Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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Donald Jewler & Cara Egan

To cite this article: Donald Jewler & Cara Egan (1996) Managing Continuous Change, Oncology Issues, 11:6, 28-35, DOI: 10.1080/10463356.1996.11904649

To link to this article: https://doi.org/10.1080/10463356.1996.11904649

Published online: 18 Oct 2017.

Managing Continuous Change

by Donald Jewler and Cara Egan

The reality of change is the only constant in the oncology landscape today. Hospital cancer programs are downsizing and combining across multiple institutions. New genetic tests are forcing cancer programs to confront new concerns and ethical dilemmas. The need for greater cost efficiencies is changing the way cancer care is delivered. Of course, managed care, oncology carve-outs, and guidelines developed by insurers and providers are all adding to the speed of change.

To help oncology health professionals cope with the continuous transformations that are part of today's oncology environment, the Association of Community Cancer Centers sponsored its 13th National Oncology Economics Conference, September 18-21, 1996, in San Francisco, Calif. The theme of this year's meeting was "Managing Continuous Change." Included in the conference were dozens of sessions on all aspects of the changes taking place in hospitals and oncology practices, as well as within the insurance, research, and government environments.

The consensus of presenters was clear. Market demands for increased value and more sophisticated, integrated data will continue to drive consolidation and present formidable challenges for everyone involved in cancer care.

Donald Jewler is managing editor of Oncology Issues. *Cara Egan is assistant editor.*

GENETIC TESTING: A NEW ERA AHEAD

A special symposium, entitled *Oncology and Genetics in the Community*, featured Henry T. Lynch, M.D., the pioneering researcher who helped establish the hereditary basis of certain colorectal, breast, and ovarian cancers. Lynch is professor and chairman of preventive medicine and public health and professor of medicine at Creighton University School of Medicine in Omaha, Nebr.

"The discipline of cancer genetics is becoming more and more complex at the clinical, molecular, sociopsychologic, economic, and ethical level," said Lynch, who was honored with ACCC's Award for Outstanding Contributions to Clinical Research. "There is even opposition to the ASCO position to move ahead with DNA testing by some clinicians, geneticists, and ethicists who say we are not ready and should halt DNA testing until we can attain more knowledge and insight as to how to handle these problems at the clinical level. However, the genie is out of the bottle, and, therefore, we must face up to these vexing issues."

Those "vexing" issues include a host of as yet unanswered questions, according to Lynch.

- What are the surveillance management strategies for patients who have tested positive for hereditary cancers and are they effective?
- How can we elucidate the genetic and environmental interaction?
- What prospects are on the horizon for gene therapy?
- Has existing molecular genetic knowledge outpaced our ability to effectively translate such knowledge into health care delivery?
- Can we relate the importance of a new gene to the natural history of a syndrome so we can advise our patient accordingly?
- Is the physician at risk for medical malpractice if he or she fails to perform DNA testing?
- What happens if the physician fails to provide counseling or targeted surveillance and management or fails to protect patient confidentiality?
- Are there sufficiently trained genetic counselors and/or physicians to meet mandatory counseling needs?

"There are *not*," said Lynch in answer to the last question. "We don't have enough counselors that are sufficiently trained in cancer and its genetics to do the job. We have to do it... ."

Lynch developed his interests in genetics during his medical residency at the University of Nebraska Medical Center in Omaha in 1961 when he had the opportunity to study a family with a high incidence of colon cancer but without the typical profusion of polyps found in familial adenomatous polyposis (FAP). This led to years of research into the history of this large family and ultimately to a description of the entity now called hereditary nonpolyposis colon cancer (HNPCC), which is often called Lynch Syndrome in his honor. With the discovery of a mutant gene involved in that syndrome in 1991, a whole new era of cancer genetic screening began. Today it is possible

to predict with 85 to 90 percent accuracy the risk of disease in patients with direct germline mutations.

The key to genetic counseling and testing is the family history, according to Lynch. "This is where we as oncologists fall down miserably. All you need to do is to look at medical records from an office or hospital setting, and you will see that there is almost invariably not enough information in those records relevant to family history to be able to establish a hereditary cancer diagnosis.

"It is crucial," Lynch continued, "to get details of the family history because we do *not* want to do genetic testing unless the family really merits such testing. In other words, is the pedigree sufficiently significant to move forward and recommend DNA testing?

"After you have established whether a molecular genetic marker, namely a germline mutation, is present, you can begin your targeted surveillance and management program. It is important that we as oncologists extend this information to all at-risk relatives. In addition, we need more physician education and research into problems of insurance, discrimination, and how we go about our surveillance."

According to Lynch, informed consent is absolutely mandatory prior to testing. The patient must be sufficiently knowledgeable about all the events that could impact his or her life. "Then, we have to let the patient in on all of the decision making. [Patients] have to know what is going on, and it is our job to tell them."

Lynch and his colleagues with the Creighton group have counseled about 400 individuals based on their DNA findings. "Surprisingly, only a paucity of serious psychological problems have been identified," noted Lynch. "However, what we have learned is that a large number of individuals who have had their DNA tested by us have failed to come forward to receive their results because of a variety of reasons, particularly their concern about insurance discrimination, and/or fear and anxiety about how they would handle this knowledge."

Lynch spent considerable time discussing the difference in germline mutations of FAP and a variant known as attenuated FAP syndrome. Patients who have the variant have polyps just like classical FAP, but the age of onset for colon/rectal cancer is about age 55 as opposed to 39.

Discoveries may lead to the development and use of genetic tests before the full implications of using this information are known or well understood.

Lynch went on to describe management strategies after genetic testing for the germline mutations MSH2 and MLH1 in HNPCC within a high-risk family. "One daughter tested negative for the gene. Think of the burden that is lifted. She...does not have to undergo the intensive screening that we recommend for this disease."

Those in the family who test positive for the germline mutation receive genetic counseling as well as an annual colonoscopy starting at age 25. "In HNPCC the cancers undergo malignant transformation in about two to three years. We offer the option of prophylactic colectomy. Think of this: there is an 85 to 90 percent likelihood that he [the individual with the MSH2 or MLH1 mutation] will get cancer. We are not able at this time to tell him if he is in the 10 to 15 percent category where he will not get cancer. We have cases where patients have elected for prophylactic colectomy, and we have found some early cancers."

HNPCC is very common, according to Lynch. It accounts for between 6 and 10 percent of the total colorectal cancer burden, and is characterized clinically by early age of onset. The average age of colorectal cancer in the syndrome onset is about age 44, which is about 15 to 20 years earlier than with sporadic colorectal cancer.

Reviewing two studies of HNPCC patients compared with sporadic colorectal carcinoma patients, Lynch noted that at all stages there are highly significant differences out to ten years in the HNPCC patients versus the sporadic patients. Twice as many patients survived in the HNPCC group as in the sporadic.

"If we can find out why they do better...my God, wouldn't that be great," said Lynch. "It would have implications throughout the whole field of colorectal cancers and perhaps many more cancers."

GENETIC TESTING: SOCIAL IMPLICATIONS

"Genetic information may be impossible to keep confidential," said Elizabeth J. Thomson, M.S., R.N., assistant director of clinical genetics research with the National Center for Human Genome Research at the National Institutes of Health. She noted there is a good chance patients may want to share that information with their physician or others. Although many people trust that their physician will not share information, insurance companies can know why tests were done and may have access to results.

Besides the issue of confidentiality, Thomson raised a number of other concerns about genetic testing:

- Discoveries may lead to the development and use of genetic tests before the full implications of using this information are known or well understood.
- Genetic information may be misinterpreted. There are many normal variations in human genes, and many alterations which can result in disease. At this time it is not always easy to know which variations are associated with disease and which are not.
- The predictive certainty of genetic testing results is unclear at the present time. We still do not know the absolute predictive nature of many genetic tests, said Thomson. For example, although there may be an 80 to 90 percent likelihood that BRCA1 carriers will develop disease, that rate has been established based

on testing people in high-risk families. The rate has not been established for BRCA1 carriers in the general population.

- A "genetic underclass" may emerge. There will be people who have access to genetic testing and services if they can pay or have access to health care insurance that will cover the tests. But there will also be people who do not have access.

According to Thomson, many assumptions are already being made about the benefits of genetic testing. One general assumption is that having this knowledge will lead to early detection, prevention, and ultimately reduction in cancer morbidity and mortality. Another assumption is that people with positive tests who are determined to have an increased risk and people with negative tests who will be determined to have a decreased risk will both benefit from having this information. We do not yet have the data to know whether any of these assumptions are true, Thomson said.

"Knowledge of this type can result in anxiety and fear. Some people may feel that if they have the gene for breast cancer, then what difference does it make if [they] smoke or drink," said Thomson. They believe their fate is determined by their genes.

Thomson expressed concern that individuals testing negative may believe they had little to no risk to develop cancer. "An individual might say, 'I don't have the gene, so I don't have to worry about good health behaviors,' when in fact an individual with a negative test may still have a high risk of developing cancer," she said.

What should patients who are found to have the BRCA1 or 2 mutations be advised with regard to follow-up care? Should they be provided earlier or more frequent mammograms than usually offered? Should they be offered chemoprevention or prophylactic mastectomy? According to Thomson, these answers have yet to be defined.

Progress, however, is being made in reaching consensus as to what to tell people who are found to have BRCA and HNPCC mutations. Thomson described a set of research projects at the National Institutes of Health designed to examine the impact of using genetic testing for inherited breast, ovarian, and colon cancer risk. The National Center for Human Genome Research, in conjunction with the Nursing and Mental Health Institutes, funded a series of eleven projects. These along with four other projects have come together to form the Cancer Genetics Studies Consortium. This group of individually funded investigators has been brought together to discuss the implications of what they are learning through their genetic studies.

"Over the past two years the Consortium has been drafting a document that will be published within a few months in a major journal. The group is trying to come to some consensus as to what to tell people who are found to have BRCA and HNPCC mutations," said Thomson. "This is not an easy task."

GENETIC TESTING: LEGAL AND ETHICAL CONCERNS

Only a handful of laboratories around the country offer testing for one or more of the cancer-predisposing genes, according to Leslie M. Alexandre, Dr.P.H., vice president of corporate affairs for OncorMed, Inc., in Gaithersburg, Md. This publicly traded company offers cancer genetic services.

"We are nowhere near putting this test in a box or kit," noted Alexandre, who said the technology is too complex. Turn-around time for cancer genetic tests ranges from two to eight weeks. Most tests are ordered by oncologists, endocrinologists, or gastroenterologists, but there is growing interest from primary care physicians and ob/gyns.

Alexandre noted that there are already a number of cancers for which susceptibility testing is commercially available, including:

- hereditary breast-ovarian cancer (BRCA1, BRCA2)
- hereditary nonpolyposis colon cancer (MSH2, MLH1)
- familial adenomatous polyposis (APC)
- familial melanoma (p16)
- familial medullary thyroid carcinoma (RET)
- Li-Fraumeni Syndrome (p53)
- retinoblastoma (RB)
- neurofibromatosis (NF)
- Von Hippel Lindau Syndrome (VHL)

These tests are not for the general population, according to Alexandre. Screening and susceptibility testing have very different purposes. Screening is for early detection of disease in an asymptomatic population; risk is based on age, sex, and sometimes ethnicity. Screening testing is periodic and generally costs less than $100. Susceptibility testing, on the other hand, aims to identify

Presenter Elizabeth J. Thomson, M.S., R.N., ponders an ethical question about genetic testing. She is assistant director of clinical genetics research with the National Center for Human Genome Research at the National Institutes of Health.

The Association of Community Cancer Centers honored President Clinton with its National Achievement Award based upon the President's and Vice President's continuing support for a number of different measures that affect cancer patient care. Foremost, the President was honored for his work to speed the new drug approval process at the Food and Drug Administration (FDA). The changes that the President announced at the White House in March 1996 are already speeding new therapies to cancer patients and hold the promise of more new therapies in the months and years ahead.

Accepting the Association's award on behalf of the President was Philip Randolph Lee, M.D., assistant secretary for health, and a central member of the President's health care team. Lee (at right) was presented the award by ACCC President John E. Feldmann, M.D.

"It is clear that we are in a time of great transition," said Lee. "We must work closely together, not only with regard to research and FDA issues, but also with regard to what must be done to assure patients with cancer or other chronic illnesses access to the best possible care—the care they deserve. We [must] not permit restrictions through managed care or other mechanisms to limit that access to care."

predisposition to disease. Only people truly at high risk—based on family history and age of onset—are tested. Testing is performed only once and costs from $300 to $1,500 per gene, depending on the amount of gene that must be analyzed.

Although third-party reimbursement is not yet widely available for the major cancer-related gene tests, progress is being made, said Alexandre. Most insurance companies will pay for RET gene testing for medullary thyroid carcinoma, and some companies are paying for BRCA1 and 2 in high-risk individuals.

"We know that the main reason high-risk women do not want to be tested for BRCA1 and 2 is because they are afraid of health insurance discrimination," said Alexandre. She noted that the recently passed Kennedy/Kassebaum bill is a major step forward in addressing discrimination concerns. Key portions of this legislation, known as the Health Insurance Portability and Accountability Act of 1996, will take effect July 1, 1997. In terms of genetic testing it provides three important provisions, as outlined by Alexandre. First, genetic information may not be treated as a pre-existing condition in the absence of a diagnosis. Second, medical plans cannot deny a person coverage (or continued coverage) based on health status, including genetic information. Third, group medical plans may not require any person to pay a higher premium on the basis of health status, including genetic information.

Alexandre raised a number of ethical and legal questions inherent in genetic testing today.

- Who owns an individual's genetic information?
- Who should be allowed to know an individual's genetic information?
- Should physicians inform at-risk family members against their patient's desires?
- What constitutes informed consent and should it be required before a test is performed?
- Should researchers be allowed to conduct different studies on an individual's genetic material without consent?

As the speakers before her, Alexandre noted that these questions remain largely unanswered.

HOSPITAL AND PHYSICIAN CONSOLIDATION: FULL SPEED AHEAD

Pushed by today's demands for greater efficiencies and value, hospital mergers and downsizings continue at a fast pace. To survive, according to several presenters, hospitals must learn to streamline the management system and support structure, implement an information and decision system that comprehensively interprets clinical and management data, and increase value in the form of better patient access, cost, measurable quality, and customer satisfaction.

At the same time hospitals are consolidating, physicians are giving up their independence. "If you are fifty or older, you can probably go it alone...or link up with one or two other docs," said John F. Randazzo, M.A., M.I.A., senior vice president for mergers and acquisitions, Value Health, Inc., in Avon, Conn. "If you are below age fifty, you will need to look to merge, whether with other groups of oncologists or with an integrated delivery system." Partners must be both "compatible and complementary."

Many options are available to physicians: group practice without walls, physician/hospital organizations, comprehensive management service organizations, and equity management service organizations. (See related article on page 21.) Over the last few years there has been significant growth in the physician practice management industry. Today there are thirty-one publicly traded physician practice management companies; five focus on oncology.

What is driving physicians to consolidate? According to presenter

J. Mark Clapp of Clapp and Associates in Morrisville, Pa., a variety of factors, including:

- increased scrutiny for utilization of services and preapproval
- threat of declining reimbursement
- movement toward bundled pricing
- commercial insurers reducing reimbursement to match Medicare levels
- increased competition in local markets from out-of-state entrepreneurial enterprises
- competition from primary care physicians or internists who are providing chemotherapy treatments
- reduced referrals due to participation with managed care organizations
- fear of decline in compensation.

"Consolidation means burying the hatchet," said Lloyd Everson, M.D., president of American Oncology Resources, Inc., in Houston, Tex. "Quite frankly, many practices do not trust the other practice across town."

According to Everson, consolidation allows physicians to build strength and develop a "dialogue of parity" with the payers. "If physicians are going to preserve top quality cancer care for our patients and be able to manage our practices and our cancer centers, whether community- or university-based, they will have to access capital and sophisticated management and information tools."

BENCHMARKING THE ONCOLOGY SERVICE LINE

As hospitals go about restructuring oncology units to streamline costs and improve quality of care, many enlist the help of other institutions to measure how they compare in the changing marketplace. This comparison study, known as benchmarking, provides an institution with data to make decisions on areas for improvement and to measure one's own efficiency and cost effectiveness with others in the marketplace, according to Joy G. Stair, M.S., B.S.N., director of oncology services at St. Joseph Mercy Hospital in Ann Arbor, Mich. With labor costs comprising a major expense, hospitals are looking at ways to decrease costs. "Our benchmarking mission was to determine how our staffing models in all areas compared with those around the country," Stair said. "We gathered data to help us achieve our goal of lowering personnel costs while maintaining quality care."

St. Joseph Mercy identified hospitals both similar and dissimilar in a number of regions across the country with varying degrees of managed care penetration. To facilitate communication with hospitals, Stair recommended selecting hospitals with which an institution already has an established link. "We purposely selected hospitals where our vice president was acquainted with the corresponding hospitals' vice presidents," Stair said. Once initial contact was made, both vice presidents submitted contact names for their respective medical, surgical, ob/gyn, critical care, and oncology units.

Conversations with hospitals were based on benchmarking parameters developed by administration and oncology unit staff as well as physicians. Stair recommended involving staff in the benchmarking development process as well as in the actual conversations with their counterparts at the other hospitals. Although logistics were sometimes difficult, Stair claimed that staff participation contributed to enhanced output of ideas for improvement.

St. Joseph Mercy's benchmarking parameters varied slightly across units, but for the most part they explored the following areas:

- average daily census
- staffing levels/FTE configurations
- nursing hours per patient day
- configuration of "not staff time" or time away from the bedside.

When comparing staffing levels and nursing hours per day across institutions, Stair advised institutions to be consistent in their definitions of these terms.

Decreasing "not staff time" was a high priority for St. Joseph Mercy, whose nursing committee structure was keeping nurses in meetings and away from patients. "Although our nurses depend on these meetings for professional development, we had to design a more formal structure to more efficiently account for their time away from patients," Stair explained. After comparing staff configurations at other hospitals, St. Joseph Mercy incorporated committee responsibilities into its budgeting structure and as a result was able to significantly decrease "not staff time."

Overall, hospitals were eager to assist with St. Joseph Mercy's benchmarking effort. "At the time of initial contact, we shared our benchmarking tool with hospitals," Stair said. "Hospitals also received a report of our findings, so they benefitted from the study as well."

THE FUTURE OF RADIATION ONCOLOGY

The rapid technological advances in radiation oncology are providing cancer patients and their physicians a wider range of treatment options than ever before. Too often, however, decisions about those options are dictated by cost, without corresponding attention to quality of care, according to Luther W. Brady, M.D., Hylda Cohn/American Cancer Society professor of clinical oncology at Allegheny University of the Health Sciences in Philadelphia, Pa. As a result, HMOs and insurance companies in some cases are denying treatment to patients based on cost data alone.

Brady offered the example of a woman faced with the option of undergoing a more expensive modified radical mastectomy rather than conservation surgery/lumpectomy. "A woman should be allowed to make that decision in consultation with a radiation oncologist who actively oversees her treatment management," argued Brady. However, in many cases HMO contracts include "gag clauses" to prevent physicians from discussing treatment options for which the insurance company is unwilling to pay. Brady has lobbied payers to reimburse treatment options on an equal basis to eliminate the financial incentive of recommending one treatment over another.

Increasingly, radiation oncologists are being left out of treatment management in an effort by the HMOs and insurance companies to cut costs by delaying or decreasing the number of referrals to specialists. Consequently, a major change in the implementation of cancer treatment has occurred. Brady reported median delays between initial visitation and the decision for treatment management within the managed care system to be six months for prostate cancer, four months for breast and colon cancers, and four and a half months for lung cancer—cancers that represent 60 percent of all invasive cancers seen in the United States.

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Insurance companies should realize that cost and quality are not as contrary as they may seem, Brady said. Early diagnosis and early treatment maximize the potential for cure—they also maximize greater cost efficiency. Treating and curing a patient can cost an estimated $35,000-$40,000, but the cost for treating a patient who is not cured can cost $350,000-$400,000. "These figures demonstrate that the first opportunity for curing a patient is the best opportunity, and therefore requires the best resources for physicians to maximize their potential ability to cure," Brady said.

Purchasers of health care plans also must learn to expect—if not demand—quality. Brady reported that when closely examined, the difference in costs of the best and poorest health care plans is relatively small ($5 to $7 per month). But health care purchasers must be educated about what quality care is, he added.

Brady described a demonstration project initiated in Detroit by the three major U.S. automobile companies and the United Automobile Workers Union to ensure quality in health coverage. The automotive companies agreed to pay a separate fee to establish a panel of experts who design standard protocols for management of care and accept responsibility for ensuring that those protocols are carried out to the highest level of quality possible. This development, which Brady describes as "a major breakthrough in the discussion of care and cost," allows the physician and the hospital to deliver care without compromising quality.

Although the Medicare/Medicaid revolution is ongoing, change is a certain outcome, Brady declared. At present there are 40 to 50 million seniors in the United States, with 4.2 million enrolled in HMO management, and these numbers will continue to rise through the next century. Brady encouraged radiation oncologists to "manage the revolution" to work in their favor. He advised radiation oncologists to position themselves to compete for this growing market through managed care contracting—both global pricing and capitation. With new technologies and combined modalities gaining momentum, Brady strongly encouraged radiation, medical, and surgical oncologists to approach clinical patient management on a more collaborative basis. Failure to do so will continue to allow nonphysician entities to influence clinical decision making.

STORMY WEATHER AHEAD?

A number of market forces are beginning to affect health care delivery in the U.S. These include medical inflation, new technology, and demographics.

"Someone in the U.S. turns fifty every eight seconds," said David Friend, M.D., M.B.A., global director of health care consulting at Watson Wyatt Worldwide, which provides strategic advice concerning the restructuring of the health care industry. The baby boomers are aging, and an older population means increasing overall incidence of cancer.

"Just by the fact that we are

SPECIAL INTEREST GROUP (SIG) ROUND-UP

Nursing SIG. "The Transition to Home Health Care" was led by Joan C. McNally, M.S.N., R.N., O.C.N., of Karmanos Cancer Institute in Detroit, Mich. McNally reviewed the skills required for efficient home health nursing and raised the ethical concerns of caring for the oncology patient at home.

Medical Director SIG. Robert H. Jacqmin, M.D., F.A.C.P., vice president of managed care, Physician Reliance Network, Inc., in Dallas, Tex., discussed "Physician Credentialing." He focused on NCQA accreditation standards.

Radiation Oncology SIG. Luther W. Brady, M.D., Hylda Cohn/ACS professor of clinical oncology, Allegheny University of the Health Sciences, Philadelphia, Pa., presented a comprehensive review of major issues in radiation oncology. (See accompanying article for more information.)

Administrator SIG. Three sessions were offered.

- "Physician/Hospital Alignment: A Model for Success." This session was presented by Valinda Rowe Rutledge, M.B.A., B.S.N., M.S.N., St. Joseph Mercy Hospital & Saline Community Hospital, Ann Arbor, Mich. She examined the structures needed for integrating physicians within the hospital's decision making and strategic process. (See page 18.)
- "Managing Your Cancer Program in a Managed Care Environment." The presenter was Steve Schulz of Ernst & Young, Chicago, Ill. He discussed marketing oncology services, global fee arrangements, and emerging trends in oncology carve-outs.
- "Benchmarking the Oncology Service Line." This session was presented by Joyce G. Stair, M.S., B.S.N., St. Joseph Mercy Hospital, Ann Arbor, Mich. (See accompanying article.)

Community Research/CCOP SIG. An update on clinical research was presented by Leslie G. Ford, M.D., of the Division of Cancer Prevention and Control at the National Cancer Institute.

SIGN UP NOW!

The Association of Community Cancer Centers currently recognizes five Special Interest Groups (SIGs): Administrator, Community Research/CCOP, Medical Director, Nursing, and Radiation Oncology. The SIGs provide a forum for members to discuss ongoing ACCC activities, including the annual meetings, *Oncology Issues*, strategic planning, and other critical issues. Increased SIG participation by the membership will continue to strengthen the Association's ability to be a national leader on issues of importance to all cancer care disciplines. For a SIG membership form or more information, please contact Kathleen Young, ACCC SIG Membership, 301-984-9496.

THE WHITE HOUSE

WASHINGTON

October 3, 1996

I want to thank the Board of Trustees, members, and staff of the Association of Community Cancer Centers for honoring me with your National Achievement Award in recognition of my Administration's initiatives on behalf of cancer patients and their families. This award means a great deal to me as we continue our efforts to ensure high-quality, cost-effective health care for all our citizens.

Many Americans have felt the impact of cancer -- either in their own lives or in the lives of loved ones. The pain and suffering caused by cancer for the individuals affected and for their families are immeasurable. But because of the hard work of organizations like the Association of Community Cancer Centers, victims and their families are getting the care, guidance, and information they need to fight this terrible disease. True heroes, your members have set a shining example of commitment and compassion, helping cancer patients and their families to overcome enormous difficulties each day. I commend you for your vital work, and on behalf of all those you have helped, I thank you for a job well done.

Best wishes for every continued success.

Bill Clinton

President Bill Clinton expressed appreciation for receiving ACCC's National Achievement Award in recognition of the Administration's initiatives on behalf of cancer patients and their families. Accepting the Association's award on behalf of the President was Philip Randolph Lee, M.D., assistant secretary for health. (See page 31 for Dr. Lee's remarks.)

getting older, the country is going to spend a lot more on health care," said Friend.

He argued that medical inflation is not under control. In fact, according to Friend, the ratio of the medical CPI to the overall CPI is rising, and is at its worst level in forty years.

"We are spending $160 billion on Medicare today. By 2030, we think that number will be $1 trillion. Total health care spending will rise from 13 to 14 percent of the gross national product to almost 25 percent. The good news is that there is tremendous demand for your services. The bad news is that we don't have the money to pay for these services," said Friend.

"For people who think that managed care is the answer and costs are under control, I say, 'Absolutely not.' We are in the eye of the hurricane, and we have to come out."

Friend foresees the end of the traditional hospital cancer center, which he called "a very inefficient cottage industry." In its place will rise the "virtual health care system," where webs of providers offer specialized services. For the patient with a broken hip, for example, a critical care provider will repair the hip. Within twenty-four hours, the patient will go elsewhere to a company that delivers rehabilitation. Another company will make sure the patient is taking the prescribed medication. Another company will run the home health care or visiting nurse services. Relationships between multiple suppliers that offer distinctive value will be developed. Each supplier will focus on its own niche. Medical informatics, new technology that offers the ability to talk to and treat anybody, anytime, from anywhere, will speed the change to a more cost-efficient health care delivery system.