

Analysis on Protecting Cancer Care through the Covid-19 Crisis and its Consequences

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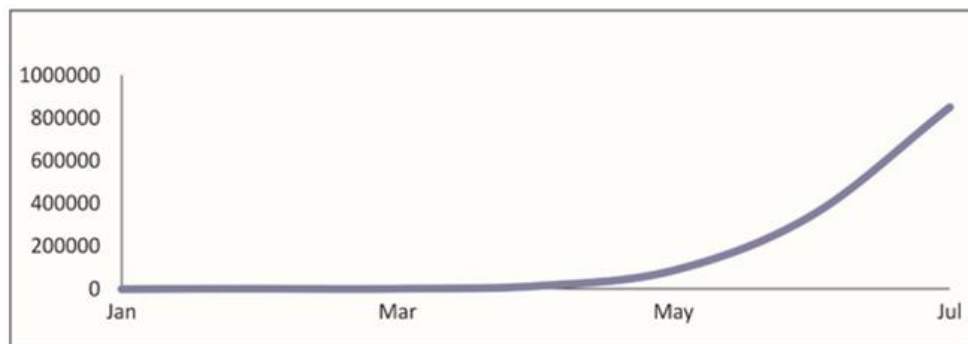
ABSTRACT: The COVID-19 pandemic is taking a huge toll on health systems across the planet. A growing concern is that efforts to manage the pandemic are undermining look after serious non-Covid illnesses like cancer. Within the UK and US, for instance, it's estimated that delays in cancer diagnosis and treatment thanks to COVID-19 will cause excess cancer deaths within the range of tens of thousands within a year. In India, where health systems are weak, it's likely that additional cancer deaths of a good higher order will occur if COVID-19 causes significant disruptions in cancer care, or indeed, if cancer patients themselves plan to delay diagnosis and life-saving treatment out of fear of contracting the virus. it's going to still be possible to avert this scenario in India by learning from the experience of nations that have skilled the worst of the COVID-19 crisis, and taking steps to make sure safe service delivery, unimpeded access to both specialist and first healthcare, and therefore the communication of reliable, evidence-based research to patients and their caregivers.

I. INTRODUCTION

The COVID-19 pandemic has demanded worldwide commitment of policy attention and resources on an Unprecedented scale. A mounting concern is that look after COVID-19 patients will displace look after those with other illnesses like cancer, especially in developing countries like India where health resources are already overstretched.

Cancer kills approximately 9.6 million people per annum globally. [1] In India, cancer causes approximately 2,000 deaths a day.[2] India's high death rate from cancer[3] is due to multiple policy failures like limited access to timely diagnosis and effective treatment,[4] and is particularly worrying as long as the country's cancer burden is projected to double within the next 20 years.[5]

In countries that were hit hard by the pandemic early, cancer care suffered serious disruptions, including delays in diagnosis and treatment, and therefore the halting of clinical trials. Alarming reports appeared in both the uk (UK) and therefore the us (US), for instance, of even high-risk patients being left with changes, delays, or interruptions to their care.[6] within the US, a model created by the National Cancer Institute predicted that tens of thousands of excess cancer deaths would arise over subsequent decade due to missed screenings and other cutbacks in oncology care precipitated by the COVID-19 crisis.[7]The initial months of the pandemic were relatively stable in India.[8] While various reductions in cancer care were reported,[9] specialist oncology services remained largely intact through the months of March, April, and May. The month of June, however, marked a transparent turn for the more severe. because the number of COVID-19 cases increased briskly, so did the strain on the country's health systems. Notably, the amount of confirmed COVID-19 cases jumped from 198,370 on 1 June 2020 to 604,641 on 1 July 2020[10] (See Figures 1)



Source for figures 1 & 2: COVID-19 Map, Johns Hopkins Corona virus Portal



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Over subsequent few months, India's healthcare system is probably going to stay under intense pressure. during this scenario, one can expect cancer patients to be thrust into competition with Covid patients for ward and ICU beds, ventilators, blood products, staff, and even basic medical supplies. This threatens the well-being of individual cancer patients and therefore the much important advancement made in oncology care. this is often because, despite cancer's heavy mortality burden in India, the disease didn't receive appropriate policy salience until fairly recently.[11] within the last five years, new treatment centres were inbuilt different parts of the country, awareness campaigns were launched, and clinical trials materialised. Moreover, in 2018, the Ayushman Bharat Health and Wellness Centres Program was initiated—a landmark intervention that aims to integrate screening for cancer and other non-communicable diseases into India's primary healthcare system.[12]

India can learn from the experience of nations that were battered by the virus within the initial phases of the pandemic. The country can avoid the surprise assault on cancer care that nations like Italy and Spain had to endure. a considerable body of literature has emerged on managing cancer care during the COVID-19 crisis that's built on the observations of oncologists practicing within the worst-off countries, also as guidelines issued by professional societies like the ecu Society of Medical Oncology (ESMO), the American Cancer Society (ACS) and therefore the UK's National Health Service (NHS).[13]

This brief draws upon the literature, also the authors' own clinical and practical experience, to specify some important challenges which will got to be met in three priority areas, by both healthcare providers and public policymakers, if cancer patients and therefore their care are to be safeguarded through the course of the coronavirus pandemic and the recovery period thereafter. These challenges are within the areas of service delivery, access to worry, and communication

II. PRIORITY AREAS FOR CANCER CARE II (1) SERVICE DELIVERY

Cancer patients tend to be older, have multiple comorbidities, and are immune suppressed either by their disease or by anti-cancer therapy. Although the info remains limited, they seem to be at greater risk of severe complications and death from the SARS-CoV-2 virus that causes COVID-19.[14]

While ideally, cancer patients should avoid all exposure to the virus while there's no vaccine or reliable therapeutic agent in view, the truth is that a lot of cancer treatments are highly time-sensitive and must be delivered swiftly, in clinical settings, to see the spread of cancer. If cancer is to be curable, moreover, it must be detected early, which suggests being vigilant about initial signs, and seeking immediate care should they arise. Since a corona-free world is unlikely any time soon,[15] most cancer patients will haven't any choice but to brave the surface world so as to get life-saving diagnosis and treatment. The onus are going to be on healthcare providers and government policymakers to guard them from the virus.

Cancer patients' exposure to the virus are often minimised through variety of various methods, including (a) Segregation of cancer and Covid facilities; (b) infection control; and (c) treatment modification.

(A) SEGREGATION OF CANCER CARE FROM COVID-19 CARE

Perhaps the foremost crucial step towards ensuring that cancer patients stay safe while obtaining care during the pandemic is to partition the facilities wont to treat cancer patients from those for COVID-19 patients. Wherever possible, separate buildings or building blocks should be used. If cancer facilities aren't fully segregated from Covid facilities, other efforts to minimise cancer patients' exposure to the virus (such as infection control measures) are unlikely to be effective. The clear separation of cancer and Covid facilities is strongly recommended by the UK's NHS and other international bodies and professional medical associations.

It is likely that as pressure on resources won't abate, government authorities are going to be prompted to order the insertion of COVID-19 patients into hospitals wherever there's room, without sufficient regard for other uses of those facilities. Multi-specialty hospitals, which are a crucial site of advanced cancer care in India, are going to be under



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special pressure during this scenario thanks to the country's limited health infrastructure. Merging Covid patients into equivalent facilities as cancer patients, however, isn't a defensible option given there's reasonably reliable data indicating that cancer patients are more in danger for serious complications from the virus than many other populations. If anything, government authorities have a special duty to guard cancer patients, who constitute a vulnerable group within the face of the pandemic.

(B) INFECTION CONTROL

In clinical settings, the target of infection control is to scale back opportunities for viral transmission between patients, their caregivers, and medical staff. This might be achieved through a spread of means, like replacing some patients' clinic visits with virtual assessments via telemedicine; arranging for home delivery of oral medicines and residential collection of blood samples; rigorous screening of patients and staff before permitting entry into outpatient clinics; controlling patient flow to minimise contact between patients; restricting the visits of relatives and other 'attendants' in outpatient clinics and inpatient wards; creating isolation wards for confirmed cases of COVID-19; transferring patients to other cities and regions that have less incidence of infections; establishing measures for aerosol containment during surgery, endoscopies, and emergency care; and instituting training courses for hospital staff on the right use of private protective equipment (PPE). Many of those protocols have already become standard Covid preparedness practice in hospitals across India.

(C) TREATMENT MODIFICATION

Other than to minimise a patient's exposure to the virus is to switch aspects of their treatment with the intent of reducing the intensity or frequency of their hospital visits. Treatment modification may, in fact, become unavoidable if Covid patients find you overwhelming the system, and therefore the burden on healthcare resources becomes acute. In Italy, as an example, which suffered the worst early outbreaks of the virus, treatment modification became a reasonably routine response to the pandemic by oncologists.[16]

The decision to delay or otherwise modify cancer treatment is usually a significant matter, involving evidence-based choices, made in accordance with the expectations of the patient and therefore the clinical judgment of their treating oncologist, on a case-by-case basis, following a transparent logic. Several general considerations, in line with international guidelines, might be wont to steer decisions on personalised treatment modification. These include the clinical condition of the patient, the biological features of the tumour, and therefore the weighing of expected benefits of the treatment against expected adverse effects.

Accordingly, patients might be stratified into different priority groups for receiving active cancer therapy, with higher priority given to those whose condition is instantly life threatening or clinically unstable; or who are in danger of developing serious co morbidities, like medulla spinalis compression; or who have certain sorts of cancers, like leukemia, that need immediate treatment. Lower priority might be given, on the opposite hand, to patients with early stage breast or prostate cancers that don't require urgent treatment, or patients in second-line or third-line chemotherapy, where there's not much survival benefit related to further treatment. While treatment modification would typically be avoided for higher priority patients, it might be considered for lower priority groups through different means, like switching from intravenous therapies to oral therapies, or reducing the frequency of maintenance treatments. Complex surgeries that are likely to need multiple blood transfusions, respirator utilisation, and prolonged postoperative ICU care could even be postponed for lower priority groups.

II (2) ACCESS TO CARE

Another important step towards safeguarding cancer care through the pandemic is to make sure that cancer patients retain physical and financial access to specialist services, which are crucial to treatment, also on primary health services, which are the primary port-of-call for effective diagnosis.



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(A) FINANCIAL ACCESS

In India, expenditure on cancer inpatient treatment is highest amongst all non-communicable diseases (NCDs), with out-of-pocket expenditure on cancer hospitalisation at about 2.5 times that of overall average hospitalisation expenditure. Many families resort to distressed modes of financing treatment, like selling off household assets and borrowing from money lenders at extortionate interest rates.[17] Indeed, data show that poorer people with cancer are more likely to die of their disease before the age of 70 than those that are more affluent.[18] The COVID-19 pandemic will only likely worsen a nasty situation. The income and job losses that are following it across the planet are playing call at India also, and can leave many cancer patients and their loved ones with even less resources to buy treatment. as long as most cancer patients are already under heavy financial stress, they ought to be targeted for various sorts of support from the govt also as private sources – within the sort of grants, special loans, insurance schemes, etc. – throughout the course of the pandemic also as during the recovery phase. Without such support, there'll be more people within the towel|chucking up the sponge|dropping by the wayside|giving up |quitting|falling by the wayside|throwing in the towel of treatment and facing premature death in the future.

(B) PHYSICAL ACCESS

The poor geographical spread of medical services in India means cancer patients will often got to travel long distances to access reliable care.[19] the supply of safe, reliable modes of transport is particularly urgent, as long as the burden of cancer is significantly higher among the elderly (70+) cohort in India, at about 385 per 100,000 persons (as compared with the general cancer prevalence of 83 per 100,000 persons).[20] The 'lockdown' phase of the Covid crisis in India was marked by complex restrictions on intra- and interstate travel and large disruptions publicly transport systems. For several cancer patients and their families, this posed grave difficulties. Arivazhagan, a 65-year-old farm labourer in Tamil Nadu, had to travel 130 km on his bicycle from his village to a cancer centre in Puducherry, in order that his wife could receive her planned chemotherapy dose on time. He was stopped by the police multiple times, and was only ready to move forward after producing his wife's medical records and chemotherapy schedule.[21] Arivazhagan's case is presumably the exception instead of rule because the typical caregiver would be postpone by the prospect of such an arduous and risky expedition with their patient. it's reasonable to assume that the Covid crisis has discouraged tens of thousands of individuals from obtaining medical attention, which is why fewer people are accessing treatment in the least levels of the system.[22] At the time of writing, many Covid-containment measures concerning movement and travel have only been partially lifted. Given the recent rapid spikes in Covid cases in many parts of the country, it's possible that state border closures and other limitations on travel, including passage within the town or region, will linger on for months. This may pose enormous difficulties for cancer and other non-Covid patients who are in need of time-sensitive care.

Such patients should be given effective, targeted support – for instance, within the sort of simplified procedures for obtaining travel passes – as they navigate their way through Covid-related bottlenecks within the country's transport systems.

(C) ACCESS TO PRIMARY HEALTH

The grim reality in India is that the bulk of cancer cases are diagnosed in advanced stages, when treatment outcomes are poor, and lots of cancer cases are related to preventable causes like infections and tobacco use. For a huge majority of the country's population, it's the first healthcare provider who is first approached with complaints of symptoms that would be indicative of cancer, and who holds the key to the timely screening and referrals that are essential for the first detection of cancer. Since the first healthcare provider is additionally liable for promoting cancer awareness, any malfunction at this level could lead on to a big jump in cancer deaths within the future. While studies on the topic are still preliminary, it seems that India's primary healthcare system has been hit by a huge diversion of fabric and human resources to manage the pandemic.[23] it's being reported, for instance, that much of the Accredited Social Health Activist (ASHA) workforce has been diverted to service Covid-related health concerns, which ASHAs who haven't been diverted have had their door-to-door movement restricted.[24] Since ASHAs are typically the primary healthcare resource to be accessed by poor and marginalised segments of the population, especially women and youngsters in rural areas, any rupture in their services is probably going to get negative consequences. The routine work performed by ASHAs in community healthcare – like the promotion of maternal health, child immunisation, and birth control – appears to possess already suffered, with reports emerging of curtailed child immunisation schedules, reduced maternal health services, and lowered access to psychological state treatment.[25] The disruption of ASHAs should even be a



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source of concern for those that have an interest in cancer care, since a minimum of some ASHAs are trained in cancer prevention, particularly within the screening and diagnosis of cervical cancer and carcinoma.[26] In India, where early detection constitutes a serious health-system gap and is that the leading factor behind the country's high cancer death rate, ASHAs help address a vastly unmet need. For all of those reasons, restoring the services of ASHAs and other primary healthcare workers to non-pandemic tasks should be treated as a priority policy issue. The most crucial step towards safeguarding early detection initiatives at the first level, however, are going to be to make sure that the Health and Wellness Centres piece of the Ayushman Bharat Program (AB-HWC) is protected and unrolled consistent with plan (the target is to possess 150,000 HWCs operational by December 2022).[27] The AB-HWC may be a groundbreaking intervention because it aims to systematically strengthen the previously anaemic promotive and preventive dimension of India's primary healthcare system. Key additions to primary health envisioned under AB-HWC that are relevant to cancer care include cancer screening and other diagnostic services, psychological state services, palliative care services, and healthy lifestyle counselling. If implemented properly, the AB-HWC initiative will revolutionise primary health in India and help close the gap in early detection services that's liable for many unnecessary cancer deaths.

III. COMMUNICATION

within the words of the U.N. Secretary General, the COVID-19 pandemic has been amid a parallel 'infodemic' of faux news.[28] False and misleading information about the pandemic has been plentiful in India, and like elsewhere, has created confusion, anxiety, and distrust among people and communities, and has served to stigmatise doctors, nurses, and other frontline medical personnel.[29]

False information about the pandemic has also deterred people from seeking time-sensitive diagnosis and treatment. Many cancer patients are led to believe that there are not any reliable ways of avoiding infection from the virus while accessing medical aid. This, of course, is untrue. If proper infection control measures are in situ, cancer treatment are often delivered safely – and is being delivered safely – in hospitals and other clinical settings. While, admittedly, nothing are going to be 100-percent safe while the virus remains active, for many cancer patients, the survival benefits of receiving timely treatment greatly outweigh the risks of infection with Covid.[30]

A key challenge for healthcare providers and public policymakers is to make sure that cancer patients are provided clear and trustworthy information about the way to manage their illness within the parameters of the pandemic. False and misleading statements about the pandemic must be countered aggressively, and reliable, evidence-based knowledge must be communicated effectively. Better regulation of social media platforms is one among many initiatives that would be considered for achieving such goals.

For their part, cancer patients and their caregivers should get on alert for false and misleading information about the virus, particularly about its mode of transmission, symptoms, origins, and so-called miracle cures. Information about the pandemic should be obtained only from reliable, official sources, like the planet Health Organization's Covid-19 Response portal and India's Ministry of Health and Family Welfare's Coronavirus portal.[31]

Most crucially, cancer patients should never take decisions to delay or modify any aspect of their treatment without first consulting with their treating oncologist.

IV. CONCLUSION

The COVID-19 pandemic is an emerging, rapidly evolving public health emergency of international concern that has taken a huge toll on economies, societies, and health systems across the planet. Consistent with the Johns Hopkins Coronavirus Resource Centre, which is updated daily, there have been approximately 17.8 million confirmed cases and 679,516 deaths worldwide, and 1.75 million cases and 37,364 deaths in India, at the time of manufacturing this brief.[32]

Given that cancer may be a major illness in India, with a dire price of quite 2,000 persons per day, it should be a matter of urgent concern that cancer care might be severely undermined by efforts to manage the pandemic. It should be noted that this is often what went on in developed countries like the united kingdom and US, which, despite having stronger health systems than India's, are estimating excess cancer deaths within the range of tens of thousands.[33] If cancer



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care suffers similar damage in India, the country's already-high cancer death rate will increase even further. Oncology care, which remains at a developmental stage within the country, also will suffer a serious setback.

It is still possible, however, to avert this scenario by taking variety of carefully planned steps that draw on the experience of nations that have already skilled acute constraints in their healthcare resources as results of COVID-19. These steps, within the areas of service delivery, access to worry, and communication, are described intimately during this brief, and are key to making sure that cancer patients retain access to the very best possible standards of care during the Covid crisis also as its aftermath.

In the future, many structural problems that are laid bare by the pandemic— including India's poor geographical spread of healthcare workers, weak tele health networks, and chronically low investment in healthcare (never quite 1.3 percent of GDP)—will also got to be addressed with renewed commitment.[34]

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