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New Firm Steps Onto Texas Battleground For Control Over Office-Based Oncology

Texas, the state that gave rise to two national oncology practice management companies, is about to become a battleground in a war for control over office-based oncology.

OnCare Inc., a startup based in the San Francisco area, earlier this week announced management deals with five practices that employ 34 oncologists in Fort Worth, San Antonio, Houston and Dallas.

The company enters the Texas market at a time when decreasing

(Continued to page 2)

In Brief

Howley, Simone Lead Cancer Policy Board; AMA Campaign Fights Youth Smoking

PETER HOWLEY, chairman of pathology, Harvard University Medical School, was appointed chairman of the newly formed National Cancer Policy Board, of the Institute of Medicine, National Academy of Sciences, NCI Director Richard Klausner said to NCI's National Cancer Advisory Board at its meeting Nov. 19. **Joseph Simone**, medical director, Huntsman Cancer Foundation, was named vice-chairman of the board. The IOM will seek nominations for board members in a statement scheduled to be released soon, sources said. . . . **AMERICAN MEDICAL ASSOCIATION** began a nationwide public health campaign to teach elementary school-age children about the dangers of smoking and nicotine addiction. AMA will work with Scholastic News to create antismoking materials featuring AMA's new cartoon superhero, "The Extinguisher" and his mentor, "Doctor Nola Know." Their mission: to help children "smoke out" and "extinguish" the cigarette industry's marketing campaigns directed toward youth. "Look out camels, cowboys and penguins. Your days of enticing kids to take up tobacco are coming to an end," said **Randolph Smoak Jr.**, member of the AMA Board of Trustees. . . . **DAVID JOFTES**, 72, a science administrator who retired from NCI in 1989 as chief of the Contracts Review Branch, Division of Extramural Activities, died of pancreatic cancer Nov. 11 at his home in Delray Beach, FL. Joftes was born in New York. He graduated from Tufts University and received a doctorate in biology from Boston University. He was a scientist at New England Deaconess Hospital in Boston before joining the National Institute of Child Health and Human Development in 1967. He joined NCI in 1974 to head the National Organ Site Programs Branch. Survivors include his wife Rosalyn Joftes, of Delray Beach and a daughter, Linda Carlton, of Bethesda.

Three PPMs Battle For Stake In Office-Based Oncology

(Continued from page 1)

earnings led to a drop in the prices of stock of its Texas-based competitors, Physicians Reliance Network Inc. of Dallas and American Oncology Resources Inc. of Houston.

According to Michael Goldberg, OnCare CEO, the difference between the newcomer and its competitors boils down to one word: informatics. The company spent over three years and millions of dollars developing its proprietary computer system, he said.

"Usable practice guidelines are the Holy Grail," Goldberg said to **The Cancer Letter**. "We are the first company to implement such guidelines. That's why we are legitimately the next generation practice management company, and that's why we are growing while other players in the industry are falling away."

Clinical guidelines are incorporated in OnCare's computer software. The software program is also designed to capture information on treatments, billing and outcomes.

"We aren't driven primarily by the desire to consolidate practices and save money in the billing office," Goldberg said. "Our desire is to forge a tight relationship with physicians who share our vision of re-engineering the cancer care delivery system."

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Officials at PRN and AOR said their companies, too, are in the process of developing software that would capture outcomes data and assist with practice management. However, neither company claims having a fully operational integrated system.

Goldberg said OnCare has a war chest of about $25 million, invested by the New York-based Beacon Group, a private equity fund. That amount of cash could be used to bring as many as another 100 oncologists into the system, he said.

The company's principal competitor in Texas, PRN, has the advantage of having been in the market longer, and having built up affiliations with 207 physicians at 50 locations in the state. Also, PRN has $13 million in cash and an untapped $90 million line of credit, said Randall Kurtz, chief financial officer.

Kurtz said PRN is working on closing the computer technology gap, and is in the final stages of selecting a vendor for a computer system. "We certainly see the opportunity to build enhanced systems, particularly as they relate to the electronic medical record," Kurtz said.

At least in Texas, AOR is unlikely to go head-to-head with OnCare. The Houston company owns only two Texas practices, in Austin and San Antonio. The company, which has pursued the strategy of absorbing high quality practices nationwide, employs 228 oncologists in 15 states.

"In the long term, informatics is going to be critical to understanding clinical and financial outcomes," said Lloyd Everson, president of AOR. "However, there are many other pieces to building a company that are key to success."

Everson said AOR has an information management system, and is working with several vendors to assemble an integrated system for informatics and office management. "There are a lot of good [information technology] companies out there, but we haven't run into anyone who does everything for oncologists today," Everson said.

Ironically, collection of outcomes data has never been a strength of office-based practices.

Outcomes data have been captured by academic cancer centers, usually in the context of clinical trials and research protocols. Now, as some academic centers are trying to systematize and share the data in their disparate systems, office-based physicians may have the advantage of a clean slate.

By starting to track treatments and outcomes,

they may be among the first to cash in on the value of outcomes data in oncology.

"The fact that these businesses are involved in informatics indicates that the data they generate aren't just of academic interest, but are useful in running the business," said Jane Weeks, director of the Center for Outcomes and Policy Research at the Dana-Farber Cancer Institute.

"There is a message here for the academic centers: Outcomes data have value."

All Eyes on Texas

The Texas market for office-based oncology services may be only a part of the stakes in the coming battle. The winner—or at least the winning strategy—could influence cancer care nationwide.

In essence, physician practice management companies (PPMs) purchase clinical oncology practices. Under these deals, physicians receive cash and stock, and sign long-term management and employment contracts.

OnCare's terms, which are similar to those offered by other companies, include a 40-year management contract for the practice and five-year contracts for employment of physicians.

The Battle of Texas is likely to be even more important because it will test the comparative advantages of two types of PPMs: companies like PRN and AOR, which consolidated first and are now developing informatics, versus OnCare, a company that developed informatics first and began to consolidate later.

According to industry estimates, nearly 90 percent of oncologists in the US remain independent. Even in Texas, fewer than half of the state's 600 oncologists have affiliated with PPMs.

Nonetheless, the triumph of the PPM model of consolidation of practices is far from inevitable, some observers say.

"I think we will see the emergence of systems of managed care that go well beyond practice management roll-ups," said Rick Lee, founder and CEO of Accountable Oncology Associates, a disease management company that assists HMOs in systematizing their existing care sites and providers.

"In the long run, the challenge of managing this disease is so great that there should be some reward for doing it successfully," Lee said to **The Cancer Letter**. "If you sell, you forego the reward for this success."

Informatics-Driven PPM

OnCare was a spin-off of Axion Inc., a company that has been involved in disease management, oncology drug distribution, and development of informatics.

The company's informatics system incorporates expertise gained by Axion through another venture, Oncology Therapeutics Network, a partnership with Bristol-Myers Squibb Co., which supplies drugs to office-based oncologists. BMS recently paid Axion $100 million, buying out that company's 50 percent share in the partnership.

While it was involved in OTN, Axion owned the data on the use of drugs and biologicals by office-based oncologists, Goldberg said. Also, the drug distribution business gave the company insight into the way oncologists use computers.

"We created OnCare in recognition that payors need tremendous help in managing cancer care, and oncologists are uniquely suited to provide it," Goldberg said. The development of the informatics system now used by the company began over three years ago, he said.

"We started by developing the methods and software systems to enable us to establish expert panel-based guidelines and disseminate them over an electronic information system," Goldberg said.

"In this form, the guidelines could be used at the point of care and at the time of treatment selection, as opposed to being put on a shelf in a binder.

"Then, the data developed pursuant to those standards of care would be integrated into a master outcomes database, which would allow us and our physicians to gain insight into the relationship between treatment selection and treatment success," Goldberg said.

In its current form, the informatics system focuses on chemotherapy outcomes and includes 20 practice guidelines for treatment and supportive care. The guidelines cover 90 percent of all malignancies seen in community practice, Goldberg said.

In the next upgrade, the system would be expanded to overall treatment outcomes, he said. Another generation of the system is being developed by KnowMed, a company run by Don Simborg, one of the founders of informatics.

Goldberg said the company's goal is to become the leading provider in each of its markets.

"In the old, fee-for-service world, the number

of physicians in a PPM equated to control of cancer care," he said. "In the outcomes based reimbursement environment, the number of physicians doesn't necessarily mean control of the market. It is the quality of information that counts most.

"We are implementing systems that will make OnCare more attractive to the health plans and large employers because we are providing patient information that allows accountability and tracking," Goldberg said.

Two Kinds of Oncologists

William Jordan, an oncologist in Fort Worth, says two kinds of oncologists can be found in the state of Texas: those who are considering affiliation, and those going out of business.

Jordan, president of Texas Cancer Care, said he has done his homework before choosing OnCare.

"I've looked at virtually every major PPM in the US, both in the oncology specialty and outside oncology, and we've had a number of proposals given to us by various organizations," Jordan said to **The Cancer Letter**.

"OnCare was, without a question, the most attractive and unique of those organizations, because they truly offer support and partnership to a physician's practice," Jordan said.

Jordan said the practice environment in the Fort Worth area began to change two years ago, when Texas Oncology, PA, a PRN unit that manages oncologists in Texas, started to recruit practices in the area.

While meeting with PPMs, Jordan was setting up an alliance with other unaffiliated oncologists in the area. In 1994, Jordan's practice employed four medical oncologists.

At the time it joined OnCare, the practice employed 6 medical oncologists, one hematologist, one bone marrow transplant specialist and a radiation oncologists at six locations in the Fort Worth area, Jordan said.

That size makes the practice strong enough to compete with TOPA, which has about 10 affiliated physicians in the area, Jordan said.

The market in the Fort Worth area has changed so profoundly that only one oncologist has remained unaffiliated, Jordan said.

"Positioning is intense right now," Jordan said. To survive, a practice needs to build a geographic network, support a management team, and rely on informatics systems that enable prediction of outcomes, Jordan said.

"Our physicians are extremely excited about having the ability to standardize cancer care and measure outcomes," Jordan said. "We know that there are a number of right ways to treat cancer. What we want to find is the best right way."

OnCare's informatics capability had similarly attracted South Texas Oncology and Hematology, a San Antonio-based practice.

"It's not enough to get a group of doctors together," said Lon Smith, one of the six physicians in the practice. "Here in Texas, it's more clear than in many other places that medicine is consolidating, and that we need to be able to do things more efficiently than in the past."

After considering PRN and AOR, the practice decided to sign up with OnCare. "Many people say that informatics systems can be easily developed," Smith said. "Michael Goldberg is the only person I have seen who has acted on it."

In addition to Texas Cancer Care and South Texas Oncology and Hematology, OnCare's transaction includes Associates in Radiation Oncology, a Fort Worth practice that employs four physicians, Houston Oncology Consultants, a six-physician practice; and Texas Cancer Associates, a Dallas-based practice that employs nine physicians.

Following the Texas transaction, which the company describes as the largest of its kind, OnCare will manage 60 oncologists.

The company is also establishing a presence in Northern California, where it manages Monterey Bay Oncology of Monterey, and Georgia, where it employs 25 physicians in Atlanta, Augusta and Macon.

The M.D. Anderson Dilemma

In the midst of the war of PPMs, M.D. Anderson Cancer Center learned that there are limits to what a public institution can do to protect itself in the managed care environment.

Last year, the cancer center developed a plan to establish a network of satellite clinics where salaried physicians would follow M.D. Anderson clinical guidelines as they treated managed care patients sent to them under managed care contracts obtained by the cancer center.

M.D. Anderson is no longer establishing satellite clinics, said Martin Raber, the cancer center's vice

president for managed care and outreach program.

"Our view is that we want to work with all oncologists in the state, and we don't care who does your billing," Raber said.

Under the current, less rigid schema, participants of M.D. Anderson's outreach would use the cancer center's guidelines when they treat M.D. Anderson managed care patients. The cancer center's affiliates include six practices in the Houston area, as well as practices in Fort Worth, Austin, and Oklahoma City.

M.D. Anderson's original plan ran into several formidable obstacles. The University of Texas Board of Regents expressed concern that the cancer center's exclusive arrangements with health care providers would be inconsistent with its mission as a state institution.

Also, the cancer center fully grasped that such arrangements could actually shrink its referral network. "Texas physicians who refer patients to M.D. Anderson are our customers, and there is no business that has ever survived by declaring war on its customers," Raber said.

Finally, about three months ago, the cancer center was informed that its Austin affiliate decided to join AOR.

Raber describes that moment as "epiphany." The cancer center had no reason to add to the fragmentation at a time when three PPMs were carving up the state's physician practice market. Getting out of the game, M.D. Anderson proceeded to redraw the practice's contract to pave the way for the affiliation.

Since that time, two other M.D. Anderson affiliates, Jordan's Fort Worth practice as well as a Houston practice, joined OnCare.

"It took us some time to figure this out: the battle of PPM companies in Texas is not our battle," Raber said.

National Cancer Act 25th Year

Cancer Mortality Rate Began Decline In 1990s, NCI, ACS Say

NCI and the American Cancer Society released two studies showing a steady decline in deaths from cancer every year from 1990 to 1995, the first time such a trend has emerged since cancer statistics began to be recorded nationally in the 1930s.

"This looks like a turning point in the 25-year war on cancer, and it should be a cause for celebration by every American," said HHS Secretary Donna Shalala in a statement. "This is not a one-time blip, but a real and promising downward trend."

American Cancer Society officials, at a news conference in Washington on Nov. 14, said it would be realistic to project that the cancer mortality rate would continue to drop about 1 percent a year for the next 20 years, for a 25 percent decline in cancer mortality by 2015.

Moreover, ACS officials said, it would be possible to cut the mortality rate by 50 percent in the next two decades if everything known about cancer prevention, detection and treatment were applied to all Americans.

NCI officials did not make such specific predictions, but said the Institute's analysis of figures released by the National Center for Health Statistics of the Centers for Disease Control and Prevention supported the finding of nearly a 2 to 3 percent drop in cancer mortality over the past five years, depending on how the data are analyzed.

"Since we started following cancer statistics in the 1930s, we have observed what appears to be an inexorable rise in age-adjusted mortality: six decades of mortality rates rising," NCI Director Richard Klausner said. "All of the analyses say that sometime in the last five years that rise ended, we have reached what appears to be the peak, and there is evidence that we are coming off that plateau and falling."

The exact rate of decline depends on the analysis, Klausner said. "Depending upon the age distribution, we calculate drops over the past five years in cancer mortality of anywhere from 3.5 percent down to 1.8 percent," he said. "The conclusion is clear: the peak has been reached, and overall mortality for the first time is dropping."

NCI: "Strides in Prevention, Tobacco Control"

Most of the overall drop in the death rate is due to declines in lung, colorectal, and prostate cancer deaths in men, and breast, colorectal, and gynecologic cancer deaths in women, NCI officials said.

Some of these trends were noted previously; for example, the breast cancer death rate has been falling since 1989, and the colorectal cancer rates have been falling for about 10 years in men and several decades in women, NCI said. Other trends, such as the decline in prostate cancer mortality, have only now become

apparent.

"The decline in mortality reveals the strides we have made in prevention through tobacco control, in early detection, and in treatment," said Brenda Edwards, associate director, NCI Cancer Control Research Program. "The knowledge that has flowed from years of research, combined with a massive effort to apply that knowledge for the benefit of people, has made the difference."

NCI said the following trends can be seen in the new data:

--The decline in mortality has been greater among men than women, although the absolute rate remains substantially higher in men. From 1991 to 1995 the rate declined 4.3 percent in men and 1.1 percent in women. By contrast, from 1971 to 1990, the rate rose 7.8 percent in men and 6.9 percent in women. The gender discrepancy in recent trends is largely a result of changes in lung cancer rates, which in turn are strongly influenced by smoking patterns. Lung cancer mortality fell 6.7 percent in men in the five-year period while rising 6.4 percent in women.

--The decline in cancer mortality has been greater among African Americans than white Americans, although rates are still about 40 percent higher in black men than in white men. For blacks the overall rate declined 5.6 percent, while for whites the rate declined 1.7 percent. The decline in cancer mortality among blacks is largely due to trends in lung cancer in men and colorectal cancer in men and women.

--The breast cancer death rate in women declined 6.3 percent between 1991 and 1995, with a larger decline in women under 65 (9.3 percent) compared with women 65 and older (2.8 percent). These gains reflect the success of both early detection and treatment advances.

--Cervical cancer deaths fell 9.7 percent, reflecting the continued widespread use of Pap screening. Ovarian cancer deaths fell 4.8 percent, nearly all of the decline due to the trend in women under age 65.

--Prostate cancer mortality declined 6.3 percent. The rate for men under age 75 fell 7.4 percent, while the rate for men 75 and older fell 3.8 percent. White men had a greater decline in prostate cancer mortality than black men. Causes of the prostate cancer trend are unclear.

--Colorectal cancer mortality continued to decline for both men and women, a trend that likely reflects the success of early detection, better treatment, and possibly changes in diet and other risk factors.

--Mortality from non-Hodgkin's lymphoma continues to increase among both men and women.

The data were obtained from 1995 preliminary cancer mortality rates provided by the National Center for Health Statistics, based on 80 percent to 90 percent of all death records for 1995, NCI said. Final rates and a more complete analysis will be released in 1997, Institute officials said.

"Despite this good news, cancer remains an enormous burden, an enormous menace," Klausner said. "This year, over a half a million Americans will die from cancer.

"The report today is not a cause for complacency," he said. "It is a demand for increased commitment, but it is a commitment that we can now go forward with, with a sense that we do know what to do."

The NCI analysis did not address cancer incidence rates. NCI estimates of cancer incidence rates are based on data from 10 population-based cancer registries that make up the Surveillance, Epidemiology, and End results Program. The most recent SEER incidence data extend to 1993, and can be found in the SEER Cancer Statistics Review 1973-1993 on the SEER World Wide Web site (http://www-seer.ims.nci.nih.gov).

Just one week following the NCI-ACS press conference, a study published in the Nov. 20 issue of the Journal of the National Cancer Institute found that the prostate cancer incidence rate dropped by 16 percent for white men and rose 2 percent for African American men between 1992-93, the latest period for which data are available.

Prostate cancer incidence rose sharply between 1989-1992: 61 percent among whites and 65 percent among African Americans, said the study, led by NCI researcher Ray Merrill. The increase has been attributed to the widespread use of PSA for screening and detection.

Merrill found that prostate cancer incidence began falling earlier than 1992 in some geographic areas and that rates vary by region. Also, incidence rate changes varied by age group and by race. Declining rates were observed in the older age groups.

The authors concluded that additional research is needed to determine why prostate cancer incidence

rates began to decline in 1992 and 1993. The decline may reflect reduced use of PSA for screening and detection due to unresolved questions about its value, the study said.

Cole Finds Reduction of 3.1 Percent

Philip Cole, professor of epidemiology at the University of Alabama at Birmingham, lead author of a study published in the Nov. 15 issue of the ACS journal Cancer, examined data from the Vital Statistics of the United States, Monthly Vital Statistics Reports of the US Centers for Disease Control and Prevention, and the NCI SEER program.

After decades of continuous rise, the overall age-adjusted cancer mortality rate declined in each subsequent year from 1990 to 1995 for a total reduction of about 3.1 percent, Cole said.

"In 1990 the annual cancer mortality rate was 135 deaths per 100,000 persons," Cole said. "By 1995, the rate had declined to just under 129.8 deaths, a reduction of 3.8 percent in five years. This decline is accelerating and is now continuing at about 2 percent per year."

The study was funded by a grant from Shell Oil Co. Foundation.

Cole and his co-author, Brad Rodu, also of University of Alabama at Birmingham, attributed the decline to prevention, particularly anti-smoking activities, early detection, and improvements in medical care.

Lung cancer mortality declined 3.9 percent, according to the study. Other smoking-related cancers declined by about 2 percent. "Smoking is the major known cause of cancer, particularly of lung cancer, and its prevalence began a long-term downtrend in 1965," Cole said. "It was inevitable that lung cancer incidence and mortality rates would begin to decline some 20 or so years later."

In an editorial in the same issue of Cancer, Curtis Mettlin, of Roswell Park Cancer Institute, wrote that cancer control involves more than scientific research. "Research plays an important role, but so do public and school health education, excellent and widely accessible treatment, outreach for early detection, workplace intervention, reduced exposure to environmental carcinogens, and improved nutrition."

Even if the declines continue, cancer will be the second leading cause of death in the US for many years, Mettlin wrote. "Death rates for some types of cancer are rising and socioeconomically disadvantaged populations do not yet share equally in the benefits of prevention, research and treatment," he wrote. "Furthermore, the decline in mortality is in the age-adjusted rate, but as the proportion of the population living to the advanced ages when risk of cancer is greatest increases, the number of persons diagnosed with cancer and dying from it actually will increase rather than decrease. These larger numbers at risk will require increased prevention efforts and greater health care resources."

According to Cole, the decline of cancer mortality is likely to continue for at least 20 years and may accelerate, unless there is a surge in incidence rates. "The decline will continue because we are just beginning to see the effects of long-term reductions in smoking and reduced exposure to other lifestyle carcinogens, such as alcohol and solar radiation, and to some industrial agents," Cole said. "The decline may accelerate as the now rising lung cancer mortality rates among women stabilize and then decline and as further advances in cancer screening, diagnosis, and treatment occur and become more widely available."

A decline in cancer mortality of 1.3 percent per year for the next 15 to 20 years is a "realistic estimate," Cole said.

ACS Issues A "Challenge"

ACS officials issued a challenge to the federal government, the private sector, and cancer organizations to work to accelerate the decline to 2 percent per year, for a 50 percent decline in cancer mortality by 2015.

"We believe that with a concerted effort to apply what we have already learned about cancer, and with renewed commitment to scientifific research and public health programs which are responsible for this new downturn in cancer mortality, we can, in the next 20 years, cut the rate of lives lost to cancer significantly, perhaps even to half the current rate," said ACS President Myles Cunningham, clinical associate professor of surgery, University of Illinois College of Medicine.

"However, this accelerated decline will take a higher level of urgency, resources and coordination of effort than is the case presently," Cunningham said. "We call on government, private sector and voluntary health groups like our own to dedicate themselves to working together to achieve this

accelrated decline in lives lost to cancer.

"With our colleages in the NCI, we make a pledge to the American people to jointly issue a regular report card of our continued progress in hastening the day when cancer is no longer a significant health problem," Cunningham said.

The society listed eight steps necessary to accelerate the decline in cancer deaths:

●Collaboration among non-profits, government and business to change health behaviors.

●Education and communications programs on cancer prevention, risk reduction and early detection.

●Tobacco regulation.

●Improved access to cancer information, early detection and treatment.

●Take advantage of improved health and cost savings offered by managed care's promotion of preventive care, early detection and risk counseling.

●Achieve consensus on standards of cancer information, screening, treatment and risk counseling.

●Increased funding for medical research.

●Intensify behavioral research.

Cunningham said ACS has not examined its screening guidelines in light of the new cancer mortality data. "We haven't looked at [screening guidelines] specifically from that point of view. We are constantly looking at our screening guidelines and we are constantly trying to update them," he said.

ACS is considering reducing the number of mammography screenings recommended for elderly women, and increasing the number of screenings for women between the ages of 40 and 50, Cunningham said.

"I'm not handing this out today as policy," Cunningham said. "I'm simply saying these are some of the challenging looks that we are constantly making based on the science."

Text of Shalala's Remarks

Following is the edited text of HHS Secretary Donna Shalala's remarks at the Nov. 14 news conference:

"Perhaps this is the beginning of a victory lap and we can celebrate Thanksgiving two weeks early, because today on behalf of all American families, those touched by cancer in the past and those who will be touched by it in the future, it is time to give thanks. We now have an entire generation of Americans who call themselves cancer survivors and another generation filled will greater hope for tomorrow.

"In our nation's battle against cancer, no one person, no one factor is responsible for this remarkable accomplishment. Each stood together on the shoulders of those who came before.

"We stand here today because of this nation's sustained, steady investment in biomedical research and in the institutions that do that research. Because of our committment to uncovering new ways to prevent, treat and prevent this menace. Because of the increasing expertise in the medical community, and because of the unwavering vigilance of scientists, of activists, of groups like the American Cancer Society and the survivor organizations themselves. We are here because the President has made fighting cancer and healing its victims a top priority.

"We should be proud of all these accomplishments—and proud of the distance we have traveled since 1971. But our journey is far from over.

"Today, too many families are still plagued by the menace of cancer and not enough of them know about what they can do to prevent it. Too many women are dying from lung cancer. Prostate cancer mortality rates among African American men are still disproportionately high, and too many of our children are picking up that first cigarette and risking their lives.

"We can and we must do better. We must never give up, despite the good news. We must continue to work for the day when our children must turn to the history books to learn about a disease called cancer.

"Reaching that day will take even more energy and more resources than we used to get here today. It will take better research, better treatments, better detection, and most important, it will take better education.

"From tobacco to poor diet to lack of reproductive screenings, we must give the American people the information they need to prevent cancer and make the best choices with the only lives they will ever have.

"I can think of no better way to celebrate the 25th anniversary of the [National] Cancer Act.

"Thank you to every scientist who ever grew up thinking that they had a chance to turn a corner on this, what seemed at the time, an impossible disease."