Skin cancer in the Philippines: The Filipino narrative

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Globally, nonmelanoma skin cancers are commonly excluded from tumor registries because of their ubiquitous presence and straightforward management. However, for low- and middle-income countries, such as the Philippines, the clinical burden of cutaneous malignancies is vastly different from the global experience. Health inequities stemming from social determinants deepen fissures in overburdened health systems, leading to complicated stages of disease.

From 2011 to 2021, the Philippine Dermatological Society documented 2102 basal cell carcinomas and 614 squamous cell carcinomas.1 However, without a national cancer registry, these are likely underestimations.

Although inherent photoprotection lowers the risk for Asians, it can be offset by cumulative exposure to carcinogens, such as ultraviolet radiation. Over 34% of Filipinos are employed outdoors in agriculture, forestry, fishing, and construction.2 Miners and quarriers are exposed to arsenic, coal, etc. Compliance to occupational safety regulations, such as protective equipment provision, is dependent on the employer, and individual photoprotection practices likely parallel low health literacy levels.3 Socioeconomic status further impedes health care access.

In the Philippines, only 1275 board-certified dermatologists4 serve 109 million Filipinos. More than 50% of these dermatologists are concentrated in the capital, whereas a region in Southern Philippines has only 1 dermatologist for 4 million inhabitants.4 Hence, for many Filipinos, the first point of contact is the community health center, where misdiagnosis is common because of the relative rarity and lack of experience in assessing suspicious lesions. Public health campaigns are virtually absent, and preventive skin examinations are seldom offered. Low health literacy levels and poor health-seeking behaviors3 magnify the burden. With devolved health services, insufficient early detection mechanisms, and fragmented referral systems, many Filipinos die without ever being seen by a skin care physician.

The minority able to successfully seek consultation face other barriers. Filipinos often present with late disease, demonstrating infiltrative growth to bones and even metastases (Figs 1 and 2). What could have been removed via simple excision is complicated by the need for special imaging, adjuvant radiotherapy/chemotherapy, and complex reconstruction—services that are not readily available in provincial areas. With limited insurance coverage for skin cancer, financial catastrophe is likely for the average Filipino, who earns $10 or less per day.5

Skin cancer is preventable; however, political and socioeconomic disparities surrounding the average Filipino patient raise nearly insurmountable barriers. The recently passed Universal Health Care Act and National Integrated Cancer Control Act (2019) provide ripe opportunities to address this issue. Intersectoral collaboration is essential to regulate occupational safety measures and champion health benefits for workers. Public health experts, health
educators, and local community leaders can together craft culturally appropriate educational campaigns. A nationwide telemedicine network and electronic medical records would expedite referrals from far-flung areas to specialized centers. Expanded national health insurance packages would reduce out-of-pocket costs and mitigate the financial toxicities accompanying a cancer diagnosis. Local research and a national cancer registry would ground future policies for Filipinos with skin cancer. Political, economic, and health stakeholders must recognize their crucial responsibility in reducing health inequities. Steadfast commitment toward these strategies can ultimately transform the guarded prognosis of skin cancer for Filipinos and people of other low- and middle-income countries.

Conflicts of interest
None disclosed.

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