Socioeconomic Status and Oncology: Another Inconvenient Truth

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To the Editor: The problem of affordability of cancer care has escalated. In my working class southern California practice, patients are increasingly unable to pay for health care. National television news broadcasts have decried the problem. Eighty percent of Americans consider our current health care system to be “broken,”¹ and economists routinely write about our current health care crisis.

Indeed, the process of fixing oncology has already started. Providers and networks are negotiating preferred rates with third-party payers, based on controlled utilization. Gosfield proposed an insurance vehicle using case rate reimbursement based on provider “scorecards.”^{2,3} The Institute of Medicine wrote that “new payment incentives must be created to encourage the redesign of structures . . . to promote higher value.”⁴

National policy initiatives are addressing this need. Cutbacks in physician reimbursement, like most efforts at price freezes, have already created shortages in supply of oncology providers. Pay-for-performance, a good first effort to reward high quality cost-effective care, is limited by its focus on process indicators and secondary end points.

The most promising initiative may be interconnected electronic medical records. This could catalyze the industrialization of our multibillion dollar industry. In combination with transparent clinical trials, a national health information network could empower a major shift in business values. This will allow us to stratify patients and their illnesses, identify the most effective approaches, and determine cost/benefit ratios prospectively.

In an abstract sense, this should sound wonderful to professionals dedicated to their patients’ welfare. However, many oncologists have a vague but overriding sense of uneasiness. Some of this is our inherent aversion to risk, but oncologists are also concerned that economists and policy makers may not be considering all factors completely that influence health outcomes. Despite intensive efforts, researchers have not completely studied all relevant variables. A good example of this is the apparent lack of perspective on the gradient of patient socioeconomic status and health.

To be fair, there has been some consideration of this gradient in recent publications. However, a lack of socioeconomic data

has hindered our progress. We need to challenge assumptions based on prior studies of select patients, if we are to understand the complex socioeconomic interactions between health care, environmental factors, and health behaviors. A college professor receiving adjuvant therapy for breast cancer is likely to have better results than a domestic worker with the same health status, tumor characteristics, and treatment plan. Unless we include socioeconomic data fields in a national health information network, our ability to explore and mitigate these complexities will be quite limited.

Now is the time for oncologists to advocate routine collection of socioeconomic data. Gathering patient income data in clinics and offices will be problematic, but asking a single question about patient education would be quite feasible.

However logical this seems, I would be naïve not to address at least one of the tremendous political difficulties alluded to in the title of this letter. A major issue remains physician mistrust of the policy development system. It seems that practicing oncologists have become the scapegoats of some policy makers. Why should we be punished for following the rules of a system not designed by us? It is not our fault that the system is failing, but we are held accountable.

Despite this issue, our only logical business option is to continue to advocate patient value. Only by embracing priorities focused on benefit to our patients, will we assume leadership in the great American health care debate. Unless we do so, our motives will be no better than other profit-driven entities in the eyes of those we have vowed to serve. Advocacy of socioeconomic stratification of outcomes will give us the authenticity that patients and policy makers demand.

By no means am I recommending that business entities focused on profitability be allowed to take advantage of our altruism. Policy decisions that financially disadvantage oncologists will result in worse provider supply problems.

Oncologists are obliged, as patients’ spokespersons, to make difficult observations and communicate in compassionate ways. As with individual patients, an honest and respectful approach will be appreciated far more than efforts to protect the public from the truth. Our intuitive grasp of factors influencing health will then be cultivated by economic theorists, business leaders, and policy makers. If not, the potential for transparency in the US health care marketplace will never be fully realized, and the socioeconomic gradient in health care will widen. Advocacy of socioeconomic stratification of outcomes should be the first step in the transition to fiscal responsibility for our industry.

There will most assuredly be those who oppose this approach. However, the impact of this inconvenient truth, of the breakdown in health care and the need for intellectually and

economically robust solutions, will continue to be felt in every oncology clinic, infusion center, and hospital, until we solve this dilemma.

Change is always difficult and radical change is even more so. Still, if we don't involve ourselves, the resulting system will be dysfunctional, and the health of this country will be in further jeopardy. Our patients rely on our advocacy, and they deserve nothing less.

References

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In Response to "Future Supply and Demand for Oncologists: Challenges to Assuring Access to Oncology Services"

To the Editor: I read with interest the ASCO-sponsored Oncology Workforce Study.¹ I am a 63-year-old medical oncologist. When I took the boards, it was only the second time they were offered. There are quite a few people in my age bracket who are about to retire, including me. My true desire would be to work part-time in my practice, but I have discovered that there are many obstacles. I happen to work for a county hospital where malpractice is covered by sovereign immunity and it is not an issue for me. There are many other physicians who are not as fortunate and who cannot work part-time because the insurance premiums are too high. The second, and most important, issue to me is the attitude of younger physicians toward older ones. I believe that part-time physicians would be fine with them as long as it had zero impact on their work loads. Gone are the days when junior MDs pitched in to keep seniors in the fold. For this, I have no answer. Perhaps ASCO could look into this issue as a way

to conserve numbers of oncologists and develop some solutions.

I have serious concerns about physician-extenders.¹ I have encountered quite a few at the hospital and a very small fraction have either the talent or the desire to do good work. More and more physicians are having extenders see patients first, and the physicians are not scrutinizing their work carefully. I am old fashioned and do everything myself, including returning my own patients' telephone calls. This type of practice helps patients feel heard and helps them to realize that you are truly concerned with their well-being and that you, their physician, are not some aloof unreachable person. The growing trend of physician-extenders will drastically diminish the role of the physician-patient relationship to the detriment of both parties.

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