



GUEST EDITORIAL

Mammography: Past—Underused, Present—Underfinanced, Future—Unavailable?

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An estimated 30 million American women have had a mammogram in the past two years (“The Politics of Mammography,” 2001). The population of women 40 years and older is projected to grow by one million per year for at least the next five years, causing an ever-increasing demand for mammography services (“The Politics of Mammography”). As oncology nurses, we often expend time and resources educating our patients about the value of obtaining screening mammography regularly.

But will the facilities for them to obtain these mammograms be available? More than a year ago, the media gave much press play to a “looming mammography crisis” (“The Politics of Mammography,” 2001, p. 26). Ominous references were made to studies in cancer detection faltering or mammography services being reduced. How did this start, and how valid is the concern?

The alarm was sounded during a panel discussion at the annual meeting of the American College of Radiology in November 2000. The echoes have been reverberating ever since. Mammography experts from prestigious institutions, such as the University of California, Los Angeles, New York University, Memorial Sloan-Kettering, and others, described cutbacks, facility closings, and increased waiting times for mammography appointments.

The causes are readily identified but more difficult to correct. The primary issue is economics. Simply stated, the reimbursement for mammography is less than the cost. Currently, Medicare pays about \$67 for screening and \$80 for diagnostic mammography (Elliott, 2000). (The amounts vary based on location and other factors.) As many private insurers use Medicare rates to guide the amount of compensation they provide, their reimbursements also fall short of actual costs. A service that does not pay for itself eventually will not be offered. In fact, this potentially life-saving procedure often actually loses money for the institution providing it.

A number of factors contribute to the expense of mammography. These include the usual costs and overhead for equipment, film, personnel, and training. But, in addition, mammography is the only study in which quality inspections are mandated by federal law. Although advocates for better health care appropriately commend this safeguard, there is a price to pay. Complying with the required paperwork, as well as the other items like time out of service for inspection, adds to the cost of the study.

The problem goes deeper than purely financial concerns. Applications for physician subspecialty training in mammography appear to be decreasing (Elliott, 2000; “The Politics of Mammography,” 2001). This may be, in part, because of decreased support funding. Another factor often cited is medical or legal concerns, which discourage radiologists from subspecializing in breast imaging (“The Politics of Mammography”). The possibility of error in the diagnosis of breast cancer is the most common condition prompting medical malpractice lawsuits against physicians (Berlin, 2001). The net result is an impending shortage of skilled mammographers.

Compounding the predicament is a dearth of qualified personnel to actually perform mammograms. Radiologic technologists are in short supply and likely to stay that way for the foreseeable future. Societal and market forces, similar to those causing the current nursing shortage, are responsible for the scarcity.

The problem does appear to be real and not just media “hype.” Oncology nurses need to be well informed about this situation on several levels. The condition in the local area should be evaluated so nurses can advise patients and their friends and family. Finding a convenient time to obtain a mammogram can be difficult given the complex demands on women’s time. Encouraging scheduling for screening mammograms well in advance of need will prevent frustration so that women do not forgo this essential examination.

At the national level, legislation is pending to address the situation, which oncology nurses should be aware of. At this writing, the Assure Access to Mammography Act of 2001 (S. 548), introduced on March 15, 2000, continues to wend its way through the congressional process. Sponsored by a bipartisan group of senators, including Tom Harkin (D-Iowa) and Olympia Snowe (R-Maine), the bill focuses on raising Medicare reimbursement payments and boosting funding for both graduate medical education and allied health professional programs. A similar bill was introduced in the House of Representatives (H.R. 1328) a few weeks later, but it languishes in committee as well.

Despite emerging new technologies, screening mammography currently remains the “gold standard” for early detection of breast cancer. This invaluable resource must not be limited, especially when public acceptance is growing steadily. Oncology nurses must be aware of current events that may affect our efforts.

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