So Many Issues, So Little Time

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So many issues affect the day-to-day delivery of care that most of us grow numb to the voices in Washington arguing about health care. One recurring argument has shaped physicians' attitudes toward the political system more than any other: the "doctor fix," or the sustainable growth rate (SGR) formula that dictates Medicare physician reimbursement. The SGR was instituted by Congress in 1997 to provide a rational linking of payment for physician services to a target determined by the rate of growth in physicians' costs (adjusted for Medicare enrollment and changes in real gross domestic product per person). At the time the rule was enacted, it was expected to affect physician reimbursement only modestly. Indeed, in its early years, the formula helped increase physician reimbursement. However, since 2002, this formula has mandated cuts in payments for physician services. Realizing that cutting physician fees would dramatically affect access to care for the nation's seniors, Congress has developed an annual ritual of reversing the mandate. Unfortunately, without reforming the formula, the annual congressional actions only put off the budget-mandated cuts in fees. These cuts will add up to more than a 21% reduction in fees if or when enforced. With this background, it is not surprising that physicians are skeptical of government involvement in health care.

Another perspective might focus on what Congress was doing when it wrote the SGR into law in 1997. The Centers for Medicare & Medicaid publish annual reports on the cost of the program to the government.¹ All citizens recognize that the trend in spending for health services in this country is rising at a startling rate. Efforts to control these costs have befuddled policy makers for years, and clearly the SGR is a failed attempt. Now we are on the threshold of more reform, and skepticism aside, might this attempt be more successful? One reform would be to change the payment structure from a volume-based, fee-for-service format to a bundled group of services keyed to a defined, deliverable episode of care. Though the current reform law does not mandate such change, it does fund pilot programs and an innovation center that will evaluate alternatives to volume-based reimbursement.

How do oncologists prepare for change? This issue of *Journal of Oncology Practice* presents the second half of a two-part article by Barkley et al that looks at innovative ways for oncologists to collaborate with institutions and others to deliver care. Such collaboration will help physicians survive shrinking reimbursements and prepare for revisions to the fee-for-service structure. Oncologists will need to understand the intricacies of these collaborative structures and possibilities.

Other themes that inform health care conversations are addressed in this issue. Two articles touch on the oncology workforce. Hinkel et al characterize nonphysician provider activities and suggest productivity benchmarks derived from 15 member institutions of the National Comprehensive Cancer Network. How to best use and benefit from the skills and efficiencies of nurse practitioners and physician assistants remains a challenge for all practices. The ethics vignette by Debono

deals with the challenge of asking patients to transition follow-up care to their primary care physicians.

Evidence-based care and patient safety are addressed by two articles. Grunfeld et al outline the challenge of providing evidence-based care to survivors of breast cancer; they note substantial variation in adherence to guideline recommendations with regard to surveillance visits and tests. Jatoi et al discuss the difficulties in providing effective and safe oral chemotherapies to patients. Both of these articles remind oncologists that providing effective and safe care requires a better system of care—dependent on multiple team members.

The evidence base that informs practice is supported by two summaries of recent ASCO guidelines. The recent guideline on germ cell tumor markers is straightforward; however, the ASCO/College of Pathology guideline concerning hormone-receptor analysis is disturbing. It is sobering to note that there is variability in the determination of this key, basic bit of information. In the accompanying commentary, Hammond does a wonderful job of putting the guideline into perspective. This should motivate all who care for patients with breast cancer to use the guideline to engage local pathologists and understand the testing used.

Zon discusses the recent ASCO provisional clinical opinion concerning screening for hepatitis B in patients before they receive chemotherapy. This provisional clinical opinion was prompted by oncologists' difficulties with recent CDC guidelines recommending such screening.

Dealing with the marked increase in cost of oncology care is a struggle. Much discussion has informed this topic in a large sense, but Hofstatter reminds us that our literature is not flush with answers on how to discuss this with the patient in an individual examination room. This perspective and review is challenging for oncologists, because we pull patients into discussions about the financial ramifications of expensive treatment choices that, at times, provide only marginal improvements in care.

Lastly, the editors received feedback on the Hopkins et al² piece on patient navigators and McAneny's perspective.³ An exchange between readers and McAneny is presented. As always, we invite your feedback and suggestions at jopeditorsdesk@asco.org. Good reading.

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