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FINANCIAL TOXICITY EXPERIENCED BY WOMEN WITH CANCER: A QUALITATIVE RESEARCH STUDY*

TOXICIDADE FINANCEIRA EXPERIENCIADA POR MULHERES COM CÂNCER: PESQUISA QUALITATIVA

TOXICIDAD FINANCIERA EXPERIMENTADA POR MUJERES CON CÁNCER: UN ESTUDIO CUALITATIVO

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RESUMO

Objetivo: Compreender como a toxicidade financeira se manifesta e interfere na vida de mulheres com câncer. **Método:** Pesquisa descritiva-exploratória, de natureza qualitativa, realizada junto a mulheres sobreviventes de câncer. Os dados foram coletados entre maio e setembro de 2025, mediante entrevistas semiestruturadas audiogravadas após autorização. Seguidamente, os dados foram submetidos à análise de conteúdo, na modalidade temática. **Resultados:** Participaram 24 mulheres que já haviam concluído o tratamento primário. Da análise dos dados emergiram quatro categorias, as quais mostram que, mesmo com acesso ao Sistema Único de Saúde ou planos de saúde, durante o tratamento, as participantes enfrentaram custos elevados com medicamentos, alimentação diferenciada, transportes, exames e terapias complementares, além de redução da renda, devido ao afastamento do trabalho por um período específico, e às vezes, até mesmo dependência de rede de apoio para questões financeiras. Esses achados mostram que a toxicidade financeira atravessa dimensões econômicas, emocionais e sociais, impactando a autonomia e o bem-estar. **Conclusão:** É fundamental reconhecer a dimensão da toxicidade financeira durante o tratamento oncológico e incluí-la nos planos de cuidado, além de sensibilizar gestores sobre a importância de implementar políticas que ampliem a proteção financeira às pacientes.

Descritores: Sobreviventes de Câncer; Neoplasias; Estresse Financeiro; Toxicidade; Qualidade de Vida.

ABSTRACT

Objective: To understand how financial toxicity is manifested and interferes in the life of women with cancer. **Method:** A descriptive-exploratory research study of a qualitative nature, conducted with female cancer survivors. The data were collected between May and September 2025 by means of semi-structured interviews that were audio-recorded after due authorization. Subsequently, the data were subjected to content analysis, in its thematic modality. **Results:** The participants were 24 women who had already finished their primary treatments. Four categories emerged from the data analysis. These categories show that, even if enjoying access to the Unified Health System or to health plans, the participants faced high costs related to medications, differentiated eating, commuting, tests and complementary therapies during their treatments, in addition to reduced incomes due to having be distanced from their work for a specific period of time, sometimes even depending on support networks for financial issues. These findings show that financial toxicity permeates economic, emotional and social dimensions, exerting impacts on autonomy and well-being. **Conclusion:** It is fundamental to acknowledge the magnitude of financial toxicity during cancer treatments and to include it in care plans, in addition to sensitizing managers about the importance of implementing policies that expand the financial protection offered to the patients.

Descriptors: Cancer Survivors; Neoplasms; Financial Stress; Toxicity; Quality of Life.

RESUMEN

Objetivo: Comprender cómo se manifiesta la toxicidad financiera y cómo interfiere en la vida de las mujeres con cáncer. **Método:** Investigación descriptivo-exploratoria, de naturaleza cualitativa, realizada con mujeres supervivientes de cáncer. Los datos se recopilaron entre mayo y septiembre de 2025 mediante entrevistas semiestructuradas audiograbadas tras autorización. Posteriormente, los datos se sometieron a un análisis temático de contenido. **Resultados:** Participaron veinticuatro mujeres que ya habían completado el tratamiento primario. Del análisis de datos surgieron cuatro categorías que muestran que, incluso con acceso al SUS o a planes de seguro médico, durante el tratamiento, las participantes enfrentaron altos costos de medicamentos, alimentación especializada, transporte, estudios médicos y terapias complementarias, además de una reducción de ingresos debido a licencia laboral, e incluso, en ocasiones, dependencia de una red de apoyo para asuntos financieros. Estos hallazgos muestran que la toxicidad financiera abarca las dimensiones económica, emocional y social, además de impactar en la autonomía y el bienestar. **Conclusión:** Es fundamental reconocer la dimensión de la toxicidad financiera durante el tratamiento oncológico e incluirla en los planes de atención, así como sensibilizar a los gestores sobre la importancia de implementar políticas que amplíen la protección financiera para los pacientes.

Descriptores: Supervivientes de cáncer; Neoplasias; Estrés Financiero; Toxicidad; Calidad de Vida.

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What is already known:

- Financial toxicity describes the economic burden faced by cancer patients, including high costs, lost incomes and debts.
- Financial toxicity is associated with worse quality of life, deeper emotional distress and even lower adherence to treatments.

What this article adds:

- The study reveals that there is financial toxicity even when treatments are funded by the SUS or by health plans.
- It is shown that indirect costs affect the economic, emotional and family life of women with cancer.
- The essential role of support networks to bridge gaps and sustain care during treatments is made evident.

INTRODUCTION

Cancer presents high incidence in our country, and its diagnosis is marked by emotional impacts that can go beyond life finitude and involve some type of scarcely discussed challenge: the financial one. Some estimates indicate that the global costs related to cancer treatments in 204 countries will total 25.2 billion dollars between 2020 and 2050[1]. In Brazil, the treatments offered by the Unified Health System (Sistema Único de Saúde, SUS) generated 3.9 billion reais in costs during 2022 alone, consolidating cancer as one of the most expensive chronic non-communicable conditions. However, this value did not include the indirect costs or some direct ones to be assumed by the patients themselves and their families and which exert significant effects on household budgets, therefore giving rise to financial toxicity[2].

Consequently, financial toxicity emerges as a significant adverse effect of cancer treatments. This concept goes beyond the expenses directly connected with the treatments (such as medications, appointments and tests); it also includes the indirect and additional expenses arising throughout the entire course of the disease. The following can be mentioned among these indirect expenses: commuting costs; specific eating; hiring or need for caregivers; and reduced or lost incomes as a result of having to be away from work, in addition to the uncertainties and fears related to future financial security[3].

The adverse effect exerted by financial toxicity is not restricted to the patients, as their families jointly experience the impact of the disease, sharing uncertainties, responsibilities and feelings. Family members (especially the closest ones) start to fund both direct/indirect medical costs and expenses not directly connected to health assistance. The expenses resulting from the disease, the productivity loss and the changes or interruptions in employment contracts are factors that significantly impair family incomes. Thus, the cancer diagnosis emerges as a collective event that permeates and mobilizes the entire family nucleus[4-5].

It is also noted that, due to frequent commuting and to other cancer-related requirements, families frequently face a new financial reality that may require adaptations in consumption patterns, selling goods or asking for loans. The distress experienced by the patients can intensify when they seek to reconcile personal and professional life demands with adverse effects, commuting to undergo treatments and increased everyday expenses[6].

Given the above, the objective of this study is to understand how financial toxicity is manifested and interferes in the life of women with cancer.

METHOD

Type of study

A descriptive-exploratory research study with a qualitative approach that integrates an ongoing matrix study entitled "Despite cancer: experiences, reinterpretations, and perspectives after diagnosis and implications for care" and developed with cancer survivors with the intention of understanding how life goes on after the diagnosis of a disease as challenging as cancer. The "cancer survivors" expression is used to refer to people with a cancer history from the diagnosis moment and for the rest of their life, and its purpose is to describe the process of living with, through and beyond cancer[7].

Study participants

The following inclusion criteria were used for this clipping: being aged at least 18 years old; having being diagnosed with any type of cancer; having finished the primary treatment; and living in the state of Paraná. A total of 16 individuals indicated by other participants were not included, as it was not possible to contact them after three attempts on varied days and times to invite them and schedule the interviews. In turn, three subjects were excluded for not making any reference to financial issues during the interview. The process to include new participants was interrupted when it was observed that the information collected started to repeat itself and failed to add substantial material, in addition to determining that the study objective had already been achieved[8].

Possible participants were located with the aid of the non-probability technique called "snowball sampling", in which individuals already taking part in a research study indicate other potential participants for meeting the inclusion criteria[9]. The first subjects to be included in the study were cancer patients followed-up by the Female Cancer Combat Network (Rede Feminina de Combate ao Câncer, RFCC) from the municipality of Maringá-PR. All the participants were initially contacted via WhatsApp text messages. At that moment, they were advised regarding the study (objectives and motivation) and about the type of participation intended; they were also invited to take part in the research. Interviews were scheduled for those who agreed.

Data collection

The data were collected from May to September 2025 by means of semi-structured interviews that were audio-

recorded after due authorization and conducted on a day, time and place defined by the participants and feasible for the researcher, preferably at the former's homes. A total of 10 interviews were conducted remotely (via Google Meet), as the patients lived in municipalities located more than 200 km away.

The interviews lasted between 11 and 62 minutes (with a mean of 30 minutes). A script made up of two parts was used during the conversations: the first part included questions for the sociodemographic, occupational and clinical characterization and the second one had questions referring to life changes after the cancer diagnosis. All the participants were interviewed only once and were not returned the transcriptions for them to complement, correct or even exclude specific parts from their reports. The participants' impressions and behaviors during the interviews were recorded immediately after finishing each meeting.

All the interviews were in charge of the same researcher (a nurse and MSc Nursing student with experience in conducting qualitative research studies) who had no pre-established connection with the participants, with the exception of a participant assisted by the extension project called "Cuidados Paliativos a pessoas com câncer e suas famílias" ("Palliative Care for people with cancer and their families"). The researcher has been part of the care team in the aforementioned project for more than three years (initially as an extension scholarship fellow and currently as an MSc student) in the supervision of undergraduate students.

Data analysis

For the analysis, the sociodemographic data were typed into a Microsoft Excel Office XP spreadsheet; in turn, those of a qualitative nature were recorded in Microsoft Word. The interviews were transcribed in full on the same day they were conducted. At that moment, it was not necessary to contact the participants to clarify any unclear aspects during the interviews.

The transcribed material was subjected to content analysis (in its thematic modality), following the three stages proposed by Bardin[10]. During the Pre-analysis phase, the material was organized based on a floating reading to identify and familiarize with relevant aspects, followed by defining the objectives, selecting the corpus and planning the categorization. Subsequently, the Exploration of the material phase consisted in coding the content by segmenting it into registration units (relevant words, phrases or excerpts) that were grouped into thematic categories. Finally, the results were analyzed, interpreted and related to the study objective in the Data treatment phase; this allowed formulating inferences and better understanding the effects exerted by toxicity on the participants' life[10].

The coding tree was divided into three hierarchical levels: 23 initial codes, directly derived from the participants' testimonies; 14 topics resulting from grouping similar codes; and four thematic categories. This structure is presented in Chart 1.

Chart 1 - Coding tree. Maringá, PR, Brazil, 2024

Codes	Topics	Thematic categories
Distancing from work; wage reduction during treatment	Lost/Reduced income	The burdens of illness: economic impacts on life
Food-related expenses; medication-related expenses	Increased expenses	
Costs related to commuting to treatment; expenses related to specific tests and care measures	Indirect costs inherent to the treatment	
Full health plan coverage; easier access to tests and treatments; no direct expenses related to the treatment	Financial protection in terms of care	When care is welcoming: experiences in health services
Copayments in health plans; costs not covered by plans; expensive medications not provided by the SUS	Care coverage limits	
Treatments in charge of the SUS	—	
Expenses related to tests performed outside the SUS	Additional costs to enable more agility or comfort	
Support from spouses; financial help from families	Financial and emotional support	The supporting basis: financial assistance from support networks
Support from institutions	Community-based care networks	
Financial help from families; donating food and basic items; organizing raffles and solidarity actions	Informal financial support	
Less concern about saving	Change in relation to money	When the present time gains value: lifestyle and consumption changes
Valuing pleasurable experiences	Lifestyle changes	
Consumption targeted at immediate well-being	Attributing a new meaning to consumption	
Sense of urgency toward life	Reorganizing priorities	

SUS: Unified Health System.
Source: prepared by the authors, 2024.

Ethical procedures

The study data were collected after due approval by the Research Ethics Committee of the signatory institution (Opinion No. 7,271,817) and once the participants had signed a Free and Informed Consent Form (FICF) in two copies. In the case of the remote interviews, the FICF was both sent and returned signed via WhatsApp. The study was conducted following the guidelines set forth in National Health Council/Ministry of Health (Conselho Nacional de Saúde/Ministério de Saúde, CNS/MS) resolutions No. 466/2012 and No. 510/2016 and in the guidelines for

research procedures with any of their stages developed in online environments: CONEP 2021. In order to ensure the participants' anonymity, in the presentation of the results the excerpts from their statements have been identified with the letter "P" (for Participant), followed by a number indicating the order in which each interview was conducted and by each participant's age.

RESULTS

The study participants were 24 women aged between 24 and 71 years old: 15 were married, one was divorced, three were single, four were in stable unions and one was a widow. Five of them were already retired and, as for schooling, three had Incomplete Elementary School, seven had completed High School and 14 had completed Higher Education. The times since diagnosis varied from two to 23 years, with 21 women stating breast cancer; another three subjects had gastric cancer, non-Hodgkin lymphoma in the mediastinum and desmoid tumor in the abdominal wall, respectively. None of them had metastasis at the time of the interviews and all had already been subjected to at least one type of treatment (chemotherapy, radiotherapy, surgery, hormone therapy or immunotherapy). It is noted that 19 of all 24 women had some health plan.

After analyzing the interviews, it was evidenced that although financial toxicity is not visible to all, it does exert effects on everyday life, on the care provided to people with cancer and on their quality of life, especially during the treatment. Marked by the coexistence of medical and non-medical expenses, forced adaptations, financial vulnerability and new configurations in the way of living in some cases, the experience undergone allowed identifying four categories, as described below.

The burdens of illness: economic impacts on life

The experiences reported reveal a complex scenario where the diagnosis triggers a chain of unexpected and indirect expenses that involve differentiated eating, tests, commuting or specific medications.

> *I had to stop working because I got a leave from the company, and you earn a whole lot less than before every day, in your job, then it was very difficult even for me.* (P16, 56 years old)

> *Mainly with eating, I also pay the laser doctor out of my own pocket, I spent more money on groceries, medications, I spend more money.* (P1, 48 years old)

> *I had an extra expense with my radiotherapy, which was really far away, then I had to virtually cross the whole city every day, but you tighten your belt here and there and we go balancing.* (P5, 67 years old)

> *My surplus expense was fuel, from commuting, and some pain medication or another and the tests; but I managed to pay everything.* (P7, 60 years old)

> *You spend a lot on medications and commuting, commuting up and down there and it's got to be by taxi where you need to go.* (P12, 71 years old)

When care is welcoming: experiences in health services

Despite the difficulties, some of the interviewees reported positive experiences with their health plans, enjoying full coverage and with guaranteed access to treatments without direct costs.

> *I can't say anything about Unimed because they were a blessing, I managed to do everything, no problems whatsoever, they even provided the medications for the analysis, they treated me really well.* (P4, 53 years old)

> *The plan covered everything, in relation to that, I had no problems at all.* (P8, 52 years old)

> *My health plan is very good, it covered everything thanks God, it's not a copay plan, I've had it for over 20 years, then it covered everything.* (P9, 55 years old)

> *Unimed set me free, I didn't need to pay anything at all, ICU, radiotherapy, all the doctors that followed me up at that time, Unimed paid everything, I never spent but one real.* (P19, 43 years old)

> *The plan paid everything, I underwent the whole treatment at the hospital, they treated me very well.* (P22, 63 years old)

However, even with easy access, the additional costs were significant, showing that formal coverage does not always fully safeguard the patients against treatment-related expenses.

> *You have many additional expenses, no doubt about that. The health plan covered 90% of my treatment. I had no difficulties for the authorizations, but that 10% that's outside the plan was a large expense.* (P2, 65 years old)

> *I pay copayments. Then, for example, even after the diagnosis, this month I'm paying almost 500 reais in copayments, for the routine tests [...] I admit that going to the SUS sometimes crosses my mind, because I have a daughter and all that has some weight on the budget.* (P3, 35 years old)

> *I spent a lot of money, because Unimed imposes copayments there. Then, I had to pay everything I used, the monthly expenses were up to 1,200–1,300 reais, it was too much money for me.* (P18, 39 years old)

The same was noticed among the women that resorted to the Unified Health System and had their needs met.

> *I had no problems from the financial point of view. Because I did everything via the SUS and I didn't need to take any medications afterwards.* (P20, 35

years old)

> *Even if I had a plan, I did my whole treatment via the SUS.* (P21, 58 years old)

However, some participants reported additional costs associated with seeking more comfort and agility in performing some tests.

> *Then we spent quite a lot of money on tests, tests that had to be faster and that were not covered by the SUS.* (P10, 49 years old)

> *My parents also had to help me financially, because there's this medication that the SUS sometimes doesn't provide and then you just have to buy it, and you also need to buy some medications for comfort.* (P13, 24 years old)

Situations characterized by deeper financial vulnerability emerged notably in some of the reports, evidencing debts, unpaid bills and impossibility to sustain previous life standards.

> *My financial situation hasn't just hit rock bottom, it's already gone below that level, even with my health plan I have to pay 30% of a quite expensive treatment [...] I'm on credit, I'm in arrears on my car installments, I haven't paid the insurance policy. I'm also behind on my water and electricity bills.* (P6, 44 years old)

> *I used to earn my little money before, I had money every day and my minimum retirement income. If I don't have medications I buy them, I no longer find it that easy to do many things [...] In addition to the medication that the government provides, I need to buy others to feel better, and food too, everything is really expensive.* (P17, 50 years old)

Finally, some participants stated unexpected expenses due to limitations in their treatments, such as the SUS not providing expensive medications or having to resort to financial reserves.

> *I had to spend around 5,000 because they made a mistake with my protocol in the treatment, they had to change it [...] they had to put me an injection for immunity (it was one a day), I took 28 in all, seven injections cost around 900+ reais. Then I had an expense there because the SUS doesn't provide that; but I had some money saved thanks God.* (P15, 50 years old)

The supporting basis: financial assistance from support networks

The repercussion in the participants' financial life revealed a scenario marked by unexpected expenses, adaptations in family budgets and need for external support.

> *I needed help; it was then that my support network helped us with a basic food basket, and hygiene items. My long-distance family organized raffles... they did a lot of things to help me too.* (P10, 49 years old)

> *My mother's employer also helped, when I had to undergo radiotherapy I got a burn in my breast, for example, then I had to buy an ointment for 300 reais, she bought it, she helped. Then all these people were financially essential.* (P11, 35 years old)

> *Everyone helped me, even here from the women's network, because I was unemployed for some time, then I enrolled and got the baskets, things like that.* (P23, 60 years old)

> *If it hadn't been for my husband that provided financial and emotional help for everything at that moment, I don't know what it would've been like... There's also medications and eating in addition to all the treatments.* (P24, 50 years old)

> *My mum helped me at that time, she was a domestic worker, and my husband also helped me then because we ended up paying copays.* (P11, 35 years old)

When the present time gains value: lifestyle and consumption changes after the disease

The cancer diagnosis also triggered changes in the way in which the women related to money and to their own life. When they admitted that they already needed to pay high treatment costs, they started not limiting themselves so much and allowing themselves to undergo experiences they used to avoid.

> *I almost didn't go out to different places before; I love cafeterias, then I now sometimes go to some coffee shop or another, I want to know places, I will spend a lot of money, I leave an arm and leg there sometimes but I go, because I also spend money on copays.* (P3, 35 years old)

> *I stopped that thing of saving, saving, I don't do that anymore.* (P14, 61 years old)

> *The diagnosis imposed some sense of urgency on me. I used to think: 'that's expensive or I'm not going to eat that, I'll choose something cheaper', now if I'm eating out, I'm going to order that dish. Can I pay for it? Then I'm going to eat that.* (P9, 55 years old)

DISCUSSION

The results found in this study evidence that the socioeconomic impact exerted by cancer constitutes an important axis in the disease experience, directly affecting everyday life, financial balance, economic autonomy and family dynamics. These findings are in line with the concept of "financial toxicity", defined as experiences undergone by patients facing difficulties to pay for their treatment

expenses and who oftentimes are affected by lost income, debts, anxiety, depression and stress, even in systems that offer some degree of assistance-related coverage[6].

As evidenced in this study, a survey conducted with cancer patients in Malaysia indicates that people with cancer experience a significant increase in the everyday expenses related to the disease-treatment process. This is not only associated with direct costs in medications, private medical appointments and copayments in health services; it also includes indirect expenses that accumulate silently, such as differentiated eating, nutritional supplements, buying specific inputs and adaptations in the home environment[11].

Oftentimes unexpected and recurrent, these costs become one of the main elements that intensify economic vulnerability while coping with the disease. When the participants' testimonies point to higher expenses related to groceries, complementary therapies, commuting to appointments and undergoing specific tests when the public system fails to offer quick responses, they illustrate the complexity and breadth of this phenomenon. Similarly, these aspects were evidenced in a systematic review that analyzed 105 studies conducted in the United States, Canada, Western Europe and Australia, consistently showing the financial burden faced by people diagnosed with cancer[12].

Even among patients with health plans, access to the supplementary system does not remove the financial toxicity risks; to the contrary, it oftentimes displaces the economic impact to other care dimensions. Two Brazilian studies corroborate this finding. Both of them focused on catastrophic health expenses, respectively defined in each study as those exceeding 10% and 25% of a family's income. The results indicated that the copayment model can generate disprotection, especially among low-income families, as it forces them to choose between treatment continuity and meeting basic needs, deepening already existing socioeconomic inequalities[13-14].

Similarly to the findings detected in these studies, a survey reveals that, although the SUS ensures full coverage for most therapies, indirect costs such as commuting, differentiated eating and medications not frequently standardized are up to the patients. Consequently, even in universal public systems, formal free access does not preclude the existence of costs that affect material life[15].

In addition, more severe situations such as debts, unpaid bills and financial autonomy losses are directly in line with international research studies that indicate financial toxicity as associated with worse quality of life, psychological distress and higher treatment non-adherence risks. Likewise, they showed that patients who face financial crises during their treatments are at an even higher mortality risk, evidencing the profound impact exerted by the economic dimension on therapeutic progress[16-17].

The change in roles also evidences the repercussions of cancer in women's social and professional life. Although unemployed or temporarily disabled cancer survivors wish to return to their jobs for different personal and contextual reasons, absence of suitable support and doubts about their own capabilities end up rendering this resumption more complex[18-19].

Given this context, the essential role of support networks stands out. In addition to financial help, family members and friends are direct actors in solving bureaucratic issues in health services and offer support in terms of commuting, lodging, medications and food. This social support contributes significantly to strengthening confidence, favoring adherence to treatments and promoting improvements in emotional well-being[20].

Therefore, cancer exerts direct effects on family dynamics. In many cases, the disease strengthens ties, stimulating union, care and support by means of the already existing networks. However, the routine marked by frequent commuting to undergo treatments can distance the patients from their home environment and from sharing time with other relatives, requiring some internal reorganization, which evidences that cancer imposes transformations of an emotional and financial nature on families[20].

In the current research, the women under study showed that they started valuing their well-being, small pleasures and the present time more. This finding corroborates results from a study conducted with 50 patients in Poland, which evidenced that cancer diagnoses can trigger a reconfiguration of individual values such as happiness, true friends, inner harmony and family confidence, which tend to gain more importance as the search for material accumulation becomes less necessary[21].

Understanding financial toxicity as a critical clinical outcome imposes reconfiguring ethics in terms of Nursing care and health management. By evidencing that the economic burden intensifies psychological distress (even with the possibility of interrupting the therapy), the findings of this study leave no space for doubting that the assistance provided cannot be limited to the biomedical model and should include socioeconomic surveillance as a patient safety strategy.

For managers and public policy-makers, this implies transiting towards a life sustainability view where SUS integrality and supplementary health regulation should be active in mitigating catastrophic expenses. The absence of supporting policies that ensure mobility, nutrition and protection to women's work supposes the risk of offering technologically advanced treatments to patients who will not be in due conditions to access or finish them due to financial exhaustion, perpetuating health vulnerability and inequality cycles.

Some possible study limitations are related to the fact that the sample was solely comprised by women and that most of them had some health plan, which may have influenced the way in which they experienced and reported financial toxicity, in addition to circumscribing the findings (or at least some of them) to this population group. Anyhow, the study results are valid and reinforce that cancer diagnoses impose profound changes on financial and material life, requiring changing habits, redefining priorities and, oftentimes, increasing dependence on third parties.

CONCLUSION

The results found in this study signal the importance of financial issues in the life of people with cancer and show that financial toxicity shapes the experiences related to the disease and its treatment. By evidencing that the economic impacts go beyond direct treatment costs, the study

allowed understanding how this phenomenon is manifested in everyday life, reaching a scale that directly interferes in well-being, in treatment continuity and even in family life organization.

Even in contexts where treatments are covered by the SUS or by health plans, some expenses require budget adaptations, even with the possibility of triggering debts and dependence on support networks. The indirect expenses are a result of distancing from work (even if temporarily), which leads to lower incomes, and of the daily need to commute to treatment centers, as well as of the need for differentiated eating or to buy medications to overcome the adverse events inherent to the treatment.

Although varied, these experiences share a common trait: recurrence of costs that accumulate continuously and silently, exerting impacts on economic autonomy and quality of life. Such findings reinforce the need to acknowledge financial toxicity as an intrinsic cancer care dimension, demanding policies that enhance social welfare, financial security and equal access to treatments.

In synthesis, this study reinforces that financial toxicity needs to be recognized as a relevant adverse effect of cancer treatments, requiring intersectoral efforts sensitive to each patient's socioeconomic reality. Taking this dimension into account is fundamental to make progress in terms of more comprehensive, fair and humanized care practices, capable of not only welcoming the disease itself but also the entire set of repercussions it imposes on life.

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CONFLICT OF INTERESTS

The authors declare no conflict of interests.

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AUTHOR CONTRIBUTIONS

Study design: Gomes BJO, Garcia GMC, Mantovani EB, Ferreira PC, Nogueira LC, Marcon SS.
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Data analysis: Gomes BJO, Garcia GMC.
Data interpretation: Gomes BJO, Garcia GMC, Nogueira LC, Marcon SS.
All authors are responsible for the textual writing and critical review of the intellectual content, the final version published, and all ethical, legal, and scientific aspects related to the accuracy and integrity of the study.