Commentary

Financial toxicity of cancer treatment: Moving the discussion from acknowledgement of the problem to identifying solutions

Aakash Desai\(^a\), Bishal Gyawali\(^{b,c,d,*,}\)

\(^a\) Department of Medicine, University of Connecticut, Farmington, CT, USA
\(^b\) Department of Oncology, Queen’s University, Kingston, Canada
\(^c\) Department of Public Health Sciences, Queen’s University, Kingston, Canada
\(^d\) Division of Cancer Care and Epidemiology, Queen’s Cancer Research Institute, Queen’s University, 10 Stuart Street, Level 2, Kingston, ON K7L 3N6, Canada

Acknowledging and Understanding the Problem

Although there is no formal definition, financial toxicity (FT) refers to the detrimental effects of the excess financial strain caused by the diagnosis of cancer on the well-being of patients, their families and society. With continued escalation in the costs of cancer treatment, FT has become an important consideration in recent cancer care.

In this article, we propose a four-step approach addressing the issue of FT in patients with cancer: first, acknowledging and understanding the problem; second, quantifying the problem; third, engaging key stakeholders and fostering communication and fourth, stand the most actionable and effective domain to intervene in the pathway of FT (Fig. 1).

Financial burden due to treatment. To our knowledge, the only validated tool so far is the “COMprehensive Score for financial Toxicity (COST)” tool to assess FT in US patients with cancer. COST has been validated as an adequate measure of FT with correlation with health related quality of life which makes it a clinically relevant patient-centered outcome [7]. In Japan, researchers have translated the COST tool into Japanese to assess FT among Japanese patients with cancer and discovered that a significant percentage of Japanese cancer patients do experience meaningful FT despite public health insurance system [4]. COST shows potential to provide us with an objective measure of FT but more research is needed to explore whether these tools correlate with clinical outcomes, and whether country specific tools are needed.

Engaging stakeholders and fostering communication – Given that FT has been shown to affect patients’ satisfaction of cancer care,
leading to delay or foregoing cancer care, bankruptcy, poor quality of life and poor survival [5,8], it is important to acknowledge that FT is not an abstract socio-political policy issue, but a clinical issue impacting patients every day. For a patient on chemotherapy, physicians proactively ask for physical toxicities such as nausea or neuropathy. Similarly, we should foster an environment where we proactively enquire patients regarding their financial concerns and have proper mitigating measures in place for those who do.

Various clinician, patient, and institutional barriers such as concerns about time, a lack of expertise or knowledge relating to cost issues, fear of providing or receiving suboptimal treatment, self-consciousness or unwillingness on the part of the patients to provide financial details can impede these conversations. Proper policy on how to incentivize such discussions and consults are needed. Training, recruitment and appropriate involvement of financial navigators and social workers is indispensable. Cancer economics could be included in the formal oncology training and oncologists get trained to detect and address FT in patients. Ultimately, FT and its impact must be communicated to key stakeholders, including policymakers and patients, to build awareness of the problem and support appropriate policy level actions.

Implementing solution strategies: International Societies/Guidelines — some steps are now being taken by global cancer societies to raise voice against the high cost of drugs and discourage low value care. Some notable examples are the ASCO value framework, Choosing Wisely initiative and the ESMO Magnitude of Clinical Benefit Scale (MCBS). These frameworks take clinical benefit, side effects, and improvement in patient symptoms or quality of life into account and provide relative rankings for decision making. The MCBS tool also helps policymakers to make assessments of clinical benefits for drug approvals or reimbursement decisions. The National Comprehensive Cancer Network guidelines also now incorporate evidence blocks, including affordability as one of the five domains.

Such societies can lead with example and a strong stance against low-value interventions will go a long way to dissuade the use of expensive but futile treatments. In 2017, the NCCN decided to remove the FDA-approved drug necitumumab for non-small cell lung cancer from its guidelines based on marginal benefits and high costs. Although this is a welcomed step, there are other oncology drugs in use that have escaped scrutiny.

National level — Policy changes at the national level to reduce the cost of cancer treatment and discourage the use of low-value cancer interventions can ease financial strain on patients while improving quality care. Such interventions include lowering cost of drugs by price negotiations, value-aligned pricing strategies, aligning price based on quality of evidence, policies separating physician reimbursements from the cost of interventions, and supporting trials testing cheaper alternatives to expensive treatment strategies [9]. The regulatory agencies should take a stronger, regulatory role in this context by discouraging the approval of low-value drugs which show minimal to no clinical benefit, or at least ask that the cost be tied to the level of evidence. Indeed, U.S spent more than $500 million in 3 years on a cancer drug olaratumab that ultimately failed, with the society—but not the industry-bearing the full financial burden of the failure.

Hospital level — cost transparency, availability of financial counselors in hospital, and elimination of low value practices [10] are strong measures that hospitals can employ to address FT. Appropriate facilities for referral to discuss financial issues should be available at cancer centres. Information on the costs of the interventions should be made available to the physicians and the patients beforehand. Increased cost discrepancy across hospitals also needs to be addressed.

Physicians and Patient level — Increased awareness of low-value practices and FT of cancer treatment is necessary both among physicians and patients. FT of new interventions should be reported and published. Although this may not be feasible for new molecules, for trials testing approved molecules in a new disease, cost is already known, and cost-effectiveness analyses should be reported when the efficacy data are reported. Patients can seek guidance on financial issues using online resources such as CancerCare.org. Some hospitals and disease specific charities also provide support for patients in need. In some countries, the government also provides financial assistance. Such information should be available upon contacting the patient advocacy organizations. Indeed, patient advocacy groups should make helping ease FT in patients with cancer one of their top priorities. Sadly, we have seen over recent years that some patients need to start their own online funding campaigns to afford the cancer treatment.

In conclusion, FT is not just a policy issue, but a real clinical problem with adverse consequences for the patient and family. Objective measurement, recognition and discussion of FT is an important step. Avoiding low-value practices in clinic is the strategy we as clinicians have at our disposal. Patient support groups have a big role by providing appropriate support and information online and via other...
resources to address financial toxicity. Cancer societies should take their responsibility more seriously in eliminating low-value practice, as should the regulatory agencies. The oncology community may not be able to prevent or cure cancers completely, but we can certainly prevent FT with appropriate steps.

**Declaration of competing interest**

The authors declare no conflict of interest.

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