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The multidisciplinary cancer care delivery platform we have today has evolved over 25 years. In the early 1970s, most cancer was treated with only surgery or surgery and radiation, and was managed entirely in the hospital setting. With the development of new chemotherapy drugs and applications, this new treatment modality—also delivered in the hospital—was added.

By the late 1970s and during the 1980s, a large number of oncology nurses and medical oncologists had been trained, an important outcome of the "War on Cancer" begun in the Nixon Administration. At the same time, much of the chemotherapy administration moved into the physician office setting, leading to some savings in the overall costs of providing chemotherapy. Chemotherapy administered in the physician's office was advantageous for patients, since the oncologist was but a few steps away. However, unlike the hospital setting, the reimbursement system for office-based chemotherapy infusion was not very well developed and certainly not based on good business principles. Physicians had little understanding about the actual cost of providing these services. The result was significantly undervalued payment for these services.

While progress was made between 1990 and 1991, the implementation of the resource-based relative value scale (RBRVS) drove reimbursements backward, with substantial decreases in payments for chemotherapy infusions beginning in 1992. For the past eight years, many groups have worked hard to correct this anomaly in the RBRVS system. Still, there have been no real improvements; chemotherapy administration codes continue to be paid at about one-third of cost.

Chemotherapy administration codes cover the services of the oncology nurse, not the medical oncologist. When the system undervalues these codes, it undervalues the oncology nurse, both economically and professionally. This unintended, unacceptable consequence of payment policy persists and must be corrected. Consider what would happen, for example, if cardiovascular surgeons found themselves professionally and economically undervalued by 65 to 70 percent. The anomaly would be promptly corrected, *or* there would be a lot fewer cardiovascular surgeons.

The oncology nurse is a vital part of the cancer care delivery platform that has evolved over the past 25 years. Without their dedicated professionalism, the platform would not succeed. Yet, there is a growing shortage of oncology nurses, and that shortage will increasingly stress the delivery system. The actual cause of the shortage of oncology nurses is not entirely clear. Certainly, the demanding nature of their work is a factor and leads to early burn out. Many oncology nurses work less than five days a week, because they need respite days off. In addition, the lack of proper economic and professional recognition may well be a factor in recruitment and retention of qualified nurses. Other professions that are less strenuous and pay better are also drawing away candidates for nursing endeavors. Certainly, the Oncology Nursing Society (ONS) is concerned and has many of its own initiatives directed at recruitment and retention.

Efforts to improve economic recognition—and ultimately improvements in recruitment and retention—have also been started through the RBRVS practice expense refinements ordered by Congress in recent legislation. The American Society of Clinical Oncology has presented accurate practice expense recommendations to the AMA/RUC (Relative Value Update Committee), and the AMA/RUC has forwarded these recommendations to the Health Care Financing Administration for consideration. The policy makers and insurers who want to reduce reimbursement or who want to ignore the current disparity in coverage for medical oncology practice expenses are undervaluing the vital role of the oncology nurse in patient management. If we want to preserve the oncology nursing profession, we must find sufficient revenues to pay competitively.

ACCC must continue to help raise the awareness of the importance of the oncology nurse in the delivery of quality cancer care. That heightened awareness is particularly important for legislators. To that end, the first Annual Policy Institute, jointly held by ACCC and ONS in February, drew 40 oncology nurses and cancer center administrators from across the country. Attendees learned about the legislative and regulatory process, and, more importantly, how to become effective political advocates at the local, state, and national level. They took their message to Congress.

If each congressman and senator could somehow spend a day in the life of the oncology nurse, they would come away with high regard for the professionalism and loving care that oncology nurses give the patient with cancer. They certainly have my respect.

David H. Regan