1995 Presidential Address

Things Will Never Be the Same Again

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The time was 25 years ago—Alvin Toffler coined the term "future shock" (1). He defined it as the dis-ease of change, a time phenomenon, a product of the greatly accelerated *rate* of change in society. He sensitized us to the concept of change run wild and the need to anticipate and manage it. Not that we should halt it, but that we should shape it.

That quarter century has gone by in the blink of an eye. For most of us it's not a matter of shaping change but hanging on for dear life as we are swept along by it. Today we live in a time of change so rapid that printed works are already outdated, equipment purchased today is obsolete even before it's delivered, and events occurring thousands of miles away are viewed as they occur, not minutes, hours, or days later. We live in a CNN society!

Toffler wrote *Future Shock* 6 years before Apple Computer was conceived and 5 years before Microsoft existed. Can you imagine a world without either one? Thirty years ago an IBM computer took up an entire room and required special climate control. Today we carry 4-lb PCs in our briefcases. We have access to libraries, databases, catalogs, and almost anything imaginable by simply turning on our computer. The Internet is poised to revolutionize business and our personal affairs once again, not just here at home, but throughout the world.

It is hard to believe that the knowledge gained in the past 3 decades dwarfs that which has accumulated from the beginning of mankind. Watson and Crick were awarded the Nobel Prize in 1962 for their discovery of DNA. Today, only 30 years later, we are routinely using DNA testing to "fingerprint" in criminal trials, and gene "mapping" shows great promise in understanding and curing human disease.

Beyond changes in technology and genetics is a revolution with even more dramatic impact for all of us in the American Diabetes Association: changes in health care delivery in the United States. Once again, the pace is breathtaking. I don't need to tell you all of the issues. The question is, Will many of us go the way of the house call if we don't play a key role in shaping this change? Unfortunately, many signs point to yes as the answer. We may become less essential. The public and employers have spoken: they can't afford to pay the bill! Have you started thinking about the steps you'll take to remain relevant?

Indemnity health insurance became a benefit of employment after World War II, in large part because of the rising cost of medical care. Even before that time, in 1945, Kaiser, anticipating the future, envisioned an all-inclusive health care plan for its employees. Today, we recognize this as the birth of managed care. Back then, health care professionals and the health care industry did not clearly recognize this as the conception of a revolution that would explode in the last decade of this century. Well, it's here! And this dramatic change is affecting every one of us!

Let me put it in perspective for you. According to the Health Insurance Association of America, in 1993, for the first time, the number of people covered by traditional indemnity medical insurance represented less than half of all people who had health coverage through employer-sponsored plans. Employees enrolled in managed-care plans constitute more than 67% of all people with employer-sponsored insurance. This figure has soared from 29% in 1988. In that same time span, enrollment in health maintenance organizations (HMOs) has increased to 45% of all people with managed-care plan health insurance. Enrollment in preferred provider organizations (PPOs) has jumped from 12% to 47%. In Southern California alone, it is estimated that 75 to 80% are enrolled in some form of managed care. However, these figures do not tell the whole story. The current threat of government-mandated health care reform without adequate health care professional input developed alongside the revolution that was already occurring within the industry. The attention by the government has been driven by concerns about the absolute number of people who are uninsured or underinsured and the bottom-line cost of medical care.

The latest bombshell is a recently released report (3) detailing the ultimate bankruptcy of Medicare soon after the turn of the century. Something must be done to change the present fiscal course. How this will be resolved has not been clearly stated by any politician, economist, or social scientist in the context of our already overburdened fiscal resources. Not surprisingly, I, too, have no answer. But I am dead certain that we, as medical professionals, need one. And we need it soon!

The shift to managed care, the potential for increasing government regulation, the impending demise of Medicare, and the moral need to provide medical care for all Americans will continue to profoundly affect each of us in the days to come.

Now what about the other side of the health care coin, the personal side? We see increasing change. Remember when

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you had a doctor who was like part of your family? Each of us now sees our personal choice of health care coverage shrinking. More and more people are forced to choose managed-care options because of cost rather than what fits their needs. Persons covered by Medicare face an increasing burden of copayment and decreasing ability to secure Medi-Gap coverage, as well as the probability in the future of being directed into managed-care programs.

As biomedical researchers, we are now experiencing a dramatic change in the way the present Congress and recent past administrations view the benefit of biomedical research. It's no longer an investment in a future of hope and promise. Biomedical research is being viewed no differently than any other line item in the budget. There is no recognition of the health care savings and improved medical outcomes of our future generations leveraged by every dollar invested in research. In fact, the House Budget Committee recently recommended a 5% cut in the NIH budget for next year. The committee also recommended the budget be frozen at that level until the year 2001 (4). This represents a significantly greater absolute cut, considering inflation and the fact that in current dollars the effective budget is no larger than it was in 1978. I probably don't need to remind you that diabetes alone costs this country more than $92 billion every year (5).

As health care educators, all of these changes will squeeze funds that have traditionally supported our medical schools and other health-related educational institutions. School after school is experiencing shortfalls in operating expenses compounded by shrinking research moneys. Many fear that we will see a significant decrease in the number of medical schools over the next decade.

As practicing physicians, especially subspecialists in diabetes and endocrinology, we wonder what our role will be as fewer people with diabetes are referred for care outside of the gatekeeper's practice and there is a diminishing ability to afford out-of-plan services. What about the roles of diabetes nurse educators, dietitians, podiatrists, pharmacists, psychologists, and other health care providers? What will this revolutionary change mean for them? One recent article in a Southern California medical publication (6) offers a hint of what it may mean for all of us. Titled "The Specialist Squeeze," the article reports on the wholesale elimination of subspecialists from independent practice association (IPA) referral panels.

My husband, a photographer as well as an endocrinologist, has been taking pictures of well-known figures in the world of diabetes for many years. When asked what he will do with the photographs, he replies that he is planning a book titled *Endangered Species*. Hopefully, it does not come to that end. However, the chances are good that will happen—*if* we remain complacent, oblivious to the winds of change, and fail to participate in the debate. Jay Skyler, a past president of the Association, warned us about "winds of change" three years ago (7). Well, those same winds now blow at gale force!

We can no longer sit back and wait. We must take control. *Control Your Destiny or Someone Else Will* (8) is the title of a book that details radical changes at General Electric that were made in an effort to keep the company competitive in a rapidly changing global market. The authors make a point that this same philosophy is as relevant to an individual as it is to a business. No one has absolute control over his or her destiny, but you must control what you can! This means taking responsibility and accepting the challenge of changing what you can and adapting to that which you cannot change.

I choose to view the present circumstances as opportunity. As practicing physicians and other health care providers, we must begin to define new roles. The managed-care setting provides a captive audience of people identified with a specific disease, diabetes. We might, for example, continue along a traditional path, proposing a diabetes care center, but within an HMO setting, which would serve as the primary care center for all people with the diagnosis of diabetes. This center would optimize diabetes management through a team approach, coordinate other subspecialty care, and demonstrate cost savings to the organization through decreased hospitalizations in the short term and decreased costs of complications in the long term. Others might choose to maintain a greater degree of autonomy by setting up such a center and contracting with multiple managed-care organizations.

I would encourage you to adopt a more futuristic approach, embracing the new information technology to implement consultation services to maintain our viability and provide the critical patient services. You can hopefully conceive of any number of innovative approaches to alternate forms of practice that will make you marketable in today's changing environment.

Only one thing is certain, and that was expressed by Max dePree, the former chairman of Herman Miller, "We cannot become what we need to be by remaining what we are" (9).

As President of the American Diabetes Association, I want to issue a challenge to all of us to view the current change as an opportunity and become creative about what we need to be. How can we use the information technology I discussed earlier to enhance our efforts? We must create new and unique models to utilize the diabetes care team in a cost-effective manner.

I am pleased to tell you that the American Diabetes Association has embraced Max dePree's sentiment and the opportunity all of this change offers. This year we embarked on a strategic planning process to set a course for the next 3 years. In line with our mission, "To prevent and cure diabetes and to improve the lives of all people affected by diabetes," it was determined that a key focus should be to increase public, patient, and practitioner awareness of the seriousness of the disease. Unfortunately, the public, patients, and, too often, doctors view diabetes as a disease that is not serious because we have medications with which to treat it.

They fail to consider that 16 million people in this country have the disease and fully 50% don't even know it! They fail to consider that diabetes is the leading cause of blindness and nontraumatic amputations and one of the leading causes of kidney failure. Although heart disease is recognized as a killer, they fail to recognize it as the leading cause of death in people with diabetes. We, the Professional Section, have an opportunity and an obligation, especially in this time of change, to help the Association educate the general population, patients, and health care providers about the seriousness of the disease and the importance of early diagnosis and treatment in the prevention of its debilitating complications. We must make it clear that not only is diabetes serious, it is also costly. How costly? Health care for people with diabetes accounts for almost 15% of the United States's health care expenditures (10).

How much could be saved if we diagnosed and treated

diabetes earlier in its course? How much could be saved if there was incentive for us to do this? A recent study showed that the Association's standards of care have not even been implemented in clinical training settings for endocrinology (11), so how can we expect them to be implemented in primary care settings? Another challenge. Another opportunity.

The means by which we, the American Diabetes Association, fulfill our mission will benefit not only the people with diabetes, but all of us in this room. I believe that in advocating for quality care for people with diabetes, we will, of necessity, advocate for more research dollars, greater access to specialty diabetes care, increased coverage of diabetes education, and increased coverage of prescriptions and diabetes supplies.

While I do not feel comfortable standing before you and outlining a situation that is threatening to each of us, I do believe we *can* make a difference! *Each one of us!* Marion Wright Edelman once said, "If you don't like the way the world is, you change it. You have an obligation to change it. You just do it one step at a time" (12). Whether we are patients, biomedical researchers, health care educators, or practicing physicians, we must take that first step!

I believe it is the responsibility of each one of us to honestly, with an open mind, assess our current situation. We need to support those things that are good and make better or different those that are not. We have to make our voices heard.

In this country, every vote counts. If you don't believe it, ask your congresspeople how they assess the sentiment of their constituents. They count the letters and phone calls! We must become proactive. We must become knowledgeable about the political process. We must become active in our professional organizations, especially in the area of government relations and advocacy. We need to add "Diabetes Advocate" to our CVs. Becoming advocates is one of the most effective ways for us to temper change.

How many of you have written to your congressperson recently? How many of you even know what bills are pending in your state legislature that will directly affect the way diabetes care is provided or medical schools are supported? How many of you know what the American Diabetes Association is doing through its Professional Education Committee, its Research Policy Committee, or its Government Relations Committee? It is no longer enough to pay our dues and "let the association do it." We must join with the Association to "do it" and take action. *Now!* Literally, right now.

An Action Alert brochure was included in every one of our scientific sessions registration packets. This alert talks about efforts to cut government funding for medical research. It also includes a form letter for you to use in making our voice heard about the need for federal support. Take 10 minutes, and that's all it will take, just 10 minutes, and write a note to Congress detailing why funding is important for continuing health care education and critical to finding a cure for diabetes. It's as easy as that.

In addition, I encourage you to sign up to participate in the Association's "Delegates for Diabetes" signature program. By doing the first activity, you have qualified yourself for becoming an important player in the second. "Delegates for Diabetes" needs individuals like you and me to write letters, make phone calls, and attend face-to-face meetings with policy makers on behalf of people with diabetes. Sign up. Get involved! Each one of us can make a difference, but collectively we can make an even greater difference. We must recruit our colleagues to join us. We cannot sit back and watch! We must accept the challenge of change and actively participate in shaping our future.

I want to leave you with a paraphrased quote that says it all: Never before has the pace of change been so great or so widespread; nothing will ever be the same again.

What an opportunity! What a great opportunity!

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