

FAST FACTS AND CONCEPTS #409
FINANCIAL TOXICITY AND CANCER CARE
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Background: Patients can experience lasting effects from cancer and its treatment. Compared to individuals without a cancer history, they have greater healthcare expenditures, higher risk of bankruptcy, and limitations in amount or kind of work (1). Financial toxicity, a term to describe the cost burden health care places on patients and families, often does not receive adequate focus for cancer patients in the US health system especially. This *Fast Fact* will identify effective ways clinicians can recognize and support those suffering from the financial burdens of cancer care.

Financial trends in US cancer care: Cost of cancer care has risen over recent years. With rising deductibles, co-insurance, and cost-sharing, patients and their families are shouldering a larger proportion of these costs. In the 1980s, the average US cancer drug cost \$100/month; in 2009, it was \$18,000/month (2). Meanwhile, median household income has not significantly changed (3). As with any adverse effect of cancer treatment, the experience of financial toxicity is diverse, but the prevalence of subjective distress, home foreclosure, and personal bankruptcy from financial toxicity is increasing (3).

Risk factors for financial toxicity: Younger patients are disproportionately affected since they are more likely to have private insurance with higher copays and typically have not yet reached peak earning capacity. Furthermore, younger adults with cancer report “job lock” - foregoing career advancement opportunities given concerns for losing health insurance coverage. Others must stop working completely leading to increased financial strain for the whole family. Among those 18-64 years old, about 30% experience material or psychological hardship, compared to 15% of adults greater than 65 (4). Other patient characteristics associated with financial toxicity include lower socioeconomic status, underinsured or uninsured, unemployed, minority race and/or ethnicity, and rural residence (4).

Impact of financial toxicity: Patients report significant out-of-pocket spending for direct and indirect health care costs including transportation, parking, lodging, caregiving, childcare, and respite care (5). These costs can have a negative impact on emotional well-being, quality of life, symptom burden, treatment adherence, and even survival (6). Nearly one-third of patients with advanced cancer report financial toxicity as being more severe than their physical or emotional distress (7). Some worry more about the financial impact of their cancer than dying from cancer (8). Stark disparities have been linked to clinical trial access with populations at highest risk for financial toxicity being least likely to enroll (9).

Engaging patients in discussions about financial toxicity: The optimal timing and method of approach to engage patients in discussions about cancer-related financial toxicity are under investigation. Most patients report a desire to discuss cost, but clinicians may be more hesitant. Time concerns, knowledge deficits relating to cost issues, fear of providing or receiving suboptimal treatment, self-consciousness, or unwillingness to provide financial details can impede clinicians and patients from engaging in these conversations (10). The literature to date is limited, though preliminary data suggests screening for and documenting financial hardship discussions has been associated with higher patient satisfaction and lower out of pocket expenses (10-12). The following clinical pearls are based on the limited available evidence, anecdotal experience, and expert opinion:

- Including a single question into initial clinical assessments can quickly and effectively screen for financial toxicity: “*Are you having difficulty paying for your medical care?*” (13).
- Ongoing communication about financial hardship during care transitions and/or disease progression, rather than a single discussion at diagnosis or treatment initiation is critical. The risk of financial hardship varies in severity over the course of cancer care and may be cumulative for many patients.
- A 3-step approach modeled from the “Ask Advise Refer” recommended by the US Department of Health and Human Services for tobacco control, offers a promising cancer care delivery model to systematically address financial hardship. (14) This approach emphasizes the proactive importance of asking patients about financial hardship, informing them of the potential high costs of cancer care, and then appropriately referring patients to financial assistance and other resources.

- Utilize an interdisciplinary team of experts. Consultations with financial navigators, social workers, and clinical pharmacists can help alleviate the financial burdens of cancer care (15).
- Be aware of support services within your health care system including prescription assistance plans, grant assistance, cancer-specific insurance support, travel grants, and travel assistance.
- When appropriate, clinicians should adjust the frequency or location of medical testing, enroll patients in clinical trials, utilize an in-network pharmacy, increase telemedicine support, use a satellite clinic site if more convenient for the patient, and transition care more locally if equitable care is available.
- Conceptualizing financial toxicity as an adverse event in cancer treatment may help health care systems develop more robust system-based, quality-improvement strategies to address this component of human suffering.

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