The Financial Impact of Cancer: an Emerging and Important Topic

The many and varied diagnostic groups that make up the generic disease category of cancer are now documented as common to all humanity irrespective to age, gender or geographical location. Not only are cancers recorded in every country but groups such as breast, lung, prostate and colorectal cancers are now listed in many areas as the leading cause of illness and death. Thus, internationally the combined impact of this set of diseases is profound.

In recent decades there has been an increasing awareness that an understanding of the impact of cancer should not be limited to the physical dimension, but needs to embrace the broader psycho-social perspective. As a consequence, there has been considerable progress in understanding the many emotional and social ramifications of cancer not only for the patient, but also for their carers and family. In part, the response to this broader understanding has been a proliferation of supportive care initiatives designed to assist individuals in coping with the many challenges associated with cancer diagnosis and treatment. One challenge that has only recently been placed on the psycho-social agenda is that of the financial cost of cancer to the individual and to society. Although still in its infancy, the research in this area is starting to document the economic cost of cancer in terms of health and medical care, loss of worker productivity and personal financial strain on patients and their families.

The financial impact on the patient and their family has been shown to be attributed to a range of factors including medical expenses, loss of employment and the costs involved in relocation for specialist care. As many cancers are now viewed as chronic illness that require long-term treatment and follow-up, even the cost of hospital parking can translate into significant costs (McGrath, 2002). A review across different types of cancers and populations consistently show that a significant percentage of individuals stop working or experience a change in employment after being diagnosed and treated for cancer (Spelten et al., 2002). Canadian research in relation to breast cancer alone demonstrates that each year over 20,000 women
are diagnosed, which has major implications for the workforce (Quinlan et al., 2009). In Korea, cancer diagnosis adversely affects employment status and the effects are widespread in almost all gender and age groups (Park et al., 2009). European research indicates that not only do almost a third of cancer survivors experience changes in their work situation after cancer, but it is also common to have problems with obtaining health insurance, life insurance and home loans (Mols et al., 2012). Research demonstrates that it is not only the patients but also the carers who report lost hours of work (Sherwood et al., 2008). In fact, an American survey on the impact of cancer found that one in four families in which a member of the household had cancer within the past 5 years led to the patient using up all or most of their savings, borrowing money from relatives to pay bills, with 10% unable to pay for basic necessities such as food, heat, or housing (Adler & Page, 2008, p.34). Australian research indicates there are a range of substantial additional costs incurred by cancer patients during relocation for specialist care including increased cost of shopping, telephone calls, medical expenses, accommodation and travel costs, and the financial strain of maintaining two households (McGrath, 2000). The financial distress of cancer is exacerbated for individuals on low incomes as inadequate income adds to everyday stress by limiting the ability to purchase food, housing, medication, transportation and health care (Kelly et al., 2006). Venkateswaran and Kumar (2006) argue from an Indian perspective, that the ongoing challenge in areas of poverty is to evolve a socio-economically appropriate system of cancer care that addresses the accessibility of long-term care for the majority of cancer patients who require it.

A recent opportunity to engage in research on survivorship provided the author with the chance to explore the financial impact in relation to the sub-group of cancer known as haematological malignancies. The research, funded by the Leukaemia Foundation of Queensland (LFQ), explores the experience of diagnosis and treatment for individuals with haematological malignancies including leukaemia, lymphoma, myeloma and a range of related conditions. The findings on the financial impact indicated that many individuals, especially those in the older age groups, were buffered from financial distress. The buffers to financial distress were varied and included the ability to continue working, already being in retirement so not having to face loss of work income, insurance or income protection, access to superannuation, ownership of home and assets, the ability to sell assets to increase cash flow, having a partner who was employed, the ability to access the pension, and medical benefits cover. However, there is a sub-group of people who did experience financial hardship for a range of reasons. The factors that contributed to this included having to give up work or being unable to return to work, having limited income from disability allowance and carers’ pension, not qualifying for a pension, having major expenditure demands (mortgage, rates, dependent children, car maintenance), the costs of medical bills and gap payments, being forced to sell assets such as the family home, having no superannuation, difficulties from being self-employed and trouble following claimable medical expenses. For some, the financial stress was acute and ongoing. Importantly, the findings identified supportive care factors that went some way to reducing the severity of the impact. The first was the free accommodation provided by LFQ that could be accessed by patients and their families during relocation for specialist care. Secondly, the financial assistance provided by LFQ to economically stressed families. Thirdly, the support and encouragement given to some by their employers who would, for example, allow for extended sick leave or even engage in fund raising to assist families in need. In short, the findings highlighted areas of hardship and the possibility of effective supportive care strategies to ameliorate the financial distress.

An understanding of the financial impact needs to be disease, culture and location specific. The findings from Queensland point to the specific need to build into the supportive care response an understanding of the financial distress for haematology families. However, the work also resonates with and contributes to the emerging body of work on the economic impact of cancer. This editorial applauds the research already completed in this area as it is making a significant contribution to enriching our understanding at both the individual and the societal level. The economic ramifications of cancer are major. A concerted and continuing research effort is required to fully explore and document this important topic in relation to cancer care.

REFERENCES


