Who Should Be Responsible for Relief of Financial Toxicity?

TO THE EDITOR:

We are writing in response to the article by Gupta et al[1] and the accompanying editorial by Giap and Chino[2] about the financial burden of drugs prescribed for cancer-associated symptoms. Financial toxicity is a growing threat to the security and long-term well-being of all patients, particularly those who receive costly therapies that require laboratory monitoring.[1,3] Lack of insurance, underinsurance, and job loss suffered as a consequence of cancer diagnosis and treatment[4] and the burden of cost shifting to patients through rising deductibles, copays, and oral antineoplastics are a few factors that contribute to financial toxicity. Worry about the financial impact of cancer adds to the survivorship burden of patients and may adversely affect outcomes/survival.[4]

We agree wholeheartedly with the need to be cognizant of this and to help patients mitigate the effects of this financial toxicity; however, we disagree with the focus aimed solely at oncologists.[2] Although the oncologist should lead this effort, it will require a team-based approach to solve this problem. Why? Oncologists are already burdened by the inefficiencies of the electronic medical record (EMR), the need for electronic narcotic prescriptions, the need to assess and address not just cancer pain but all pain *at every visit*, to address distress at every visit (often in settings without social work or psychiatry backup), and to address smoking cessation, while still addressing the primary focus of the visit (ie, the treatment of the underlying cancer), all in a 15-20 minutes time frame and with the specter of patient satisfaction ratings hanging over them. To add another task to their work bucket may drive some into early retirement. Furthermore, many factors that contribute to the rising cumulative costs of therapy are outside the control of the physician—the high cost of prescription drugs, variability of drug prices by pharmacy, geography and patient insurance, and lack of transparency in pricing to name a few.[5,6] A physician must be able to readily access cost information to incorporate it into their clinical decision making. Finally, many rural oncologists practice in personnel-challenged environments. Thus, any solution would need to include recognition that resources outside of the individual physician are required.

We believe both radiation oncologists and medical oncologists should be sensitive to the costs and the cost-effectiveness of the therapies they recommend. We should continue to advocate for our patients; we should continue to provide them with resources to mitigate the impact of these costs, and perhaps most importantly, we should continue to lobby for pricing that is sensible and transparent. We already have dedicated financial navigators who help patients receive financial aid for the therapies we prescribe and who help patients obtain adequate insurance or charity care, when possible. Many providers have opened their wallets to help pay for prescriptions for their patients. A better solution would be to recognize that while physicians should lead the effort, they cannot do so without resources provided by hospitals, insurance companies, EMR vendors, etc. These resources might include embedded EMR tools that provide both ASCO guideline–based symptom management recommendations and best drug price information on the basis of patient-specific demographic data, a pharmacist-led financial advocacy team to seek the best coverage/lowest cost form of symptom-mitigating medications when appropriate, and a scribe to help relieve some of the clerical burdens so doctors have more time to teach why a prescription medication may not be the best solution.

Although we have proposed individual solutions above, an overarching solution would be universal health care that includes prescription drug coverage. This is a goal we strive for although it has eluded us for decades.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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