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ACS' Freeman: Declare New War On Cancer; Poor Get Substandard Treatment, Lose Dignity

Poor Americans are forced to accept substandard health care services and endure assaults on their personal dignity when seeking cancer treatment, a report issued this week by the American Cancer Society has found. The document, "Cancer and the Poor: A Report to the Nation," is the culmination of a series of fact finding hearings the society

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In Brief

NCI Providing Information On Levamisole To Patients; MacDonald Joins Temple, Salick

NCI HAS TAKEN the unusual step of encouraging patients to call the institute directly for information on levamisole. The number is 301/496-5725, which is the office of Clarence Fortner, who handles distribution of Group C drugs to physicians. Fortner is chief of the Drug Management & Authorization Section in the Investigational Drug Branch, Cancer Therapy Evaluation Program, Div. of Cancer Treatment. Levamisole was recently given Group C status, which means that NCI will distribute it free to physicians for use with 5-FU in treatment of Dukes C colon cancer. Patients who call for information are told that unpublished results of clinical trials show that the combination increases survival in Dukes C colon cancer, and that their physicians can get levamisole free for them by phoning that same number. **Janssen Pharmaceutica**, which owns the rights to levamisole, has agreed to supply the drug free of charge. . . . **JOHN MACDONALD**, chief of the Div. of Hematology/Oncology at Markey Cancer Center in Lexington, KY, has been appointed medical director of the Temple Univ. Cancer Center. He will also be chief of medical oncology and professor of medicine at Temple Univ. The cancer center, which will open in September, is a joint venture of the university and Salick Health Care Inc., the latest addition to Salick's nationwide network of cancer centers. MacDonald is former director of NCI's Cancer Therapy Evaluation Program. . . . **"IMMUNOLOGY** of Solid Tumors: Animal Models" is a workshop scheduled for Sept. 11-12 at the Crowne Plaza in Rockville, MD. The workshop is sponsored by the Extramural Research Program of NCI's Div. of Cancer Biology & Diagnosis. Contact John Finerty, Program Director for Cellular Immunology, Cancer Immunology Branch, EPS Rm 634, Bethes- da, MD, phone 301/496-7815; or Fran Oscar, CSR, 202/842-7600.

Poor Americans Receive Substandard Cancer Treatment, ACS Report Finds

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the society held in collaboration with NCI and the Centers for Disease Control in May and June.

At the hearings, about 70 economically disadvantaged people and 100 health professionals presented testimony concerning their personal experiences. More than 70 other individuals submitted written testimony at the hearings.

The report found that the five most critical issues related to cancer and the poor were:

--Poor people endure greater pain and suffering from cancer than other Americans, mainly due to late diagnosis.

--Poor people and their families must make extraordinary personal sacrifices to obtain and pay for care.

--Poor people face substantial obstacles in obtaining and using health insurance and often don't seek care if they can't pay for it. Less than 45 percent of those below the federal poverty level are eligible for Medicaid.

--Cancer education is insensitive and irrelevant to many poor people. There is a serious education gap in cancer prevention and detection for the poor.

--Fatalism about cancer is prevalent among the poor and prevents them from seeking care. Many believe that a diagnosis of cancer is a death sentence and that little can be done to help them.

"Based on the findings of this report, we need to declare a new kind of war on cancer--a guerilla war--that will tear down the economic and cultural barriers to early and adequate cancer prevention, diagnosis and treatment, and dramatically increase cancer survival rates for all Americans," said ACS President Harold Freeman in releasing the report this week.

The society estimates that 178,000 people with cancer who might be saved through early diagnosis and treatment will die this year alone. The survival rate of cancer among poor people is 10 to 15 percent lower than other Americans, according to ACS.

ACS is sending the report to health policymakers, advocacy groups, professional societies, social service agencies and other organizations as a national "call to action." Freeman urged local, state and national policymakers to address the issues in the report.

"Restricted access to health care is a devastating national problem that further impoverishes patients and their families, regardless of the disease involved," Freeman said.

"On a daily basis, the conditions of poverty are all but impossible for many poor people to overcome. When a serious health problem is added to the equation, the problems become insurmountable."

Freeman also emphasized that poverty should not be viewed as a problem of others. "The circle of poverty is not a closed circle. There are middle class people today who will become poor tomorrow. Let us see our own reflections in the faces of the poor," he said.

Kathleen Horsch, chairman of the board of ACS, announced the society's commitment to a three year demonstration project, designed to help develop and promote effective ways to address the cancer education, prevention and detection needs of the poor.

On Aug. 15, ACS will convene a task force of key national volunteers and staff leaders in Atlanta to review the hearings and the findings of the report, Horsch said. ACS will hold a national conference on cancer in the poor in September.

At the conference, the "action plan" devised by the task force will be presented to volunteers and staff leaders of the 57 ACS divisions and leaders of community service organizations and other health agencies. Then a final plan will be presented to the ACS Board of Directors for their approval in early November.

Starting in October, the society will provide $1.8 million in grants for three communities to develop and test program models that can be duplicated in other communities. It will be the first phase of the three year project. ACS is

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reviewing applications for projects in Harlem, Oakland, CA; and Miami.

Recently, ACS committed nearly $1 million to support local pilot education and research activities around the country that are targeted to the disadvantaged.

Horsch also outlined the society's plans to get the report in the hands of people who can influence health care for the poor. HHS Assistant Secretary James Mason attended the press briefing. President Bush, Congressional leaders, HHS Secretary Louis Sullivan and key members of the White House domestic policy staff also will be receiving copies of the report.

The report lists 10 "challenges" the country will face in addressing the problems of the poor in seeking cancer education, prevention and treatment services:

--Assure that cancer prevention, detection, treatment and rehabilitation services are available and accessible to all who need them, regardless of the ability to pay.

--Improved cancer prevention and early detection among poor Americans to eliminate unnecessary pain, suffering and death.

--Undertake aggressive educational efforts to counteract fatalism, overcome fears and enable poor people to reduce cancer risk.

--Improve and expand public and private assistance for the poor, including health insurance.

--Develop cancer education materials and outreach programs which are culturally sensitive, understandable and relevant to poor people.

--Establish patient advocates and referral services to help poor patients navigate the health system and manage personal problems that result from cancer treatment.

--Involve community organizations serving the poor and poor people themselves in cancer education and patient advocacy programs.

--Train health care providers to be sensitive to the needs of poor patients and to better serve their needs.

--Expand availability of and accessibility to health services for poor people in rural areas that are now underserved.

--Conduct research to further document the scope of the problem and identify effective interventions.

The hearings that were the basis of the report were held in seven cities: Atlanta, GA; El Paso, TX; Jackson, MS; Newark, NJ; St. Louis, MO; Phoenix, AZ; and Sacramento, CA. A panel of ACS volunteers, representatives from NCI and CDC, and state and local policymakers questioned those testifying.

At the briefing announcing the report, two women representing the poor spoke about their experiences.

Barbara Johnstone, of Grand Junction, CO, had cancer that was originally misdiagnosed and she delayed seeking further treatment. She is uninsured and has had breast, bone and other cancers. She lost her job and home, and moved from her hometown to be near a treatment facility.

Cassandra Middleton, of John's Island, SC, single with two children, had sought treatment for a leg ailment for months before she was finally diagnosed with osteosarcoma in 1985. A physician told her that her leg had to be amputated, but her family encouraged her to seek a second opinion. She was eventually admitted for treatment at NIH. She is unemployed.

Freeman said that at the hearings, the disadvantaged "described with passion the frustrations the poor experience in seeking and obtaining care, their lack of information and their battles with insensitive providers. They told of their struggles with bureaucracies where obstacles to care seemed to broaden the more they tried to understand the procedures involved.

"They talked about their fears about cancer, their hesitations about going for cancer screenings, and the devastating impact cancer had on them and their families," Freeman said.

"ACS has been the public's advocate for cancer control and we are committed to helping people who are at greatest risk of dying from cancer," Horsch said. "That is why we believe it is our responsibility to raise attention to the problems disadvantaged persons face. The hearings provided a valuable snapshot of the problem and reinforced the urgency to move forward.

"ACS intends to make sure that the nearly 39 million Americans now living below the poverty level have the same opportunity to protect themselves against cancer as we do."

NCI Director's Statement

NCI Director Samuel Broder called the ACS report "a milestone" in the effort to prevent and control cancer.

NCI "shares the Society's conviction and concern that poor people face a disproportionately increased risk of dying from cancer than do other Americans," Broder said. "NCI staff who served as panel members (for the

hearings) were struck both by the awesome challenges facing our traditional medical system and by the indomitable spirit of individuals trying to cope with their disease. The many hours of heartfelt testimony sharpened our sensitivity to the cancer control needs of poor people and rekindled our sense of urgency in helping.

"The Society's report confirms and adds to the findings of our own public participation hearings sponsored by the National Cancer Advisory Board in 1987 and 1988. Among the NCAB's key recommendations were achieving increased access to more affordable screening procedures and improving information programs for underserved populations, including the indigent and older Americans.

"I have set as an institute priority the reduction of cancer mortality rates among minorities and other underserved groups.

"The solution to providing adequate cancer prevention and treatment for our nation's poor demands the commitment of both governmental and private organizations. Resolving the complex medical, economic and social issues of cancer in the midst of poverty will challenge the imagination and resources of all sectors in our society.

"NCI applauds this bold initiative of the ACS. We pledge our full support and cooperation in addressing the recommendations of the report," Broder concluded.

The CDC "enthusiastically endorsed" the ACS report, said Assistant Surgeon General Jeffrey Koplan, who is director of the Center for Chronic Disease Prevention and Health Promotion at the CDC.

"CDC's insight and work have been enriched by the Society's firsthand look into cancer among the poor," Koplan said. "We look forward to further cooperative efforts with the Society."

Sondik Named Acting Deputy Director Of DCPC; Sinks Leaving At End Of July

Peter Greenwald, director of NCI's Div. of Cancer Prevention & Control, has named Edward Sondik acting deputy director, filling the position left vacant when Joseph Cullen departed last month. Cullen is now director of AMC Cancer Center in Denver.

Sondik is associate director of DCPC and director of the Surveillance Program.

In another development that further depletes the already decimated DCPC staff, Lucius Sinks, who has been chief of the Cancer Centers Branch for the past five years, will leave NCI at the end of July. He plans to spend several months at Georgetown Univ. in teaching and patient care.

"I feel privileged to have served NCI and NIH," Sinks told **The Cancer Letter**. "I believe the NIH system of awarding grants through peer review is exemplary and represents the highest standards of excellence in the U.S. government." Donald Fox, acting director of the Centers & Community Oncology Program, will be acting chief of the branch.

Regulations require that the deputy director, as well as the vacant associate director positions, be competed. Greenwald indicated, however, through announcements simultaneously with Sondik's appointment that Sondik is his choice for permanent deputy director.

Brenda Edwards, who has been Sondik's assistant in the Surveillance Program, has been named acting associate director and director of that program.

Sondik will move immediately from DCPC offices in Executive Plaza North to the deputy director's office in Building 31 on the NIH campus.

Sondik will continue as acting director of the Cancer Control Science Program, a position he has held since replacing Lillian Gigliotti last year. But Greenwald said he is actively recruiting for a permanent appointment to that position.

The Cancer Prevention Research Program also lost its director when Daniel Nixon left to join the American Cancer Society. Greenwald announced that Richard Costlow, who has been assistant associate director, has been named acting associate director.

Inquiry Of NCI Researcher Triggers Erroneous Journalism About Gallo Lab

A conflict of interest inquiry by HHS involving a member of Robert Gallo's Laboratory of Tumor Cell Biology has triggered an outbreak of sloppy journalism on the part of two Washington and New York publications which reported the lab was under "criminal investigation."

The story was first reported by Bonar Menninger of the "Washington Business Journal," who then alerted Charles Ortleb, publisher of the "New York Native," a publication with a history of AIDS program bashing.

The result was a dramatic, albeit erroneous,

headline in the "New York Native": "Criminal Investigation of Gallo's Lab Begins."

The package of stories prepared by Menninger for the "Washington Business Journal" quoted Ortleb, while Ortleb's story in the "New York Native" quoted Menninger's story.

Despite the headline, Gallo's lab was not under criminal investigation, but Sayid Zaki Salahuddin, an AIDS researcher at the lab, is indeed being investigated. The investigation is apparently in connection with allegations that Salahuddin maintained a close relationship with Pan Data, a firm his wife started, then left after a brief tenure.

Another matter under investigation is Salahuddin's recommendation that Pan Data receive a subcontract from Microbiological Associates Inc. of Rockville.

Microbiological Associates officials refused to discuss the value of the subcontract, but **The Cancer Letter** has learned that the deal, which involved work with antibodies to detect the HHV6 virus, was valued at $10,000.

Attorneys for Salahuddin and Pan Data deny the allegations of impropriety. No formal accusations have been made.

The "Washington Business Journal," a weekly publication based in Vienna, VA, relied on unnamed "sources at the National Cancer Institute and elsewhere" who have alleged that "Salahuddin has maintained a close relationship with Pan Data for a number of years and regularly made key decisions involving marketing, hiring, and procurement opportunities for the company in violation of the federal conflict of interest laws."

The only official comment quoted on the matter was a statement by the HHS Inspector General's office that Salahuddin was under investigation.

According to his curriculum vitae, Salahuddin, 48, has a master's degree in zoology and cytology from Univ. of Dacca, and has written 99 papers, including several co-authored with Gallo.

"It is my feeling as a division director that Salahuddin is a valuable scientist in the Laboratory of Tumor Cell Biology," said Richard Adamson, Director of NCI's Div. of Cancer Etiology, which oversees the lab's work.

"The entire lab, including him, was peer reviewed in December, 1986," said Adamson. "His projects were very favorably reviewed, and he was recommended to be promoted with tenure."

Julian Greenspun, an attorney for Pan Data, said that Firoza Salahuddin was involved in starting up the firm in early 1984, but left later that year.

At the time Pan Data was a bookkeeping support services firm with one full time and two part time employees.

Mrs. Salahuddin, a bookkeeper and clerk, worked part time for several months in 1984, left, then returned as a consultant for a short time a year later, Greenspun said.

In the last few years Pan Data became a laboratory that employs 40 and does business with NCI, but attorneys who represent the company and the Salahuddins said the couple had no financial interest in the firm.

In January, Pan Data won a $1 million contract from NCI, but, sources at NCI say, standard contract award procedures precluded any staff scientist from influencing the award process.

"I can't conceive of how Salahuddin would have had any input at all with regards to the recent award of the Pan Data contract," said Adamson.

"It was concept reviewed by the DCE Board of Scientific Counselors in an open public session. It had a review by an initial technical review group, and by the DEA Contracts Review Branch, and it was further evaluated by a source evaluation group.

"Salahuddin had no input to any of those groups, and, in fact, there were no voting members from the laboratory [of Tumor Cell Biology] on any of those groups," Adamson said.

Adamson refused to comment on allegations concerning the subcontract from Micorbiological Associates to Pan Data, saying only that there is no connection between that and the NCI contract award.

"It's my impression that some people, for whatever reasons, are trying to mix the two," Adamson said.

Sources close to the case said the HHS investigation was begun in response to a complaint from a disgruntled former employee.

"The article in the Washington Business Journal is misleading, distorted, pointless and based upon disinformation insofar as it relates to Mr. Salahuddin," said Seymour Glanzer, an attorney retained by Salahuddin.

The "Washington Business Journal" story took the controversy beyond the matter under investigation by HHS.

"Allegations of conflict of interest in the laboratory of Robert Gallo... could fuel an

obscure, but potentially explosive controversy centering on the origin of AIDS and the relationship between top researchers and the biotechnology industry," said the story, launching into an exposition of the theory that the HIV virus does not cause AIDS.

Menninger, who is a general assignment reporter, said that after finishing his story he telephoned Ortleb.

"I spoke with him, but there were no specifics on what the story involved," Menninger said.

Ortleb tells it differently: "I got an advance copy. We've given him [Menninger] tips on bigger stories."

After getting an advance copy, Ortleb said, "I added a whole twist to that thing."

As evidence of that new twist, a subheadline, done in a slightly smaller font, announced: "Gallo May Have to Return Money Stolen from LAV Discoverers."

NCI Stands To Lose 382 Cancer FTEs In 1990; DCE Board Expresses Concern

NCI will lose a total of 382 full time positions devoted to cancer in fiscal 1990 under the President's Budget, NCI Director Samuel Broder has said.

Broder gave an update of the situation of full time equivalents, or positions, at the recent meeting of the Div. of Cancer Etiology Board of Scientific Counselors.

The loss of cancer FTEs will be offset slightly by a gain of 116 FTEs for AIDS, but the net result is a loss of 266 FTEs for NCI.

By comparison, NCI had 2,000 FTEs in fiscal 1984. In fiscal 1989, NCI had 1,962 cancer FTEs and 188 AIDS FTEs.

Broder said he is concerned about the situation, since lack of staffing limits the director's ability to implement new programs.

"If we don't have good staff, nothing else matters," Broder told the DCE Board.

Board Chairman Hilary Koprowski noted that the DCE Board had sent a letter to HHS Secretary Louis Sullivan expressing its concern about the FTE situation.

Koprowski read Sullivan's response:

"Thank you for your letter expressing concern that NCI will gain AIDS research full time equivalents but will lose cancer dedicated FTEs. I understand the FY 1990 budget assumes that NIH can reduce its FY 1989 estimate of 13,252 FTEs by about 145 through management improvements. I agree that the nation's research base on AIDS needs to be increased, but that this should not come about as a result of a loss of cancer dedicated FTEs.

"I appreciate your bringing to my attention the concerns" of the DCE Board, Sullivan continued.

"Having served two years on the National Cancer Advisory Board prior to being appointed Secretary, I am very much aware of the excellent basic and applied research ongoing at NCI. Please be assured of my continued support in this matter."

Board member William Benedict told Broder, "I think we are at the point where NCI is not viable."

Broder disagreed. "I don't want to contribute to a sense of despair. NCI is a viable institution, a lot of people do good work here. We are viable, but the patient needs some attention."

Koprowski, echoing Broder's statement that he had provided Congress with "good news and bad news about cancer," noted that, "The bad news of the budget has outweighed the good news."

"It really will bring a disaster to science" if these tight budgets continue, Koprowski said. "The only weapon we know how to use in this battle is to place pressure on Congress."

Cancer Care Driven Toward "Triage" System, Puerto Rico Dean Tells AACI

Cancer care in the near future may be driven toward a "triage" system, in response to sociological changes, the changing demographics of cancer as well as competition for appropriations from AIDS, said Angel Roman-Franco, dean of academic affairs of the Puerto Rico Medical Science Campus.

Physicians in Puerto Rico and nationwide will soon have to decide "who will get such and such a cancer treatment, and who will not," said Romano-Franco, addressing a meeting of the American Assn. of Cancer Institutes, held in Puerto Rico.

"Seen in the broader context of society, the question being posited is one that is infrequently discussed in polite company, because it raises the specter of triage," he said.

In a way, triage has already begun, as the health care system favors the well to do over the poor, he continued.

"The nation is beginning to triage between the haves and the have nots," he said. "Those who have go through the 'immediate door.' The

rest join the other triage categories; categories whose landmark is: Wait.

"Indeed, I was surprised that it required a study by the American Cancer Society to demonstrate that the reason minorities have a mortality rate due to cancer higher than that of the mainstream population is not because of all the biological rationalizations I read about in many a grant application, but because of the raw fact that members of such minority groups can't buy into the system," he said.

"But let us look at several other societal aspects of cancer. Today we are speaking of investing enormous quantities of money in the prevention of cancer and in education, as well as research, while at the same time we are confronted with an impending dearth of resources. I therefore find it inexplicable that we still subsidize a carcinogen industry: the tobacco industry.

"Indeed, it is an economical situation so bizarre that it is as if one were to introduce poisons into the environment in order to provide justification for an antidote industry.

"But this folly is not just of our time. Only a century ago a phenomenon similar to the tobacco and tobacco induced illness dyad occurred, and with similarly nefarious consequences. The cravings of the Europeans for two particular non-nutrients: refined sugar and tea, led to the near destruction of one society via drug addiction, the Chinese, and to the mass killing of 30 million black Africans brought as slaves to this island and other islands of the Caribbean over the course of 150 years, to cultivate the sugar cane.

"Tobacco was one of the industries for which slaves were imported into the United States and the Caribbean. Repercussions of this historical reality are still with us today in the form of racial prejudice.

"Another societal aspect has one of its roots in the biology of cancer. If our own data is to be believed, one out of every three to four of us will develop cancer at some point in our lives.

"Clearly, the cancer patients of the year 2000 are already walking the sidewalks of San Juan with an incipient malignancy lurking some distance away. And many of these people will have to confront the reality of their disease in a society ill prepared to care for them.

"Today, the divorce rate in many places in the nation stands at around 50 percent. The average duration of these ephemeral, transient alliances leads to children being born to live a nomadic existence, in transit between parents. The end result is the demise of the family. So, the probability is very high that not only will persons develop cancer, but that they will suffer through it alone, bereft of the comfort of a caring family, not because the family is callous, but because there is no family left.

"Solitude is no adjuvant to cancer therapy. On the contrary, it increases costs because custodial care becomes necessary. It leads to poor compliance with therapeutic regimes, which in turn increases costs and diminishes the rate of cure or control.

"In other words, there is a price to pay for social dissolution, and in cancer sociology (what I call oncosociology) that can be measured in dollars that will not be available for bench research.

"This merits the full attention of AACI. Yours is a highly respected association that should promote research into the impact of these social developments on the well being of cancer patients.

"Today, a lifesaving discovery as important and as valuable as the measles vaccine, is useless for the prevention of disease in many parts of the world because political, economic and cultural forces prevent it from reaching the intended target population: children die as a result.

"That is the reason I am alarmed when I hear subterranean voices uttering dark words about money being wasted on so called soft science--meaning the social sciences--instead of on bench research. I know, for I am a veteran of many a cancer control program battle.

"It should be a priority of this group (AACI) to stimulate the appropriate agencies to make available the monies for research. Simply put, we cannot allow valuable discoveries, such as the potential of prophylactic treatment of lymphoma patients with verapamil to curb the expression of p-glycoprotein, and hence multidrug resistance, to wither on the vine.

"In Puerto Rico the problems I have addressed manifest a unique dimension: we have the added problem of the return migrant. Studies sponsored by the Puerto Rico Cancer Center showed that we are experiencing a demographic phenomenon that is leading to an accelerated aging of the Puerto Rican population. Our population's median age will increase from 24 years in 1980 to 32 years by the year 2000; the figures for males are 23 for 1980 and 30 for the year 2000, whereas the female population will age appreciably faster, from a median of 25 years in 1980 to 33 at

the turn of the century.

"A factor contributing to this ageing is the phenomenon of the return migrant. Puerto Ricans who migrated to the mainland five or six decades ago are coming back, while at the same time our brightest and youngest are moving to the mainland. Several of your cancer centers have benefited from this emigration.

"Given the above figures it should not come as a surprise that the profile of the typical return migrant is as follows: an elderly woman, whose husband died, or divorced her, or in some cases abandoned her years ago. Her children are long gone, living a continent away, and she returns to Puerto Rico seeking the social support network that cradled her in her youth, but that no longer exists. At her age only early detection is available to her as an effective cancer management tool, because she is well past the stage of prevention. But she is ill informed, alone and without money to purchase the necessary wherewithals to secure adequate information or adequate treatment.

"The cancer patient of the year 2000 will be an elderly patient, most probably female, bereft of resources, waiting in solitude. Our cancer center, under the leadership of Reynold Lopez Enriquez, is insistently pressing the local authorities to prepare themselves for the impact this demographic dislocation entails vis-a-vis health care in general, and cancer care in particular.

"But as if these kinds of problems were not enough, we have now the competing reality of AIDS. During the current fiscal year the monies devoted to education, prevention and research in cancer nationwide amounts to close to $1.4 billion. AIDS commands a budgetary attention of $1.3 billion. But 500,000 persons will die this year from cancer, whereas 35,000 are expected to die this year from AIDS. That's 12 cancer deaths for every AIDS death. But how swiftly this will change for the worse.

"In Puerto Rico alone, by the year 1992 the number of new HIV positive persons diagnosed that year will far exceed the number of new cancer cases for the same year; the number of newly diagnosed AIDS cases will reach 5,000. When that memorable date arrives, Puerto Rico will face the expense of its celebration with a bill of $330 million for medical costs for AIDS victims alone, and a total bill of $1.4 billion when the indirect costs, such as years of lost productivity, are factored in: amazingly, this is the exact total amount we are spending today, nationwide, in cancer education, research and prevention.

"This should be viewed in the context of the total budget of the government of Puerto Rico: $7 billion. We are going to be forced to do some very hard thinking concerning our social priorities.

"Although AIDS and cancer are germane diseases in some respects, the reality is that maternal/pediatric AIDS, the psychology of drug dependency and other such topics remote from cancer, but intimately linked to AIDS, will drain cancer dollars away from the agencies the AACI traditionally deals with.

"It should not come as a surprise if monies for cancer research actually stabilize or decline appreciably in the near future, although they may appear artificially inflated by the fact that sizable amounts of money devoted to AIDS will flow into the cancer centers. If we are not careful such a skewed distribution of resources will defocus some cancer centers and turn them into centers for the study of a very narrow range of malignancies."

RFPs Available

Requests for proposals described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Executive Plaza South room number shown, National Cancer Institute, Bethesda MD 20892. Proposals may be hand delivered to the Executive Plaza South Building, 6130 Executive Blvd., Rockville MD. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CN-85071-43

Title: Cancer prevention and control surveillance master agreement

Deadline: Aug. 25

NCI's Div. of Cancer Prevention & Control is soliciting proposals to provide information required for cancer control surveillance, the primary conduct of surveys, and similar evaluation processes. The term "survey" is used to connote a full range of studies, including probability sample surveys and abstracting data from existing primary and secondary sources for analysis.

The master agreement announcement is tentatively scheduled for release on or about Aug. 25, 1989. It is anticipated that multiple master agreements will be awarded pursuant to the MAA, each having a four year period of performance. Since master agreements are unfunded, the obligation of funds shall be accomplished solely through the award of master agreement orders, issued under the terms of this master agreement.

The master agreement orders will be issued on either a cost or fixed price basis.

The master agreement holder, upon award of a master agreement order, shall coordinate and implement the requested survey(s), including data collection, processing, and reporting for surveillance activities to be designed and developed by NCI alone or in collabortation with other organizations.

Contract Specialist: Diana Wheeler
RCB Executive Plaza South Rm 635
301/496-8603