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# The Business of Oncology

Sooner or later every health care professional understands that medicine, like any industry, must be profitable. It wasn't until I got out into the real world and began to practice, in both academic and community-based settings, that I realized: 1) medicine needs to be profitable to cover expenses and salaries, with money left to maintain and develop the practice, and 2) to be successful in the long run, any specialty must be economically viable on its own and not dependent on other medical specialties or business entities to survive. Financial success, no matter how distasteful it may seem, is a necessity for the viability of oncology care.

In the university setting, revenue traditionally has been driven by patient charges, grants for research, tuition for various types of students, and perhaps some business money generated from patents held by the university. Each department within the university hospital is a separate financial entity responsible for generating income to cover operational and personnel costs as well as various administrative taxes. As grant money has become more scarce, the need for patient-generated revenue has become more imperative. University hospital departments must earn a profit to successfully compete for staffing and new equipment as well as space and programs within the university.

The community-based hospital setting faces a similar scenario. While most of the revenue generated comes from patient care rather than grants, tuition, or patents, within this setting there is also competition for space, new equipment, program development, and personnel. However, the community-based hospital setting does provide support of necessary core services such as lab reporting that may not necessarily be reimbursed at a profit.

Because most oncology-related services are performed as outpatient care, many of the inpatient economic policies have not applied to outpatient hospital programs. In the past five years, outpatient programs and revenues have become extremely important for the economic viability of a hospital system. As a result, much more attention has been placed on outpatient programs and the revenue they generate. The past five years has seen the evolution of state-of-the-art freestanding radiation oncology centers, freestanding surgery centers, and private medical oncology offices. These centers, for the most part, are an economically viable solution to rising inpatient hospital costs. Economic viability has allowed these centers to provide quality care and everything that goes with it: state-of-the-art equipment, supplies, as well as personnel and the salaries to attract and retain them. Without adequate reimbursement at the outset, these centers would never have been able to provide such high levels of quality care to patients.

There is no question that cutting back on reimbursement by 10, 15, or 20 percent—as HCFA is proposing in its practice expense regulations—will have a devastating effect on all oncology programs in every setting in this country. These regulations will directly affect Medicare and Medicaid reimbursement, which has significantly declined over the past five years, as well as reimbursement by private insurance companies and HMOs, which tend to follow HCFA's lead. Under HCFA's new reimbursement scheme, any radiation oncology facility facing a 20 to 25 percent cut in reimbursement will not make a profit at any level of utilization. I cannot imagine how any responsible individual fails to understand these very simple economic principles. It is extremely time-consuming to re-educate HCFA and Congress about the devastation that such changes will bring to the oncology community. In the future I would hope that, before a policy is proposed, there be a responsible economic assessment of what that policy would do to cancer care in the United States.

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