Financial hardship associated with cancer care in the US is complex in its definition and quantification and is even more complex in its mitigation. Elements of financial hardship include (1) material consequences of treatment, such as out-of-pocket expenses, debt, and decreased income; (2) psychological distress because of costs; and (3) deleterious coping mechanisms, such as delaying or skipping medications or care. Despite evolving definitions and imperfect measurement tools, we know that financial hardship from cancer treatment is a common adverse event for patients; the prevalence of financial hardship varies across sociodemographic groups, but adverse implications can be seen in at least half of patients. Financial burdens associated with cancer are associated with increased financial strain, decreased willingness to pay for care, and increased mortality. We have a growing understanding of populations who are most at risk for financial hardship: those who are underinsured or uninsured; those who are minoritized and/or made vulnerable by structural racism, geographic barriers to care, language differences, ageism, sexism, undocumented immigration status, and health literacy, among other means; and those who lack financial reserves. We ought to be beyond simply describing the problem; future research can and must be geared toward designing and testing interventions.

In the survey study by Khera et al involving more than 400 patients with cancer, the prevalence of financial hardship was high (48%-68%). Increased health insurance literacy was associated with lower risk of financial hardship. When adjusted for both health insurance literacy and financial literacy, however, the association did not hold. Khera et al interpreted these findings as suggesting that improving both health insurance literacy and financial literacy may mitigate the downstream consequences of financial hardship, such as poor treatment adherence and decreased emotional well-being.

Given the multifactorial nature of financial hardship, the development of objective and validated measures to describe, quantify, and qualify financial hardship continues to be challenging. It is critical to ask and define what financial toxicity, financial hardship, and financial distress (which are interlinked but not identical concepts) truly mean for patients. The current health insurance structure in the US relies on the patient responsibly asking, essentially begging, the difficult question of what is an acceptable level of financial sacrifice for cancer care. Khera et al used the COST–FACIT (Comprehensive Score for Financial Toxicity–Functional Assessment of Chronic Illness Therapy), a validated survey of subjective financial concerns associated with quality-of-life decreases. There is no established cutoff for financial toxicity screening with the COST–FACIT score; for example, Khera et al used a median score, whereas other studies have used 20 or 26 (out of 44) points as the positive screen for financial toxicity. Newer studies are exploring more objective measures, such as credit record–based financial events (eg, delinquent mortgage payments, foreclosures, and third-party collections) and changes in credit score. Quality-of-life questionnaires, such as the EORTC QLQ-C30 (European Organisation for Research and Treatment of Cancer Core Quality of Life Questionnaire), have also included items that attempt to measure financial hardship; some studies have used question 28 as a single-item measure of financial hardship. Similarly, better tools are also needed to measure health insurance literacy and financial literacy. Khera et al used the validated 21-item Health Insurance Literacy Measure and 5 questions from the National Financial Capability
Study as well as a self-assessment question to assess financial literacy. Shorter, more practical tools may be helpful to minimize survey fatigue and improve response or completion rates.

It is important to note that even the best metrics and most well-intentioned interventions may not benefit patients equitably. The consequences of cancer’s financial burden go well beyond direct health outcomes. Jaggi et al found that 1 in 20 Black or Latina patients lost their home, and nearly half of Black patients and more than one-third of Latina patients had to reduce their food spending because of breast cancer treatment. Another study found that more than half of Black women reported adverse financial consequences associated with cancer, including higher rates of job loss, transportation barriers, and income loss compared with those experienced by White women. Smaller baseline financial reserves in vulnerable communities may result in inequitable benefit of blanket interventions, potentially exacerbating the disparities experienced by the most vulnerable groups. For example, investments in a pharmaceutical financial assistance program aimed at providing low-cost medications may not help patients who already have a low copayment ($2 on Medicaid) but may have substantial transportation barriers to get to a clinic to receive treatment.

Metrics that were developed and validated in one group may not apply directly to another group, even within the same health care system. Studies assessing financial hardship have focused on White patients, with insufficient representation of racial and ethnic minority individuals. Khera et al recognized this gap and designed their study to include patients from a second cancer center in an attempt to enroll a more racially and ethnically diverse sample. Minoritized groups may be more likely to have unmeasured or underappreciated cost-related barriers to care and disparities that stem from systemic and structural racism. It is critical to note that many financial hardship studies excluded non-English speakers from their sample, underscoring how little we know about groups that may be most vulnerable. In addition, interventions that are preferable to one group may not be preferred by other groups: a recent study found that Black patients may be less interested in cost conversations, with 0% (vs 38% of non-Hispanic White patients) indicating they wanted to know the cost of their health care up front. This finding highlights the variation not just in needs but also in potential preferred interventions across different sociodemographic groups.

Given the reality of the US health care system and clinicians’ ongoing responsibility to mitigate the financial hardship in patients, the work by Khera et al is important because the team evaluated targets that were potentially amenable to interventions. The study supports education-based interventions to improve financial literacy and empower patients. Our own institution provides online classes to patients and caregivers on health insurance basics, tips for managing health care costs, and available financial support and resources; similar classes are offered by the Mayo Clinic. In addition, systems should be designed to make information about costs more readily available to patients and clinicians to facilitate some aspects of financial health literacy; for example, hospitals should adhere to the mandate of the Centers for Medicare & Medicaid Services to improve price transparency. Embedding cost tools in the electronic medical record may empower both patients and clinicians to discuss costs at the point of care when making treatment decisions. Furthermore, financial navigators have helped decrease both patient and health system costs because navigators link patients to support and services that are designed to improve access; making financial navigators available, particularly at institutions that serve economically vulnerable populations, is an important goal. Work is under way (eg, SWOG CREDIT [A Randomized Trial Addressing Cancer-Related Financial Hardship Through Delivery of a Proactive Financial Navigation Intervention] study) to prospectively evaluate how financial navigation programs may reduce material financial hardship for households.

As clinicians, we should not underestimate our ability to advocate for patients by supporting systems that mitigate financial toxicity, which decreases access to care and undermines outcomes for economically vulnerable people. The study by Khera et al highlighted several targets for decreasing financial hardship. It should now be our goal to start the hard work of translating clinical research into real patient benefits.