher in outpatient settings and among

poorer quintiles. The study found that enrolment in PM-JAY or state-sponsored schemes substantially reduces the odds of CHE and impoverishment during hospitalization. However, outpatient care—where many targeted therapies and follow-ups occur—remains largely unprotected. Indirect costs further exacerbate the burden, pushing CHE prevalence close to 100% in some scenarios when fully accounted.

NSSO 75th Round (2017-18) data on social consumption in health, though older, remains a key reference. It highlights that cancer-related hospitalization and outpatient visits incur higher average expenditures than many other conditions, with private facilities driving costs upward. Subsequent analyses adjusting for inflation and recent treatment patterns confirm persistent high OOPE shares (often 60-70%+ of total cancer care expenses).

Other studies echo these findings. Systematic reviews on financial toxicity in Indian cancer patients note treatment abandonment rates linked to cost, psychological distress, and family-level economic shocks. Factors such as rural residence, lack of insurance, advanced-stage diagnosis, and reliance on costly biologics amplify vulnerability. Pre-GST 2.0, taxation added another layer: 12% GST on many lifesaving oncology agents (e.g., Daratumumab for multiple myeloma, Atezolizumab for lung and other cancers, Alectinib for ALK-positive lung cancer) increased effective costs without full input tax credit benefits flowing to patients. Medical devices like stents, imaging consumables, and glucometers attracted 12-18% GST, raising hospital bills. Insurance premiums taxed at 18% made comprehensive coverage less attractive, contributing to low penetration.

Internationally, countries with VAT/GST systems often apply reduced or zero rates to essential medicines and health services to promote access. India's pre-2025 multi-slab approach, while revenue-generating, created complexity and added to patient burdens in a high-OOPE environment. AIIMS researchers and policy commentators had long advocated for tax relief on cancer drugs as a feasible lever to reduce financial toxicity, provided benefits reach end-users through transparent pricing and supply chain adjustments.

The GST 2.0 reforms respond to such concerns by rationalizing rates and explicitly prioritizing health. They build on the original GST framework introduced in 2017 while addressing criticisms regarding essential goods. By exempting 36 critical drugs (33 from 12% to Nil; 3 from 5% to Nil) and lowering broader medicine and device rates, alongside zero-rating individual insurance, the policy signals a deliberate alignment of taxation with UHC goals. Early post-reform analyses (early 2026) from AIIMS suggest this could meaningfully lower OOPE if pass-through is effective, though challenges in monitoring remain. (Word count so far: ~1,650)

4. GST 2.0 Reforms: Key Healthcare Provisions

The 56th GST Council meeting marked a pivotal moment. Beyond rate rationalization into a simpler structure (largely 5% for essentials, 18% for standard goods, and higher rates up to 40% on luxury/sin items), the Council delivered substantial healthcare relief effective September 22, 2025.

Drugs and Medicines:

4 33 lifesaving drugs and medicines previously at 12% GST were exempted to Nil (0%). This list includes several key oncology and supportive therapies: Pegylated Liposomal Irinotecan, Daratumumab (including subcutaneous formulation), Teclistamab, Amivantamab, Alectinib, Obinutuzumab, Polatuzumab vedotin, Entrectinib, Atezolizumab, Spesolimab, Tepotinib, Avelumab, Emicizumab, Belumosudil, and others such as Onasemnogene abeparvovec, Asciminib, Mepolizumab, Risdiplam, Velaglucerase Alpha, Agalsidase Alfa, and Inclisiran.

5 3 critical drugs previously at 5% GST were also reduced to Nil: Agalsidase Beta, Imiglucerase, and Eptacog alfa (activated recombinant coagulation factor VIIa). These address rare diseases and severe conditions with cancer overlaps or supportive roles.

6 All other drugs and medicines saw GST reduced from 12% to 5%, covering a wide range of chemotherapy agents, supportive care drugs, and general formulations.

This exemption covers patented drugs with limited generics, directly benefiting high-cost regimens in multiple myeloma, lung cancer, lymphoma, and rare cancers.

Medical Devices and Diagnostics:

GST on various medical apparatus and devices used for medical, surgical, dental, or veterinary purposes (or for physical/chemical analysis) was reduced from 18% or 12% to 5%. Specific supplies like wadding, gauze, bandages, diagnostic kits and reagents, blood glucose monitoring systems (glucometers), and related equipment also moved to 5%. These changes lower procurement costs for hospitals and clinics, potentially reducing billed amounts for imaging, biopsies, infusions, and supportive procedures central to cancer pathways.

Insurance:

A landmark provision exempted all individual health and life insurance policies —including term life, ULIP, endowment, family floater, and senior citizen plans—from GST (previously 18%). This applies to reinsurance as well. Group insurance continues to attract 18% GST. The exemption is expected to reduce premium costs by roughly 15-

18%, making coverage more accessible for middle-income households facing repeated cancer treatment cycles.

These provisions were part of a broader "Next-Gen" reform package emphasizing ease of doing business, support for common citizens, and alignment with sectors like agriculture, labour-intensive industries, and health. The health measures complement other government initiatives such as PM-JAY, Janaushadhi stores for generics, and efforts to strengthen public oncology infrastructure. Official notifications and PIB releases detail the annexures listing exempted drugs, confirming the focus on cancer and rare disease therapies.

Implementation began on September 22, 2025, with clarifications on MRP adjustments, inventory transition, and compliance issued subsequently. Early industry feedback welcomed the moves as structurally positive for affordability, though concerns about full pass-through and monitoring were raised. (Word count so far: ~2,250)

5. Methodology

This is a desk-based policy analysis employing mixed methods for depth and balance.

Quantitative Component:

Official GST Council press releases and notifications provide pre- and post-reform rates. Illustrative price impacts for example drugs (Daratumumab, Alectinib, Atezolizumab) draw from pharmaceutical portals, hospital procurement data, and AIIMS-linked commentaries (approximate 2025-26 figures). Savings estimates assume varying degrees of tax pass-through (full, partial, or minimal) to reflect real-world variability. Baseline OOPE and CHE data come from NSSO 75th Round and Prinja et al. (2023). Simple arithmetic estimations calculate potential percentage and absolute reductions per cycle or annual course. No new primary data were collected.

Qualitative Component:

Synthesis of stakeholder views from AIIMS researcher commentaries (Sahni & Shankar, 2026), patient advocacy reports, oncologist perspectives in media, and policy discussions. Themes include pass-through efficacy, need for regulation, equity implications, and integration with existing schemes.

Analytical Approach:

A basic cost-benefit lens weighs revenue foregone against projected patient savings, reduced CHE, and broader economic gains (e.g., productivity, domestic manufacturing incentives). Limitations include the relatively short post-implementation period (as of early 2026), variability in actual MRP adjustments, regional supply chain differences, and reliance on secondary sources. Future empirical studies with post-reform NSSO-style surveys will be valuable.

This methodology ensures a rigorous yet accessible assessment suitable for policy audiences.

6. Impact Analysis on Cancer Treatment Affordability

6.1 Direct Cost Reductions on Oncology Drugs

The exemption of key drugs from 12% to 0% GST offers the most direct relief. For high-value biologics:

1. **Daratumumab** (used in multiple myeloma): Pre-reform prices for a 400mg vial often exceeded ₹60,000–70,000 including tax. The 12% exemption could yield theoretical savings of ~₹7,000–8,500 per vial if fully passed on. Regimens involving multiple doses per cycle amplify this.
2. **Alectinib** (ALK-positive lung cancer, oral targeted therapy): Monthly packs previously carried 12% GST on base prices often above ₹40,000. Post-exemption relief of ~10-12% translates to several thousand rupees monthly.
3. **Atezolizumab** (immunotherapy for lung, bladder, and other cancers): Doses can range from ₹95,000 to over ₹3 lakh depending on regimen. Zero GST potentially saves ₹10,000–40,000+ per administration.

Across a typical 4-6 cycle regimen or annual maintenance therapy, savings on exempted drugs alone can reach ₹42,000–50,000 or higher in high-value protocols, consistent with preliminary AIIMS estimates. The broader 12% to 5% reduction on other medicines adds incremental relief (~5-7% effective) on supportive drugs, anti-emetics, growth factors, and standard chemotherapy. Overall, direct medicine-related cost reductions for many regimens are estimated at 10-15%, with higher proportional benefits in biologics-heavy or targeted therapy protocols.

Actual realization depends on manufacturer pricing decisions, pharmacy margins, hospital mark-ups, and state-level variations. Early reports (2025-26) indicate partial pass-through in some segments, with calls for mandatory disclosure or audits. Complementary generic promotion via Pradhan Mantri Bhartiya Janaushadhi Pariyojana remains important for further cost control.

6.2 Impact on Medical Devices and Diagnostics

Reductions to 5% on diagnostic kits, reagents, glucometers, bandages, gauze, and various surgical/medical apparatus lower input costs for hospitals and diagnostic centres. In cancer care, diagnostics (biopsies, PET-CT, MRI, blood tests) often comprise 16-36% of OOPE. Lower procurement costs can translate into moderated billed amounts for

procedures and monitoring, benefiting both inpatient and outpatient pathways. Stents and infusion-related devices used in supportive care also gain. While the percentage reduction (7-13% effective depending on prior slab) is smaller than for exempted drugs, cumulative effects across repeated scans and interventions are meaningful, especially in public and charitable hospitals.

6.3 Insurance Premium Exemption and Indirect Benefits

Exempting 18% GST on individual health and life insurance premiums is a game-changer for affordability. Premiums for family floater or senior citizen plans are now lower by approximately 15-18%. This encourages uptake among middle-income groups previously deterred by the tax component. Higher coverage can shift costs from OOPE to pooled risk, reducing CHE odds (as evidenced by PM-JAY data showing protective effects). For cancer patients requiring multi-year or repeated treatment, this indirect benefit may prove as significant as direct drug relief. Group policies (common in corporate settings) remain at 18%, so the impact is strongest for retail/individual buyers. Awareness campaigns and integration with tax-saving instruments under Section 80D could further amplify enrolment.

6.4 Overall Affordability, Equity, and Stakeholder Insights

Combining direct tax cuts and insurance effects, GST 2.0 is projected to ease financial toxicity across the cancer care continuum. Low-income patients in public facilities benefit from cheaper inputs and potential ripple effects on procurement. Middle-income households gain most from insurance relief and reduced medicine costs in private settings. Equity improves if benefits are equitably distributed across urban-rural divides and income quintiles, though challenges like rural pharmacy networks and awareness persist.

Stakeholder perspectives are largely positive yet cautious. AIIMS researchers (Sahni & Shankar, 2026) describe the reforms as a "key shift" toward affordable cancer care, noting potential OOPE reductions provided manufacturers pass on benefits. Oncologists emphasize that tax relief must pair with price regulation and generic acceleration to prevent margin absorption. Patient advocacy groups welcome relief but call for billing transparency and real-time price monitoring apps. Policymakers view it as alignment with UHC, complementing increased public health spending. Concerns centre on revenue foregone (offset partly by higher volumes and simplified compliance), transition inventory issues, and the need for ongoing GST Council-health ministry coordination.

Table 1: GST Rate Changes Relevant to Cancer Care (Pre- vs post-GST 2.0)

Category	Pre-Reform GST Rate	Post-Reform GST Rate	Key Examples	Potential Impact
33 Lifesaving Drugs	12%	0%	Daratumumab,Alectinib, Atezolizumab, Pegylated Liposomal Irinotecan, etc.	10-12% savings on high-value biologics
3 Critical Drugs	5%	0%	Agalsidase Beta, Imiglucerase, Eptacog alfa	Relief for rare/severe conditions
Other Medicines	12%	5%	Supportive chemo, anti-emetics	Incremental 5-7% relief
Medical Devices & Diagnostics	12-18%	5%	Kits, glucometers, bandages, apparatus	Lower hospital & procedure costs
Individual Health/Life Insurance	18%	0%	Term, floater, senior citizen plans	15-18% premium reduction,higher uptake

Note: Savings are illustrative and depend on full/partial pass-through. Sources: GST Council 56th Meeting recommendations (2025) and related notifications.

7. Cost-Benefit Considerations and Challenges

Benefits:

Reduced OOPE and CHE can improve treatment adherence, quality of life, and survival outcomes. Insurance uptake may expand pooled financing. Hospitals gain from lower input costs, potentially supporting infrastructure upgrades. Broader gains include incentives for domestic pharma and device manufacturing, productivity preservation, and progress toward UHC. Revenue foregone is partially offset by increased consumption volumes and simplified compliance reducing evasion.

Challenges and Risks:

Incomplete pass-through could limit patient benefits, with margins absorbed higher in the chain. Short-term transition issues (inventory re-labelling, MRP adjustments) were noted in official FAQs. Regional disparities in supply chains and enforcement may create uneven impacts. Residual barriers—non-drug costs (travel, accommodation), late-stage diagnosis, and limited public oncology capacity—require parallel action. Monitoring mechanisms are not yet fully institutionalized, risking suboptimal outcomes.

Equity risks include urban-private skew if private providers do not adjust prices transparently. Long-term fiscal sustainability depends on economic growth and volume effects.

8. Conclusion and Recommendations

GST 2.0 represents a significant and progressive policy intervention. By exempting 36 critical drugs (many oncology-related), reducing rates on medicines and devices, and zero-rating individual insurance, the reforms directly address major drivers of financial toxicity in cancer care. Estimated 10-15% direct cost reductions, combined with insurance-driven coverage gains, can meaningfully improve affordability and access, particularly for low- and middle-income patients. AIIMS commentaries affirm this as a step toward aligning taxation with public health priorities.

However, tax relief alone is insufficient. Full benefits hinge on effective implementation. To achieve the four objectives and maximize impact:

5 **Establish robust monitoring:** Implement real-time price tracking dashboards, mandatory pass-through disclosures by manufacturers/pharmacies, and periodic supply chain audits involving the GST Council, Ministry of Health, and state authorities.

6 **Enhance transparency and regulation:** Link reforms with strengthened price regulation for key therapies, expansion of Janaushadhi outlets in cancer hubs, and clear guidelines on MRP adjustments post-tax changes.

7 **Boost complementary measures:** Launch awareness campaigns on insurance benefits and generic options; integrate GST monitoring with National Health Accounts and cancer registries; expand PM-JAY coverage for outpatient and high-cost therapies.

8 **Ensure periodic review and equity focus:** Conduct GST Council reviews with health sector input every 6-12 months; prioritize rural and underserved regions; fund independent evaluations using updated household surveys to quantify

actual OOPE and CHE reductions.

Sustained multi-stakeholder collaboration—government, industry, clinicians, patients, and researchers—will determine whether GST 2.0 translates into tangible reductions in catastrophic expenditure and accelerated progress toward equitable cancer care. Future research should track longitudinal outcomes, assess regional variations, and explore synergies with other health financing reforms.

Ultimately, GST 2.0 demonstrates how fiscal policy can support health goals in a large, diverse economy. With vigilant implementation and complementary actions, it can contribute meaningfully to reducing the economic burden of cancer and improving outcomes for millions of Indian families.

References

GST Council (2025). Recommendations of the 56th Meeting of the GST Council.