

THE WORKPLACE IMPERATIVE TO PREVENT, DETECT, AND TREAT CANCER

I. PREAMBLE AND MISSION CONTEXT

The Cancer Alliance is a global collective (hosted by ISOPT) dedicated to advancing cancer prevention, early detection, and treatment education across all nations and sectors of society. Our founding conviction is that half of all cancers are preventable or curable with knowledge and technology available today, and that closing the gap between what is known and what is practiced requires sustained, coordinated action by medical professionals, policymakers, and the private sector alike.

A healthy workforce has long been recognized as a strategic priority by leading organizations worldwide. For decades, institutions including the World Health Organization, the Union for International Cancer Control, the World Economic Forum, the U.S. Centers for Disease Control and Prevention, the American Cancer Society, the Milken Institute, and major academic cancer centers across six continents have documented the value of workplace health programs and built a substantial body of evidence and recommendations for the business community. The moral case is clear. The scientific case is compelling. Yet a convergence of new and urgent forces now demands that corporate leaders act on that evidence with a resolve that previous generations did not need to summon, because the stakes, and the opportunities, have never been greater.

What has fundamentally changed, and what will define the next decade of workforce health, is the convergence of five accelerating realities.

First, cancer is increasingly striking adults aged 25 to 64 at precisely the moment when their economic contributions and family responsibilities are greatest. This working-age population represents the most productive segment of every nation's workforce and, paradoxically, one of the least protected by conventional screening systems.

Second, science has firmly established that modifiable lifestyle factors, including tobacco use, obesity, physical inactivity, excessive alcohol consumption, and poor nutrition, account for nearly 40% of all cancers globally, and that the workplace is one of the most powerful environments available for changing these behaviors at scale.

Third, treatment advances, while genuinely remarkable, are no substitute for early detection, and early detection achieves its full value only when connected to timely diagnostic confirmation, staging, and access to multidisciplinary cancer care. Today's most effective therapies are also the most intensive, prolonged, and expensive, meaning that every late-stage diagnosis represents not only a profound human cost but an enormous and largely avoidable financial burden on patients, families, employers, and national health systems alike.

Fourth, the science of prevention and early detection has been transformed, and health benefits need to modernize. Molecular diagnostics, genetic testing, risk-based screening technologies, next-generation vaccines, and precision surgical interventions now make it possible to identify cancer risk, detect disease at its earliest and most treatable stage, and intervene before harm becomes irreversible, at a scale and accuracy that were unimaginable a generation ago.

Fifth, and most urgently: approximately half of all cancers are preventable or curable using knowledge and technologies that already exist (Emmons and Colditz, 2017). The barrier is not scientific. It is organizational. This reality constitutes a direct call to every corporation, government, and health organization worldwide to act on evidence that is already sufficient, with tools that are already available, to save lives that need not be lost.

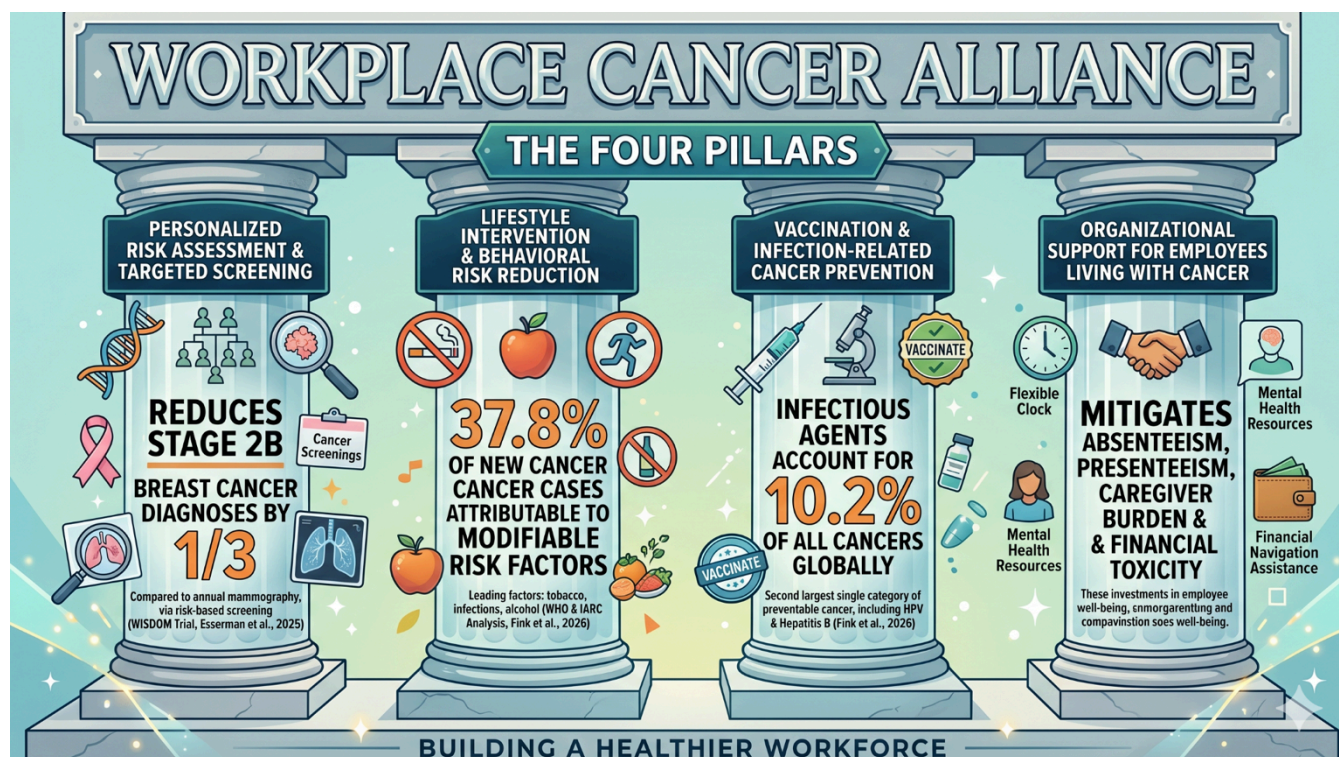
Every prevention and early detection program must be connected to clear pathways for abnormal findings, including timely diagnostic confirmation, pathology, staging, referral to multidisciplinary treatment, survivorship support, and return-to-work planning. Early detection is not an end in itself. It fulfills its promise only when linked to timely, high-quality cancer care.

II. STRATEGIES FOR CORPORATE IMPLEMENTATION

Workplaces represent a uniquely powerful platform for cancer prevention and early detection, one that no other sector of society can replicate at comparable scale. They provide structured, recurring access to large populations of working-age adults: precisely the population most at risk and least served by conventional community-based screening. Employers also have a compelling and quantifiable vested interest in activating that platform. As documented in Finding 3, premature cancer deaths among working-age adults generated a global productivity loss of US\$566 billion in 2022 alone, equivalent to 0.6% of global GDP, and the cumulative global macroeconomic cost of cancer from 2020 to 2050 is projected at \$25.2 trillion (Kong et al., JNCI, 2025; Chen et al., JAMA Oncology, 2023). The workplace is not merely a convenient venue for cancer prevention and early detection. It is the most consequential one available.

The Four Pillars of an Effective Workplace Cancer Prevention and Early Detection Program

Drawing on peer-reviewed literature and the landmark studies synthesized in this Declaration, the Cancer Alliance identifies four evidence-based pillars on which every effective workplace cancer prevention and early detection program should be built.



The first pillar is personalized risk assessment and targeted screening. Every effective program begins with identifying the employees most at risk, through genetic testing where feasible, family history evaluation, and risk-stratified screening protocols for high-prevalence cancers including breast, cervical, colorectal, and lung cancer.

The second pillar is lifestyle intervention and behavioral risk reduction. The workplace is one of the most effective environments available for addressing these factors at scale. Programs encompassing tobacco cessation, nutritional guidance, weight management, alcohol reduction, and physical activity promotion engage the behavioral drivers of cancer at the precise point in daily life where they are most accessible and most amenable to sustained change.

The third pillar is vaccination and infection-related cancer prevention. HPV and hepatitis B vaccination, delivered through occupational health infrastructure that already exists in most organizations, eliminate the viral infections responsible for the majority of infection-attributable cancers before clinical disease develops.

The fourth pillar is organizational support for employees living with cancer. Flexible work arrangements, mental health resources, caregiver accommodations, and financial navigation assistance are not peripheral benefits. They are organizational investments that directly mitigate the absenteeism, presenteeism, caregiver burden, and financial toxicity determine whether an employee living with cancer can remain a contributing member of the workforce through and beyond treatment. Every prevention and early detection program must also be connected to clear pathways for abnormal findings, including timely diagnostic confirmation, pathology, staging, referral to multidisciplinary treatment, survivorship support, and return-to-work planning. Early detection fulfills its promise only when it is linked to timely, high-quality cancer care.

All four pillars must be adapted to the social, economic, cultural, and technological context of each corporate location. A program designed for a well-resourced organization in a high-income country with ready access to molecular diagnostics and genetic testing infrastructure carries different implementation requirements than the same program adapted for a workforce in a setting with more limited clinical resources. Both are valuable. Both are achievable. And the evidence base to support both is sufficient to act on now.

Removing Barriers to Participation

The most rigorously designed prevention and early detection program delivers no benefit if employees cannot or do not participate. Participation is not a secondary consideration. It is the primary determinant of whether a program achieves the population-level impact that makes it cost-effective. The barriers to participation are well understood and include: time constraints, limited health literacy, financial concerns, language and cultural distance, and privacy fears about genetic and health information. They are also, without exception, solvable.

The scale of the participation gap makes this a matter of urgency. Research published by the Working with Cancer Pledge found that 20 million U.S. workers neglect to use available time off for cancer screening, and that up to 100,000 American lives could be saved annually through raised screening compliance alone (Working with Cancer Pledge, 2025). Among private-sector workers in the United States, cancer screening rates were measurably higher in regions where paid sick leave mandates had been adopted, establishing that the absence of paid leave presents a direct and quantifiable barrier to cancer screening (Callison et al., NEJM, 2023). A nationwide study across Japan found that manual workers had significantly lower cancer screening participation rates than upper non-manual workers across colorectal, lung, stomach, and cervical cancers, confirming that participation barriers fall most heavily on the employees least likely to access screening through alternative channels (Tanaka et al., BMC Cancer, 2025). Designing for participation is not an afterthought. It is a primary obligation of program design.

Evidence-based solutions consistently shown to increase participation include paid time off for screening and vaccination appointments; on-site or near-site program delivery; multilingual and culturally adapted educational materials; and confidential genetic testing with professional counseling. The systematic review of 21 workplace cancer screening interventions established that on-site delivery and paid appointment time were the most consistently powerful enablers of screening uptake across all cancer types and national contexts examined (Cavers et al., BMC Cancer, 2024). Organizations should also account for the ways in which cultural norms, language barriers, and varying levels of health literacy across different corporate locations may suppress participation among specific workforce segments and design outreach strategies accordingly.

When employees receive a proactive, comprehensive health assessment that identifies their specific cancer risks, including genetic, familial, and behavioral, they are significantly more likely to engage with prevention and screening programs not as isolated interventions but as sustained, lifelong commitments. Understanding one's personalized cancer risk transforms participation from a compliance behavior into a personal investment. Employer-sponsored health assessments that deliver this level of personalized insight are not merely a clinical

tool. They are the foundation of a prevention and early detection culture that sustains and strengthens itself over time.

Workplace Culture as the Multiplier

Programs and participation rates are necessary but not sufficient. The evidence consistently shows that the organizational culture in which a prevention and early detection program operates is as consequential as the program itself. A systematic review of organizational determinants of cancer screening participation, spanning studies published between 2015 and 2025, found that successful programs share a set of organizational features beyond clinical design: coordinated management, personalized outreach, community trust-building, culturally adapted education, and continuous quality monitoring. Programs lacking these features consistently underperformed clinically comparable programs that had them, regardless of the screening modality offered (Amicizia et al., *Cancers*, 2025). Culture is not a background condition. It is an active determinant of whether a program works.

The returns of building that culture are documented and substantial. A study of more than 2,000 HR leaders across nine countries found that 95% of organizations measuring the return on investment of corporate wellness programs reported positive returns, with 99% reporting that wellness programs increase employee productivity and 91% reporting measurable decreases in healthcare benefit costs as a direct result (Wellhub Return on Wellbeing Report, 2024). Reduced absenteeism, lower disability claims, shorter treatment durations, and higher retention rates are not incidental benefits of a strong prevention and early detection culture. They are its direct and documented economic consequences. The organization that invests in the health of its people is not making a concession to social responsibility. It is making one of the most strategically sound investments available to any leadership team, with returns that compound year over year as prevention and early detection becomes embedded in how the organization operates.

III. MEASURING SUCCESS

Corporate investment in cancer prevention and early detection must be accompanied by rigorous, transparent measurement of outcomes: to validate what works, to identify what does not, to make the financial and human case visible to the leaders and shareholders who must sustain these investments, and to build the global body of evidence that will accelerate adoption across every industry and every nation. Measurement must also account for the reality that these strategies will be implemented across profoundly different national, cultural, and economic contexts, with varying access to molecular diagnostics, genetic testing infrastructure, and screening technologies. Effective accountability frameworks are therefore not uniform checklists. They are adaptive instruments calibrated to what is feasible, measurable, and meaningful in each corporate location, while remaining anchored to the universal standards of evidence that make cross-organizational learning possible.

Organizational Adoption

The first measure of success is institutional commitment: the number of corporations, governments, and health organizations that formally adopt this Declaration and publicly align their health strategies with its principles. Adoption is not a symbolic act. It is a public commitment, communicating to employees, shareholders, communities, and peer organizations that the institution has accepted responsibility for the cancer prevention and early detection outcomes of the people it employs and serves. Organizations operating in settings with limited access to advanced screening technologies or molecular diagnostics should document their adoption commitments alongside their resource context, enabling the global community to assess progress accurately and to direct technical support and capacity-building investment where it is most needed.

Program Initiation and Expansion

Commitment must be followed by action. Adopting organizations should report annually on the cancer prevention and early detection programs initiated, expanded, or strengthened as a direct result of adopting this Declaration, including personalized risk assessment and genetic testing programs where technology access permits, family

history screening initiatives adaptable to all resource settings, workplace vaccination campaigns calibrated to locally prevalent infection-related cancers, lifestyle intervention programs responsive to the behavioral and cultural norms of each workforce, and on-site or near-site screening services appropriate to local healthcare infrastructure. Progress should be measured against pre-adoption baselines and tracked year over year, with findings contributed to shared data platforms to enable benchmarking across industries, geographies, organizational sizes, and resource contexts. Organizations in lower-resource settings that cannot yet implement the full program spectrum should be recognized and supported for the progress they achieve within their constraints, rather than measured against standards designed for settings with unrestricted access to technology and clinical infrastructure.

Employee Participation Rates

Population-level impact requires population-level participation. Adopting organizations should measure and report annual participation rates for each prevention and screening program offered, including the proportion of identified high-risk employees who engage with targeted interventions. Participation rates should be disaggregated by program type, demographic group, geography, and workforce segment to identify access gaps and guide targeted outreach. Participation data is among the most actionable metrics available to program designers: it reveals not only how many employees are being reached but which populations remain unserved, and where the next effort should be directed. Organizations should also account for the ways in which cultural norms, language barriers, and varying levels of health literacy across different corporate locations may suppress participation among specific workforce segments, and should design outreach strategies accordingly.

Financial Return on Investment

The financial case for prevention and early detection is one of the most powerful arguments available for sustaining corporate commitment over time, and it must be measured explicitly. Adopting organizations should track and report the year-over-year change in cancer-related healthcare expenditures, including treatment costs, disability claims, and insurance utilization, attributable to their prevention and early detection programs. Where programs are generating the 4:1 to 12:1 returns documented in this Declaration, that evidence should be shared widely and without reservation. Return on investment calculations should be contextualized to local healthcare cost structures and benefit systems, recognizing that the financial architecture of prevention differs substantially between high-income countries with advanced insurance infrastructure and lower-resource settings where out-of-pocket costs and productivity losses carry a proportionally greater burden.

Reduction in Cancer-Related Absenteeism and Presenteeism

A measurable reduction in the days employees lose from work due to cancer diagnosis, treatment, and recovery is one of the most direct expressions of program effectiveness available to any organization. Adopting organizations should report annually on the change in cancer-related absenteeism, including treatment-related absences and disability claims, and where possible on the change in presenteeism rates among employees managing cancer or cancer treatment, relative to pre-program baselines. The relationship between cancer stage at diagnosis and subsequent absenteeism is among the most well-documented in the health economics literature, making this metric a particularly sensitive indicator of whether early detection programs are functioning as intended.

Reduction in Cancer-Related Morbidity and Mortality

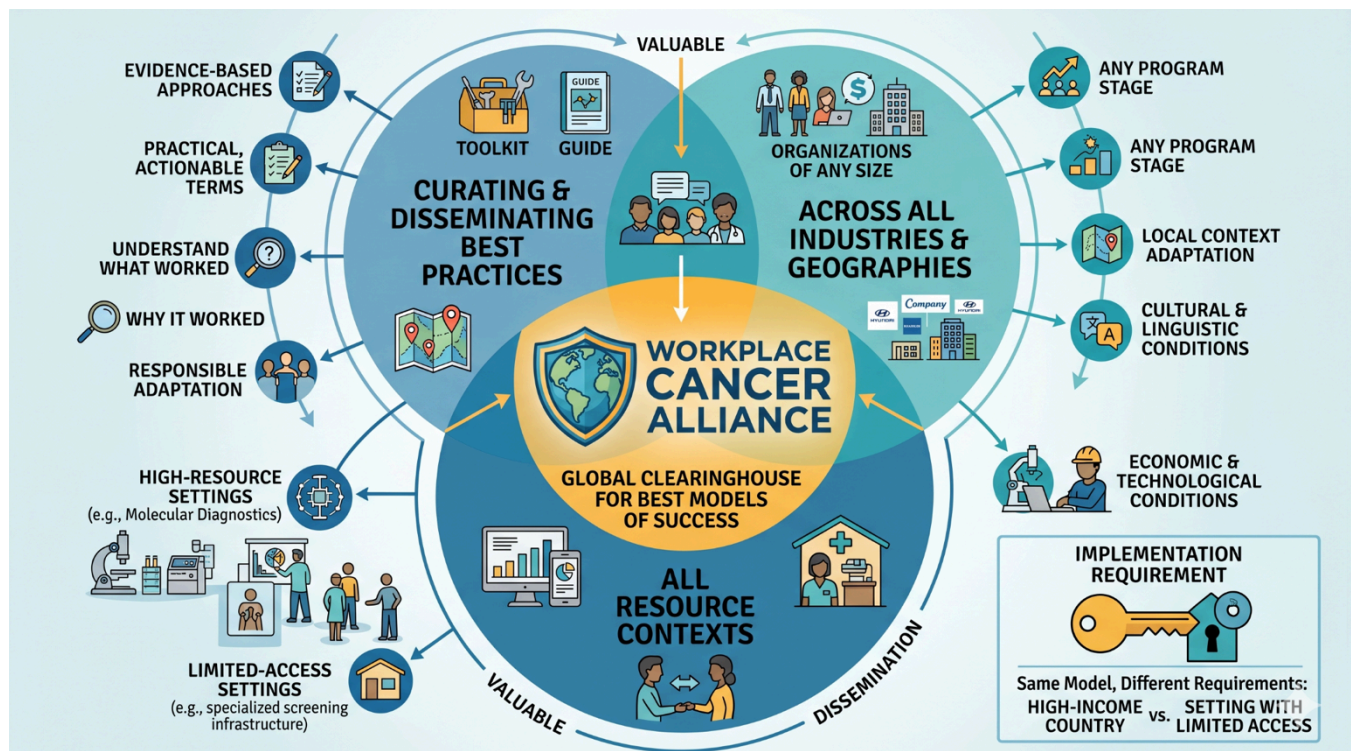
The ultimate measure of success is better outcomes and lives saved. Outcome metrics should include age, sex, and stage at cancer diagnosis; time from abnormal screening to diagnostic confirmation; time from diagnosis to first treatment; treatment completion rates; survivorship outcomes; and return-to-work support utilization. Adopting organizations should track and report the year-over-year change in cancer-related mortality among employees relative to pre-program baselines and relevant population benchmarks. Organizations in settings with limited access to molecular staging, pathology infrastructure, or advanced imaging should report on the metrics that are available within their context and should be supported in building the data collection capacity needed to expand their measurement over time.

Data Collaboration and Shared Learning

No single organization's dataset will be statistically sufficient to demonstrate population-level impact. That is precisely the argument for data collaboration. When organizations contribute de-identified program and outcomes data to a shared registry, whether through a consortium of peer employers, an academic research partnership, or a national health surveillance system, individual datasets aggregate into population-scale evidence capable of demonstrating program impact, informing national policy, and making the case for prevention and early detection in terms no financial metric can fully capture. Collaboration transforms what each organization knows into what every organization can learn from.

IV. BEST PRACTICES AND SHARED MODELS OF SUCCESS

Many corporations worldwide have already made meaningful investments in workplace cancer prevention and early detection, accumulating valuable operational experience, clinical partnerships, and measurable outcomes that the broader employer community urgently needs. The Cancer Alliance will serve as a global clearinghouse for best models of success, curating and disseminating the most effective, evidence-based approaches to workplace cancer prevention and early detection from organizations across all industries, geographies, and resource contexts. Best practices will be presented in practical, actionable terms that allow organizations of any size, and at any stage of program development, to understand what worked, why it worked, and how to adapt it responsibly to their own workforce context, including the cultural, linguistic, economic, and technological conditions that shape what is feasible in each corporate location. A model that succeeds in a well-resourced organization in a high-income country carries different implementation requirements than the same model adapted for a workforce in a setting with limited access to molecular diagnostics or specialized screening infrastructure. Both are valuable. Both deserve documentation and dissemination.



The goal is to accelerate the transfer of knowledge across the global corporate community at a speed commensurate with the urgency of the cancer burden it is designed to address. Every organization that learns from a proven model and implements it effectively becomes a potential source of new evidence and a new contributor to the global community of practice. The evidentiary foundation for workplace cancer prevention and early detection grows stronger with each program that measures, shares, and builds on its results.

APPENDIX:

FINDING 1: THE RISING CANCER BURDEN AMONG WORKING-AGE ADULTS

Cancer remains a leading cause of morbidity and mortality worldwide, with an estimated 20.9 million new cases and 9.9 million deaths recorded in 2024 alone (Bray, 2024). A critical and largely underrecognized dimension of this burden falls on working-age adults between the ages of 25 and 64. Global epidemiological data accumulated over the past two decades reveals a steady and significant rise in cancer incidence among this age group across every region studied.

An international analysis spanning 44 countries found that incidence rates for major cancers, including colorectal, breast, and prostate cancer, have increased across middle-aged cohorts in the majority of nations examined (Pilleron et al., 2022). A landmark global review concluded that early-onset cancer has emerged as a rising epidemic across multiple cancer types and geographies (Kundu R. et al. 2026, Ugai et al., 2022). In the United States, a comprehensive NIH analysis of more than two million cancer cases confirmed that between 2010 and 2019, incidence rose for 14 of 33 cancer types among adults under 50, with the largest increases in breast, colorectal, kidney, and uterine cancers (Shiels et al., 2025). In some regions, cancer diagnoses among adults aged 40 to 64 have risen by 20 to 30% over the past fifteen years. In the United States, illustrative of trends seen across the world, adults aged 45 to 54 account for 11% of all new cancer diagnoses, while those aged 55 to 64 account for an additional 24%, together representing 35% of all cases nationally. Cancer incidence rises steadily from early adulthood onward and working-age cohorts now represent a growing and disproportionate share of the global caseload.

These are not abstract statistics. They are the people who manage organizations, raise families, teach children, care for patients, build businesses, and keep economies moving, in every nation and at every income level, taken in the years when their contributions matter most and their absence is felt most deeply. Behind every data point is an organization that lost someone irreplaceable, a family that lost someone irretrievable, and a community that lost someone who will not be forgotten. That loss is largely preventable. And preventable loss, allowed to continue, is not a tragedy. It is a choice.

FINDING 2: THE STRUCTURAL FAILURE OF STANDARD SCREENING GUIDELINES TO PROTECT WORKING-AGE ADULTS

The epidemiological burden documented in Finding 1 is compounded by a systemic one. Most population-based screening guidelines were designed for older age groups whose cancer risk profiles differ substantially from those of younger working-age adults. As a result, working-age adults routinely fall outside the parameters of early detection at precisely the stage when intervention would be most effective and least costly. The consequence is both predictable and largely preventable: the majority of working-age cancer patients are diagnosed at an advanced stage, when treatment is more aggressive, outcomes are poorer, and the human and financial costs are vastly greater than they need to be.

Approximately 20% of working-age adults carry elevated cancer risk due to inherited genetic mutations, a family history of cancer, or modifiable lifestyle factors including obesity, smoking, excessive alcohol consumption, and physical inactivity (IARC, 2024). Identifying these individuals early, ideally between the ages of 25 and 40 and before cancer develops or advances beyond the reach of curative treatment, represents one of the most consequential opportunities available to employers and health systems today.

The clinical evidence is unambiguous. Individuals with BRCA mutations who begin annual mammography at age 30 have a 90% probability of detecting breast cancer at an early, curable stage, compared to only 40% if screening

is deferred until age 50 (NCI, 2024). Those with Lynch syndrome who begin colonoscopy at age 25 experience an 85% reduction in late-stage colorectal cancer diagnoses (IARC, 2024). These are not aspirational outcomes. They are achievable with tools and knowledge that exist today, applied to populations that current screening guidelines leave systematically unprotected.

At the population level, targeted early detection programs can reduce cancer-related mortality by up to 20% and lower treatment costs by 30 to 40% (IARC, 2024). The gap in protection is real. The means to close it are available. What is required is the organizational will and institutional infrastructure to act.

FINDING 3: THE ECONOMIC CONSEQUENCES OF LATE-STAGE CANCER DIAGNOSIS

The financial burden of late-stage cancer diagnosis extends far beyond the walls of a hospital or the balance of an insurance claim. It is borne by patients and their families, by employers absorbing the costs of prolonged absence and lost productivity, by health systems strained by treatment expenditures that early detection could have dramatically reduced, and by national economies depleted of the human capital they depend on to grow. The scale of this burden, documented across multiple countries and healthcare systems, makes an inescapable case for prevention and early detection.

For patients and their families, the financial consequences of an advanced cancer diagnosis can be as devastating as the diagnosis itself. A systematic review and meta-analysis found that financial toxicity, defined as the severe financial hardship imposed by cancer-related costs, affects 35.3% of cancer patients in high-income countries and 78.8% in those in low- and middle-income countries (Ehsan et al., 2023; Kitaw et al., 2025). Patients experiencing financial hardship delay or forgo treatment, reduce medication adherence, and exhaust savings accumulated over working lifetimes. They return to work before they are medically ready or cannot return at all. Financial toxicity is not a secondary consequence of cancer. It is a primary driver of the poorer outcomes, higher system costs, and greater productivity losses that late-stage diagnosis consistently produces. Addressing it is inseparable from addressing the cancer burden itself.

The cost differential between early and late-stage diagnosis is among the most consistently documented findings in cancer health economics. A landmark study of more than half a million patients across 17 cancer types found that diagnosis at the most advanced stages generated costs up to seven times higher than diagnosis at Stage I (Reddy et al., 2022; McGarvey, 2022). First-year treatment costs for Stage IV cancer ranged from 1.6 to 7.7 times those of Stage I depending on cancer type, with elevated costs evident as early as six months after diagnosis and persisting for at least five years, a prolonged financial burden that extends well beyond the period of acute treatment. These findings, while drawn from a single national context, are consistent with cost-differential data reported across health systems in Europe, Asia, and beyond.

The productivity dimension of this burden is equally consequential. A landmark IARC study estimated that premature cancer deaths among working-age adults aged 15 to 64 generated a global productivity loss of US\$566 billion in 2022 alone, equivalent to 0.6% of global GDP, encompassing both paid and unpaid work across 36 cancer types in 185 countries (Kong et al., 2025). The cancers responsible for the greatest productivity losses, including lung, colorectal, and liver cancer, are also among the most preventable. Tobacco cessation, improved nutrition, reduced alcohol consumption, and hepatitis B vaccination are interventions with well-documented efficacy and well-documented returns on investment. The human capital these cancers deplete need not be lost. The financial burden they impose need not be incurred. Prevention and early detection, applied with genuine organizational commitment and at sufficient scale, can recover both.

FINDING 4: THE HIDDEN WORKPLACE COST OF LATE-STAGE DIAGNOSIS: ABSENTEEISM, PRESENTEEISM, AND CAREGIVER BURDEN

Absenteeism and Presenteeism

The difference in workplace impact between an early-stage and a late-stage cancer diagnosis is the difference between a managed disruption and a prolonged organizational burden. A landmark study documented this divergence with precision; among employees with metastatic cancer, days absent from work reached 33 at three months post-diagnosis, 64 at six months, and 106 at twelve months, representing 2.3 to 2.4 times more lost workdays than their early-stage counterparts, who missed 15, 27, and 46 days over the same intervals respectively (Cong et al., 2022). Late-stage patients were also significantly more likely to transition to short-term or long-term disability claims, with the indirect cost differential between early- and late-stage patients ranging from \$6,877 to \$22,283 in the first year alone. These findings are consistent across geographies. A systematic review of 21 workplace studies found that employees diagnosed with late-stage cancer missed an average of 47 workdays annually, nearly seven times the 7-day average recorded for early-stage patients (Hsu et al., 2024).

Beyond absenteeism, late-stage cancer generates a second and less visible form of productivity loss: presenteeism. This is the condition in which employees remain physically present at work but are so diminished by illness, treatment side effects, pain, fatigue, or psychological distress that their effective contribution is severely reduced. Among late-stage cancer patients, presenteeism reduces individual productivity by 40 to 60%, while simultaneously straining team dynamics and imposing performance costs on the colleagues and systems around them (Ali MA et al. 2026, So et al 2022, WHO, 2024). Unlike absenteeism, presenteeism does not appear in attendance records or disability claims. It is absorbed silently by teams, managers, and organizations that rarely recognize it as a cancer-related cost and almost never account for it when assessing the full financial impact of a late-stage diagnosis.

The Hidden Burden of Caregiving

Late-stage cancer creates a secondary wave of workplace disruption that organizations rarely account for: the productivity loss sustained by the family members and colleagues who provide informal care (Bradley et al., 2023). Advanced cancer requires intensive caregiving, including coordination of medical appointments, transportation, medication management, nutritional support, and sustained emotional presence, that consistently and unavoidably spills into working hours. The employees who absorb this burden experience their own cycles of absenteeism and presenteeism, driving up organizational costs through unplanned coverage, overtime, and attrition. This burden is not incidental. It scales directly with the stage at which cancer is diagnosed. Earlier detection means less intensive caregiving demands, shorter treatment durations, fewer workplace disruptions, and materially lower hidden costs for every organization that employs a caregiver.

Financial Hardship and Its Organizational Consequences

The workplace costs of late-stage cancer do not stop at the boundary between an employee's professional and personal life (McGarvey, 2023). Financial toxicity, defined as the severe financial hardship imposed on patients and families by cancer-related costs, reaches deep into organizational performance. Employees experiencing financial distress demonstrate elevated rates of presenteeism, heightened mental health burden, reduced engagement, and increased voluntary turnover, all of which erode team stability, institutional knowledge, and organizational effectiveness. Financial hardship is not a peripheral consequence of cancer. It is an active driver of the workplace costs that employers bear, and it is substantially more prevalent and more severe when cancer is diagnosed at a late stage.

Taken together, the evidence on absenteeism, presenteeism, caregiver burden, and financial toxicity establishes a comprehensive and quantifiable case. The stage at which an employee's cancer is diagnosed is among the most consequential variables in the total organizational cost that cancer imposes. Earlier detection does not merely improve survival. It reduces absenteeism, shortens disability, limits caregiving disruption, mitigates financial

hardship, and preserves the team cohesion and institutional knowledge that no organization can easily replace. The human and financial returns of early detection accrue simultaneously, and they accrue to everyone.

FINDING 5: THE ECONOMIC RETURN OF CANCER PREVENTION AND EARLY DETECTION

The preceding findings document what is lost when cancer is caught late: lives shortened, workdays surrendered, productivity eroded, healthcare systems strained, and families devastated by costs that timely intervention could have dramatically reduced. This finding documents the other side of that equation, what is gained, in concrete and measurable terms, when employers invest proactively in prevention, risk stratification, and early detection. The evidence across multiple intervention types, industries, and geographies is consistent and compelling: prevention and early detection yield substantial, durable, and quantifiable financial returns.

Personalized Risk Assessment: Genetic Testing and Family History

Inherited genetic mutations, now formally classified as pathogenic variants, including BRCA1/2, PALB2, CHEK2, ATM, and Lynch syndrome variants, account for 5 to 10% of all cancers and increase lifetime cancer risk by two to ten times (NCI, 2024; Kurian AW 2023; Ramdzan, 2021). The risk magnitudes are clinically significant. Individuals with BRCA1 mutations carry a 72% lifetime risk of breast cancer and a 44% risk of ovarian cancer, while those with Lynch syndrome face a 60 to 70% lifetime risk of colorectal cancer. These risks are not inevitable. They are actionable, and the workplace is one of the most effective platforms available for identifying and acting on them.

Emerging evidence from real-world workplace genetic testing programs confirms both the feasibility and the clinical yield of this approach. When at-risk individuals know they have elevated risk, they are more likely to follow-through on lifestyle changes (Wang et al. 2024). A study of employees at a large U.S. healthcare system found that 12% of those who participated in voluntary workplace genetic testing received results indicating elevated cancer risk, and that elevated-risk results were strongly and independently associated with subsequent health behavior changes and increased preventive healthcare utilization (Charnysh et al., 2024). For organizations without the resources for comprehensive genetic testing programs, family history assessment offers a complementary and substantially lower-cost alternative.

A systematic review of workplace cancer screening interventions confirmed that the workplace setting provides consistent access to employees across diverse sociodemographic and economic backgrounds and can meaningfully increase engagement in cancer screening and prevention programs, including risk stratification through family history evaluation (Cavers et al., BMC Cancer, 2024). The evidence base for personalized risk assessment in workplace settings is growing rapidly. What it already establishes is sufficient to act on: a meaningful proportion of every workforce carries elevated, actionable cancer risk that standard population guidelines will not detect, and the workplace is a proven platform for finding and protecting them.

Lifestyle Intervention Programs

A landmark global analysis by WHO and IARC found that approximately 37.8% of all new cancer cases worldwide, representing 7.1 million diagnoses in 2022 alone, were attributable to 30 modifiable risk factors spanning behavioral, environmental, occupational, and infectious causes, with tobacco smoking, infections, and alcohol consumption as the three leading contributors (Fink et al., Nature Medicine, 2026). This finding carries a direct and urgent implication for the workplace: because the modifiable risk factors driving nearly four in ten cancers globally are precisely the factors that structured workplace programs are best positioned to address, employers occupy a uniquely consequential position in the global prevention landscape.

The evidence that workplace interventions can meaningfully reduce cancer risk is well established. A systematic review of 21 workplace cancer screening and prevention studies found a positive effect direction for every intervention examined, spanning breast, lung, colorectal, and cervical cancer across multiple national and

industry contexts (Cavers et al., BMC Cancer, 2024). On the critical dimension of weight management, a systematic literature review found that intentional weight loss through lifestyle interventions was associated with reduced cancer incidence in the majority of studies analyzed, with risk reductions ranging from 11 to 33% for all cancers combined and 20 to 60% for colorectal cancer specifically (Liao et al., 2025). Reductions in smoking quantity, even short of complete cessation, produce measurable and significant reductions in lung cancer risk, reinforcing the value of progressive workplace tobacco intervention programs that meet employees where they are rather than requiring immediate abstinence (Gutierrez-Torres et al., JNCI, 2024). The behavioral levers are well understood. The workplace infrastructure to deploy them is already in place.

Vaccination: HPV and Hepatitis B

The same IARC analysis confirmed that infectious agents account for 10.2% of all cancer cases globally, the second largest single contributor to preventable cancer after tobacco, with human papillomavirus and hepatitis B and C viruses responsible for the majority of infection-attributable cases (Fink et al., Nature Medicine, 2026). Workplace vaccination programs represent a primary prevention strategy of exceptional cost-effectiveness: the delivery infrastructure already exists within occupational health systems, the science is unambiguous, and the case for action is supported across multiple health systems and geographies. The hepatitis B vaccine, recognized as the world's first anti-cancer vaccine and administered over one billion times globally, protects against the leading infectious cause of liver cancer worldwide. The CPW project, a Horizon Europe funded initiative operating across Italy, Romania, Slovakia, and Spain, is currently demonstrating the feasibility of integrating HPV vaccination, hepatitis C screening, and *Helicobacter pylori* detection directly into routine occupational health surveillance programs, with cost-effectiveness analysis underway across all four national contexts (Roth, 2026, CPW Project, 2025). These represent cancers that need never occur, treatments that need never be administered, and costs that need never be incurred.

Risk-Adjusted Screening Programs

Workplace-based cancer screening programs consistently and significantly outperform their community-based equivalents for a straightforward reason: the workplace eliminates the scheduling, transportation, time, and financial barriers that most commonly prevent working-age adults from accessing screening through conventional channels. The scientific case for moving from age-based to risk-stratified screening has now been established by a landmark randomized clinical trial. The WISDOM study, enrolling more than 46,000 U.S. women, demonstrated that individualized risk-based breast cancer screening produced a one-third reduction in Stage 2B cancers compared to annual mammography, while proving non-inferior to annual screening in safety over five years (Esserman et al., JAMA, 2025). The lead author concluded that these findings should transform clinical guidelines for breast cancer screening and alter clinical practice, and among the 18,000 women in the study who were offered a choice, 89% selected risk-based screening over annual mammography, underscoring both the clinical validity and the patient acceptability of the personalized approach.

A systematic review of 21 studies found that workplace cancer screening interventions produced a positive effect direction in every case examined, with more than 30% improvements in screening rates achieved in the majority of breast and colorectal cancer interventions across multiple national and industry contexts (Cavers et al., BMC Cancer, 2024). Reductions in screening barriers through on-site delivery and paid appointment time were consistently identified as the most powerful enablers of uptake. A landmark IARC study published in the Journal of the National Cancer Institute estimated that in 2022 alone, premature cancer deaths among working-age adults generated a global productivity loss of US\$566 billion, equivalent to 0.6% of global GDP (Kong et al., JNCI, 2025). Looking further ahead, a comprehensive modeling study projected the cumulative global macroeconomic cost of cancer from 2020 to 2050 at \$25.2 trillion (Chen et al., JAMA Oncology, 2023; AACR Cancer Progress Report, 2025). The Organization for Economic Co-operation and Development (OECD) has confirmed that addressing the key modifiable cancer risk factors through workplace and population-level programs would simultaneously lower cancer rates, reduce health expenditure, and increase workforce productivity across member nations (OECD, 2024). The question is no longer whether organizations can afford to invest in cancer prevention and early detection. It is whether they can afford not to.

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CLOSING

The signers of this Cancer Alliance Declaration act in a spirit of shared purpose and shared possibility. Across every industry and every nation, employers hold extraordinary influence to protect the people who drive their organizations: to detect cancer earlier, prevent it more effectively, and build workplaces where health is not a benefit but a prerequisite. The returns are measurable, in lives saved, in families kept whole, in workforces sustained, and in healthcare costs that need never be incurred. The evidence is sufficient, the tools are available, and the moment for action is now. We invite every corporation, government, and health organization that shares our commitment to human health and human potential to stand with us in making that conviction a global reality.

LEADERS OF GLOBAL ONCOLOGY ORGANIZATIONS, INSTITUTIONS AND POLICYMAKERS

Individuals on the following pages have reviewed and endorsed this Declaration:

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