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Health equity has to be built into the process from the beginning, not treated as an afterthought

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Mohit Manrao, SVP and Head of US Oncology at AstraZeneca, leads the company's effort to drive impact for cancer patients across the US. He elaborates on what it means to realise AstraZeneca's bold ambition to eliminate cancer as a cause of death and shares how this mission goes beyond developing a comprehensive oncology portfolio to working at the community level to close the health equity gaps that prevent innovation from reaching patients.

Can you introduce yourself and your mandate as head of US oncology at AstraZeneca?

I am the SVP and head of US oncology for AstraZeneca, and also president of the AstraZeneca Foundation, through which we partner with NGOs across the US. I have been with AstraZeneca for 15 years, working across different markets and different parts of the value chain, from global development to bringing innovations to patients in local markets. My current focus is on driving impact for patients in the US, which is a critical market for AstraZeneca and one with significant opportunity.

What drew me to oncology, and what continues to drive me, is the sense of purpose that comes with this work. Like many of my colleagues, I am personally connected to cancer in some way. For me this role is both a personal commitment to supporting cancer patients and a professional one, aligned with AstraZeneca's bold ambition to eliminate cancer as a cause of death.

What is AstraZeneca’s oncology ethos in approaching the goal of eliminating cancer deaths?

At AstraZeneca, we believe we are standing at the forefront of redefining what cancer care looks like. Our ambition to eliminate cancer as a cause of death means building the next generation of cancer care delivery, one focused on early detection, smarter diagnostics, precision medicine, and supporting patients throughout their entire survivorship journey, from detection through living with, through, and beyond cancer.

We are living in a golden era of oncology. Cancer is no longer a death sentence. It is detectable, screenable, treatable, and survivable. Our opportunity is to ensure that reality reaches every patient, regardless of where they live. Where you live should not determine your outcomes, and we are working closely with ecosystem partners to make sure the zip code lottery is no longer a defining feature of cancer care in the US. That is what drives us day in, day out.

What is the strategic thread running through AstraZeneca’s oncology portfolio, and what does the pipeline look like going forward?

Our strategy is built around two broad modality platforms. The first encompasses everything that targets and kills cancer cells directly: antibody-drug conjugates, radioconjugates, tumor driver and resistance mechanisms, DNA damage response, and epigenetics. The second is harnessing the power of the immune system, through immuno-oncology agents, T cell engagers, cell therapies, and the next generation of all of those.

Having both platforms in-house means we can combine them, pairing an ADC with an immuno-oncology agent, for example, to drive deeper and more durable responses. It also means we can move earlier in the disease. We are not only supporting patients in the metastatic setting. We are intervening at earlier stages where the cancer is less aggressive, using precision medicine-based combinations that are time-bound and response-guided. Technologies like circulating tumor DNA allow us to treat, monitor the response, and reintervene only if needed. That is what smart cancer intervention looks like.

The pipeline momentum reflects that approach. In the last 12 months we have had eight or more positive phase three readouts and six launches in the first six months of the year, all of which are practice-changing. That means they are genuinely moving the needle on patient outcomes, not incremental additions to an established category.

On the commercial side, scale is central to the strategy. We are operating across multiple tumor types, including lung, gastrointestinal, genitourinary, ovarian, hematology, and breast, in each case asking where the unmet need is and how we can transform care across the full continuum, from earlier detection and smarter diagnostics through to precision treatment and survivorship support.

AstraZeneca and Daiichi Sankyo have uniquely partnered to successfully advanced the development of ADC. What has it demonstrated about the value of collaboration between two leading innovators?

We have built a broad portfolio internally, but we also recognize that we will not always have the right asset at the right time. That is why we are always looking for partnerships where we believe in the asset and in the partner's ability to drive impact together. The Daiichi Sankyo partnership on two ADCs, trastuzumab deruxtecan and datopotamab deruxtecan, has proven to be exactly that kind of meaningful collaboration, developing and commercializing assets together, not only as monotherapies but in combination with our broader portfolio and with other agents.

Trastuzumab deruxtecan is a good illustration of what is possible. Over the last six years it has transformed HER2-positive disease, reintroduced HER2 as a meaningful target in the ultra-low expression setting, and through its tumor-agnostic indication, opened up treatment options across multiple cancer types where HER2 is prevalent. Datopotamab deruxtecan is advancing along a similar trajectory in breast cancer, lung cancer, and most recently in triple-negative breast cancer, which is one of the hardest disease settings to treat.

What this partnership demonstrates is what happens when two organizations are aligned on a common purpose and committed to maximizing the impact of innovation for patients. It has also informed how we think about ADCs internally. We now have six in-house ADCs in the clinic, being tested across multiple warheads and payloads as part of our broader ADC program.

What are the biggest gaps in translating oncology innovation to patients, and what is AstraZeneca doing to close them?

Access is the doorkeeper. Many patients today cannot reach the innovations that exist, and health equity has to be built into the process from the beginning, not treated as an afterthought.

That starts in discovery and development. Clinical trials cannot be run only at sites that lack diverse patient populations, and translational science cannot rely on bio samples that do not reflect the breadth of patients who will ultimately use these medicines. Around 90 percent of cancer patients are treated in community settings, which means trials need to be conducted there too. That serves two purposes: physicians in those settings gain experience with experimental therapies before approval, and we are able to recruit the diverse patient populations who will actually receive these treatments once they reach the market.

After approval, equity has to remain front and center. There are significant gaps in who gets screened, who has access to screening, and who receives biomarker testing after a diagnosis. Biomarker testing is the gateway to precision medicine, but barriers remain across the system. We have worked with the broader ecosystem and with the American Cancer Society's policy and advocacy arm to pass biomarker legislation in 25 states, removing barriers to testing for all state-approved plans. But there are 25 more states where that work still needs to happen. Until biomarker testing is universally accessible, the right patient will not always reach the right treatment, and that is a gap the entire healthcare system needs to close.

As president of the AstraZeneca Foundation, how does the company go beyond its commercial activities to engage directly with communities on health equity?

We work on this through two main programs. The first is our Accelerate Change Together initiative, focused on improving access and affordability. We have made over USD 2 million in investments in community-based solutions since 2021, supporting more than 160 organizations that are present at the grassroots level and working on challenges that exist there. The second is the AstraZeneca Foundation's Change program, which provides financial grants alongside advisory support and consultation, helping organizations not just design and implement health equity programs but make them sustainable over the long term. Our partners are now presenting their work at conferences so that other organizations can learn from what has been built.

Why do we do this? Three reasons. First, access barriers get in the way of people getting the best possible outcomes for the disease they are dealing with. Second, no single company, organization, or individual can solve this alone, which makes partnership essential. Third, and perhaps most importantly, the challenges at the grassroots level are best understood by the local communities working within them. Partnering with those organizations builds trust, closes gaps faster, and produces more sustainable results.

Beyond the health system, there is also a role for broader society. Cancer carries a stigma that stops people from having the conversations that could prompt earlier action. Our partnership with Hockey Fights Cancer and the NHL is one example of how we try to bridge that gap, showing up at arenas, running public service announcements, and using platforms people already engage with to open up conversations about cancer risk factors and the importance of speaking with a doctor.

At the institutional level, the impact of partnership is equally clear. Lung cancer screening rates in California were at roughly one percent five years ago. Through the Healthy California program, which AstraZeneca was part of, multiple partners came together to mobilize at a health system level, and screening rates have now reached close to 20 percent. The lesson is consistent: challenges are local, partnerships are essential, and solving them requires engaging every stakeholder, within the health system and beyond it.

Where do you see the greatest near-term potential for AI in oncology?

We think of AI as a multiplier that helps us uncover patterns the human eye cannot see alone. That translates into faster delivery, more personalized treatments, and more precise decision-making. We are focused on embedding AI across the entire value chain, from discovery through to commercialization.

In drug discovery, 90 percent of the small molecules in our pipeline are now AI-assisted in some way, and we are spending 50 percent less time identifying potential drug molecules than we were without AI. That acceleration has a direct impact on how quickly new treatments can reach patients.

On early detection, we partnered with a company to deploy AI-enabled chest X-rays across 20 countries, completing five million scans that help identify which individuals need follow-up with a low-dose CT. In settings where infrastructure, cost, and reimbursement create barriers to lung cancer screening, that kind of scalable AI application can meaningfully close the gap.

We have also developed a tool called MILTON, which is able to predict around 1,000 diseases before they present symptoms, including early-stage cancers, using routine biomarkers already collected in clinical settings. The World Economic Forum has recognized it as a potential game changer in population-level risk stratification.

On precision medicine, AI is enabling us to see patterns in biomarker data that were previously invisible. We have developed what we call a quantitative continuous scoring platform for IHC,

which allows us to identify more precisely the biomarker profile needed to match patients to our ADCs. The FDA granted breakthrough designation to that biomarker, which is now being studied in a phase three trial. If successful, it would be the first AI-enabled end-to-end biomarker for a TROP2 ADC. That is the direction we are heading: AI as a multiplier of speed, precision, and innovation across the full pipeline.

What are the most critical pieces that need to come together to get closer to eliminating cancer as a cause of death, and how does that translate into AstraZeneca's near-term priorities?

The American Cancer Society published data earlier this year showing that seven out of ten patients diagnosed between 2015 and 2021 are surviving more than five years. That is a profound shift from a time when cancer was broadly considered a death sentence, and it has been driven by precision medicine and the wave of innovation that preceded it. Today, 18 million people in the US are living with cancer, and that number will continue to rise as incidence increases, detection improves, and more patients survive longer. The first priority is to keep fueling the engine of innovation that made that possible.

The US has been the primary driver of oncology innovation, and ensuring that continues is both a scientific and a policy priority. Whether it is pushing the boundaries of ADCs, radioconjugates, epigenetics, or cell therapies, which represent a significant area of investment for us as the next frontier in tackling this disease, or ensuring that the policy environment continues to support funding for innovation, we have to protect the conditions that have made this progress possible.

From an AstraZeneca perspective, we have committed to delivering USD 80 billion in revenue and launching 20 new medicines by 2030, with the US contributing approximately 50 percent of that. We have recently announced a USD 50 billion investment in US manufacturing and R&D. In the US alone, we reached ten million patients across our portfolio last year, and in oncology specifically we touched 100,000 patients in the first quarter of this year. We currently have close to 50 oncology indications on the market in the US, and we intend to grow that to approximately 85 within the next three years.

The third priority is ensuring that scale of innovation reaches patients at the community level. Having 85 indications means nothing if they are not being adopted and used where patients are actually treated. Getting these medicines to the zip code level, with the precision and equity that entails, is where the work of the next chapter of oncology care will be done.

What is your final message to the healthcare community on behalf of AstraZeneca?

Three things. First, eliminating cancer as a cause of death is an ambition we all need to share and work toward together. Cancer has moved from being a death sentence to something that is screenable, detectable, treatable, and survivable. We need to keep pushing in that direction.

Second, no one can do this alone. Partnerships are essential, whether for innovation or for delivery. Policymakers, patients, society, health systems, every part of the ecosystem has a role to play, and we need to engage all of them.

Third, health equity cannot be an afterthought. It has to be built in from day one, from ensuring diverse populations are represented in the development of new medicines all the way through to delivering those medicines at the zip code level and working with communities that face the greatest barriers to access. Health equity should be at the center of every decision we make.

Those are the three things I would bring back and highlight as AstraZeneca continues on this bold journey.

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