THE CANCER LETTER

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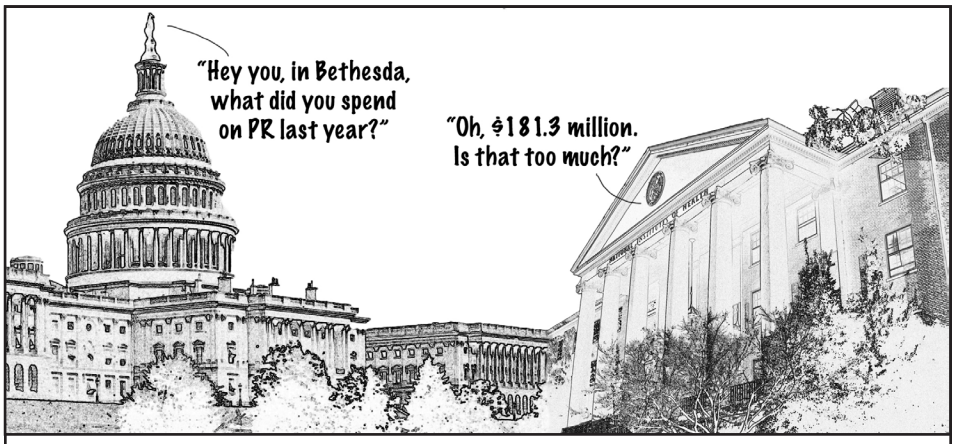

Congress Mandates NIH Cut PR Costs, Coordinate Spending on Communications

By Paul Goldberg

Congressional appropriators instructed NIH to cut spending on communications activities and coordinate the broad range of activities that fall under the category of public relations.

The mandate is a part of the report that accompanied the recently passed appropriations bill.

The report states: "The NIH has an important role in communications activities. The NIH Director is expected to develop an NIH-wide process to reduce duplication of effort, consolidate, improve efficiencies, improve coordination of messages and generally reduce costs in this area."

(Continued to page 2)

Conversation with The Cancer Letter

IPRI's Peter Boyle on Closing the Gap In Global Cancer Treatment and Outcomes

By Matthew Bin Han Ong

The International Prevention Research Institute has published "The State of Oncology 2013," a report that highlights disparate cancer outcomes between higher- and lower-resource countries and proposes long-term recommendations.

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In Brief

Vera Bradley Pledges $15 Mil. to IU Center

THE INDIANA UNIVERSITY Melvin and Bren Simon Cancer Center received a pledge of $15 million to support breast cancer research from **The Vera Bradley Foundation**.

This new pledge adds to the previous $20 million in commitments

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To Peter Boyle's Conversation with The Cancer Letter

Congress Investigates NIH's $181.3 Mil. Spent on PR in 2012

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The reports that accompany the appropriations bills don't have the force of law, but agencies that ignore such mandates do so at their peril.

The language is the result of an unusual—and likely unprecedented—investigation by the majority on the House appropriating and authorizing committees.

The investigation, publicly announced in a letter April 12, was started in response to a series of stories in which The Cancer Letter examined the cost of cancer communications.

Altogether, NIH spent $181.3 million on communications in the 2012 fiscal year, and NCI was by far the largest spender on campus.

The cancer institute spent $46.2 million on cancer communications that year. However, NCI Director Harold Varmus cut the budget by about 15 percent in 2013, as part of his response to sequestration and questions from Congress. He was expected to cut another 15 percent in fiscal 2014, aiming to bring the budget down to about $30 million.

The NCI Office of Communications and Education had spent a total of $381.2 million between 2006 and 2012. Varmus inherited the vast communications enterprise, which at its height—in fiscal 2006—devoted $68.135 million to activities that included supporting a call center, websites, warehouses, and a group of writers tasked to produce a news publication.

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These totals caused some consternation among scientists as well as on Capitol Hill, where the friends of NIH have been working to boost spending on biomedical research.

Last year, NIH officials said they had no uniform way of tracking expenditures on communications across institutes.

When The Cancer Letter began its investigation, NIH officials reported differences in accounting and classification of expenses across institutes. However, after Congress stepped in, the expenditures were tabulated more systematically.

Figures show that in fiscal 2012, NCI was the biggest spender on PR at NIH. Its spending amounted to 26 percent of the aggregate NIH spending on these activities.

The NIH Office of the Director was a distant second among the institutes and centers—with a $21.8 million budget divided among a large number of activities.

NCI's public relations and education budget was also roughly double that of FDA's PR operations that support health and medical programs. These offices run vitally important communications about outbreaks of disease.

The examination of NIH spending on communications started a debate among scientists.

In an editorial published March 13, 2012, the journal Nature said NCI's spending on cancer communications was high enough "to make even bureaucratically hardened Washington, D.C., insiders gasp,"

Taking the opposing view, the Federation of American Societies for Experimental Biology said in a letter to Nature that questions about NCI's spending on public relations and cancer education detract attention from a bigger problem: the drop in the government's funding of research.

In an apparent effort to cut costs, Varmus closed the NCI Cancer Bulletin, a newsletter that was designed by former NCI Director Andrew von Eschenbach in order to drown out this publication's coverage of his efforts to "eliminate suffering and death due to cancer" by the year 2015.

Though von Eschenbach failed to reach the goals to eliminate either cancer or The Cancer Letter, the publication he launched continued.

At the time it was terminated, the Bulletin employed at least four full-time equivalent employees, who, altogether, drew salaries of $468,080 annually. The Bulletin also used the services of contract writers

NIH IC	Total IC Appropriations FY 2012[1]	IC Communications Budget FY 2012[1]	Communications Budget as Percent of Overall IC Budget
NCI	$5,072,183,421	$46,186,000	0.911%
NIAID	$4,490,711,484	$7,254,286	0.162%
NHLBI	$3,079,020,632	$10,076,000	0.327%
NIGMS	$2,430,035,536	$2,285,435	0.094%
NIDDK	$1,947,044,155[2]	$11,847,191	0.608%
NINDS	$1,626,365,349	$5,491,044	0.338%
NIMH	$1,480,265,001	$6,559,455	0.443%
OD-OCPL	$1,459,117,047	$7,331,980	0.502%
Other OD Program Offices[3]	$1,459,117,047	$14,458,272	0.991%
NICHD	$1,321,397,829	$5,422,849	0.410%
NIA	$1,103,440,548	$5,366,490	0.486%
NIDA	$1,053,367,366	$9,313,586	0.884%
NIEHS	$764,498,332	$10,238,473	1.339%
NEI	$702,712,359	$6,764,502	0.963%
NCATS	$575,366,498	$3,175,874	0.552%
NIAMS	$535,786,446	$4,483,594	0.837%
NHGRI	$512,872,835	$2,950,000	0.575%
NIAAA	$459,518,865	$4,243,500	0.923%
NIDCD	$416,272,755	$2,729,000	0.656%
NIDCR	$410,710,288	$2,507,984	0.611%
NIBIB	$338,357,294	$1,360,854	0.402%
NLM	$337,638,655	$3,551,000	1.052%
NIMHD	$276,439,540	$666,000	0.241%
NINR	$144,768,869	$1,265,000	0.874%
NCCAM	$128,056,515	$5,113,043	3.993%
FIC	$69,622,165	$619,643	0.890%
Total NIH budget	$30,860,913,436[4,5]	$181,261,055	0.587%*

*Communications budgets across the NIH ICs represent less than one percent of the total NIH IC appropriations (FY 2012).

Notes on this table:

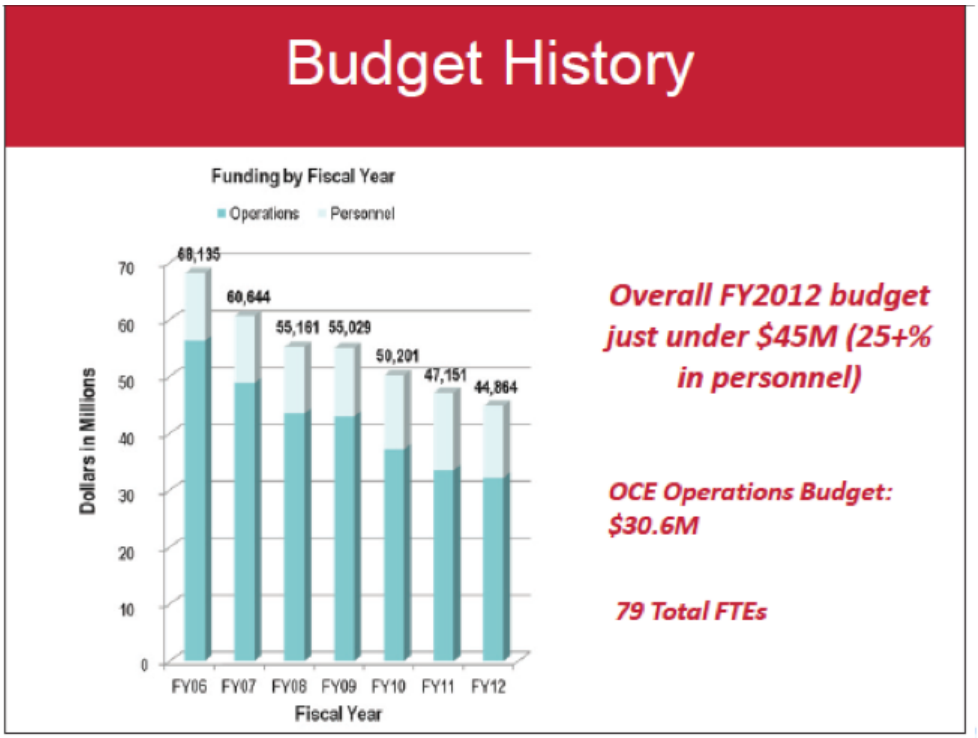
1) This column's individual components do not sum to the 'Total NIH budget' due to the nature of both centrally funded initiatives and offices at the NIH, as well as notes #3 and #4.
2) Includes $150 million from the Special Statutory Funding Program for Type 1 Diabetes Research. This appropriation is administered by the NIDDK on behalf of the HHS Secretary. These funds are separate from the regular appropriation and are dedicated to pursuing research on type 1 diabetes.
3) 'Other OD Program Offices' include the following OD offices: OIR, OER, ORS-ORF, and DPCPSI.
4) CSR, CC, and CIT are not included in this table, as they are funded through trans-NIH mechanisms.
5) While not a separate line on the table, the overall total appropriated dollars of $30.86 billion includes $125,343,652 in funds for the NIH Buildings and Facilities program (B&F), which supports the design and construction of new facilities for the NIH and the continuing repair and improvement of existing facilities.

Source: NIH

who, together, were paid $110,000 in 2012. The bills for website development services came to $31,440. In total: $609,520.

The Bulletin had other costs. The Spanish-language edition cost about $24,000 a year, NCI officials said. Some additional staff members—including two videographers—were involved part-time.

Assuming this level of spending over nine years—a conservative assumption—had the money spent on the Bulletin been redirected toward research, it could have provided direct support for 18 years' worth of R01 grants.



Overall, the 2012 OCE budget could have been redirected to provide direct support for more than 110 additional R01 grants, increasing the total number of grants by about 10 percent.

Alternatively, this sum could have reversed the cut the NCI cancer centers program sustained in 2011, boost the cooperative groups program by about 15 percent, or double Varmus's signature program, the Provocative Questions initiative.

Originally, Varmus asked a subcommittee of NCAB to advise him on the institute's communications. However, that charge was apparently eclipsed by development of the controversy.

Now, the issue will go to the President's Cancer Panel, which is completing a report on the HPV vaccine. At its March 3 meeting this year, the panel will turn to its new topic: "Cancer Communications in the Digital Era: Opportunities and Challenges."

Recently, OCE Director Lenora Johnson was named director of health education, communications, and science policy at the **National Heart Lung and Blood Institute.** Johnson had served as OCE director for over seven years.

Nelvis Castro was appointed acting director of OCE. Also during the transition, **Peter Garrett** will join NCI as Varmus's senior advisor for communications. Garrett was previously the director of communications and public affairs at HHS Office of the National Coordinator for Health Information Technology. He replaced Rick Borchelt, who left for the Department of Energy Office of Science in August.

According to the Public Relations Society of America, "public relations is a strategic communication process that builds mutually beneficial relationships between organizations and their publics."

A Series by The Cancer Letter
On the Cost of Cancer Communications

• Dec. 7, 2012: "Is $45 Million Too Much to Spend on PR? NCAB Panel Weighs NCI Communications Budget"

• Feb. 1, 2013: "NCI Ends Brash Foray Into the News Business—Emails Tell the Story of the NCI Cancer Bulletin"

• March 1, 2013: "NCI Spent $381.2 Million on PR from 2006 to 2012, Vastly Outspending Other NIH, FDA Units"

• March 15, 2013: "Nature Editorial Criticizes NCI PR spending"

• April 12, 2013: "House Launches Probe of NCI Spending On Cancer Communications, Education"

• June 14, 2013: "FASEB: Focus on Research Funding, Not PR"

• July 12, 2013: "NIH Spent $181.3 Million on PR Last Year; House Probe Prompts Analysis of Spending"

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Conversation with The Cancer Letter

Boyle: "We've Got to Think In a Very Long Time Frame"

(Continued from page 1)

In a conversation with The Cancer Letter, lead author and IPRI President Peter Boyle said the nearly 500-page document is "different from most books and textbooks in that it concentrates on patients and their problems, rather than basic science, genetics, and all the underlying scientific work that is going on in cancer at the present time."

The full report is available on the IPRI website.

According to the report, the global cancer burden has doubled over the past 25 years and is set to double again before 2030. As incidence, mortality, and prevalence increase, low- and middle-income countries struggle to keep up as these nations have limited access to cancer diagnostics and treatments. About 30 African countries have no radiotherapy machines.

"The issue is long-term," said Boyle, professor of global public health at Strathclyde University and former director of the International Agency for Research on Cancer at the World Health Organization. "If nothing is done, then the situation of the cancer outcome, in a broader sense, between the high and the lower-resource countries is going to deteriorate."

The report is important because it defines cancer disparities around the world, said co-author Otis Brawley, chief medical and scientific officer of the American Cancer Society.

"One of the reasons that I participated in this report was to try to convince people that these are legitimate problems that need to be addressed," Brawley said to The Cancer Letter. "We need to be rational, and on some respects, that means we don't be outrageous advocates of screening at the expense of not being an advocate for cancer prevention."

"That's the big difference between France or Germany and the United States—that's the reason why we were the 31st country, with a 20 percent decline in mortality," Brawley said.

"In the report, we talk about how Africa seems to be a place of growth for the tobacco industry—we need to do anti-tobacco work in Africa. We need to focus on five things: smoking cessation, nutrition and physical activity, regional focus on specific cancers, access to drugs, and prevention."

It takes decades to build a sustainable infrastructure in lower-resource countries, but prevention can be achieved more quickly and cheaply, Brawley said.

"Even in the United States, the biggest bang for the buck is prevention of disease," Brawley. "The greatest successes that we have had in the Western world in cancer control have actually come through prevention and not through cancer treatment, and the challenge is to an appropriate balance of the two."

If nothing is done, targeted therapy will not be at all available for lower-resource countries in the foreseeable future, Boyle said.

"There's a need for basic things to do—to get treatments available, to get access, to get all the diagnostics and the pathology, the surgery and the medical oncology, radiotherapy that we need to treat patients," Boyle said. "There is a need to get access to the markets in the individual countries to make all that available.

"It's really not a task for a generation or two generations, but we need to have a plan in place so that we can continue to make progress in the long term."

The global cancer movement is equally disparate, Boyle said, and a strong collaboration between the public and private sectors is needed to improve access to cancer services in lower-resource countries.

"Personally, I don't think we should go alone on the cancer front," Boyle said. "I think the problems that the lower-resource countries are facing—in diabetes in 20 years for example—are probably going to be greater than the cancer situation.

"And the thing that may be worthwhile to try is to consider packaging the whole thing up, and try to keep it as a chronic disease movement rather than just a simple cancer movement, which would be difficult to get together and is a lot of work."

The key word is sustainable—to create projects and infrastructures that can be maintained.

"I think we can spend our lives—this generation and the next generation—in high-resource countries, we can write reports, we can sit on committees, we can do all sorts of things from a distance, but unless society actually goes and does something on the ground in lower-resource countries, then we're not really going to make much of an improvement in their situation," Boyle said.

"The big lesson that we've got to take is not just the question of throwing money around, hoping something will grow."

MO: *How is this report different from all the other reports?*

PB: For the first thing, it's different from most books and textbooks in that it concentrates on patients and their problems rather, than the basic science,

genetics, and all the underlying scientific work that is going on in cancer at the present time. This is a very patient-oriented book and report and it highlights very clearly the huge disparities that exist throughout the world.

MO: *What would be your projection of the cancer problem worldwide in five to 10 years, assuming something is done?*

PB: I think we've got to think in a very long time frame. I think it's a myth that if we spend millions and billions and trillions of dollars on the cancer problem that we're going to find a cure for cancer, or indeed if we're going to resolve the disparities that exist.

The issue is long-term. There's a need for basic things to do—to get treatments available, to get access, to get all the diagnostics and the pathology, the surgery and the medical oncology, radiotherapy that we need to treat patients. There is a need to get access to the markets in the individual countries to make all that available.

But more importantly, when all that becomes available, patients have got to have access to all these diagnostics and treatments. So the key issue is the huge issue surrounding access. Everyone in the private and public sector wants access to markets in the lower-income countries, but you must tie that in to access of patients to those resources in the lower-resource countries.

So it's a very complex thing. It can't be done overnight. We can do that fairly quickly, getting access to the markets. It'll take a while longer to get all the patients in those markets to have access to the appropriate diagnostics and therapy, and it's going to take even longer to train enough technicians, enough nurses, enough specialist doctors to take care of the cancer problem in the lower-resource countries.

It's really not a task for a generation or two generations, but we need to have a plan in place so that we can continue to make progress in the long term.

MO: *This may sound rhetorical, but what if nothing is done?*

PB: If nothing is done, then the situation of cancer outcome, in a broader sense, between the high and the lower-resource countries is going to deteriorate. If we accept that targeted therapy (personalized medicine) is going to have a big impact on cancer extending lives, and improving quality of life, improving survival in the higher-resource countries, then it's something which is not going to be at all available for the lower-resource countries, because they just don't have the laboratory technicians, the bio banks, the training and equipment to measure the necessary biomarkers.

Peter Boyle

They don't have it, never mind the expensive drugs which they'll need. I see that as we continue to make progress in higher-resource countries, then the gap between the outcomes, in general terms, between the patients in higher-resource countries and the lower-resource countries, is just bound to increase. It is a very worrying situation that we're sitting here in the 21st century and the gap between high- and low-resource countries is increasing.

MO: *Is there a push for a cohesive global effort to address cancer now? Is this unprecedented?*

PB: I think there have been previous attempts. For example, at the United Nations Summit two years ago in September—while it opened up many channels and many doors and lots of discussion, it unfortunately hasn't resulted in very much activity on behalf of patients in the lower-resource countries.

I think we can spend our lives—this generation and the next generation—in high-resource countries, we can write reports, we can sit on committees, we can do all sorts of things from a distance, but unless society actually goes and does something on the ground in lower-resource countries, then we're not really going to make much of an improvement in their situation.

MO: *Speaking of the lower-resource countries, what does it take for the ones with little or no oncology expertise to develop the necessary technology and human capital?*

PB: We need to help them. You look around at the lower-resource countries—you think, well, the whole

Table 1: Reported five-year curability rates in common types of malignant Neoplasms (Nathanson, 1943)

Cancer site	Curability rate
Skin	48-68%
Breast	22-28%
Lip	59-70%
Tongue	15-32%
Thyroid	26%
Melanoma	22-42%
Cervix	20-40%
Ovary	16-35%
Stomach	5%
Colon	29%
Rectum	25%
Bladder	16-55%
Kidney	19-33%
Testis	15-53%
Prostate	8%
Osteogenic sarcoma	19-39%

Table 2: Number of new cancer cases (millions) expected globally in 2030 (based on 2002 rates and annual percentage changes)

Annual Percentage Change	Men	Women	Both Sexes
-1.50(%):	7.183	5.893	13.076
-1.25(%):	7.712	6.326	14.038
-1.00(%):	8.277	6.791	15.068
-0.75(%):	8.883	7.287	16.171
-0.50(%):	9.531	7.819	17.351
-0.25(%):	10.225	8.388	18.614
0.00(%):	10.968	8.997	19.965
0.25(%):	11.762	9.649	21.411
0.50(%):	12.611	10.346	22.957
0.75(%):	13.520	11.091	24.611
1.00(%):	14.491	11.888	26.380
1.25(%):	15.530	12.740	28.270
1.50(%):	16.640	13.651	30.291

Table 3: Number of cancer deaths (millions) expected globally in 2030 (based on 2002 rates and annual percentage changes)

Annual Percentage Change	Men	Women	Both sexes
-1.50(%):	4.837	3.605	8.442
-1.25(%):	5.193	3.870	9.063
-1.00(%):	5.574	4.154	9.728
-0.75(%):	5.982	4.458	10.440
-0.50(%):	6.419	4.783	11.202
-0.25(%):	6.886	5.131	12.017
0.00(%):	7.386	5.504	12.890
0.25(%):	7.921	5.902	13.823
0.50(%):	8.493	6.329	14.821
0.75(%):	9.104	6.785	15.889
1.00(%):	9.759	7.272	17.031
1.25(%):	10.458	7.794	18.252
1.50(%):	11.206	8.351	19.556

From IPRI's 2013 State of Oncology Report.

situation looks really pretty bad. But there are some gems in there we've got to learn from.

One of the real gems is something that's been going on through AMPATH [The Academic Model Providing Access to Healthcare] for over 20 years now in Eldoret, Kenya.

That's a consortium of U.S. universities working with Moi University in Kenya. They created initially a HIV-AIDS program, which extended into a hospital, and now they've got a cancer hospital. It's something that is high quality and sustainable. And sustainable is a keyword.

When you look at Lahore in Pakistan and Imran Khan, the famous cricketer-turned-politician—his mother died of cancer, so he decided that he would contact his friends and fundraise to build a large cancer hospital—he's built a most magnificent cancer hospital in Lahore which is beautifully equipped, wonderfully staffed. Excellent staff, and patients are treated in a way that wouldn't be out of place in some of the best institutes in the higher-resource countries.

These are some isolated examples. We've got to learn from one of the key things about both of them—the word *sustainable*. The big lesson that we've got to take is not just the question of throwing money around, hoping something will grow. What we've got to think about is learn from the fabulous lesson of PEPFAR [President's Emergency Plan for AIDS Relief].

PEPFAR program was started by President George W. Bush, who devoted a lot of his discretionary presidential funds to start this program. It's been a dramatic success, and it's a great success with identifying countries, people in countries, and empowering them to change the situation. PEPFAR provided funds, the necessary equipment, the necessary drugs, etc.—but most of all, local individuals and groups were empowered to change the local situation.

I think we've got to think of that rather than just throwing money around; throwing seed on the ground hoping a substantial crop will grow. There are good models out there. We've got to use them a lot better.

MO: *So you wouldn't say that it comes down to only the resources that each country has, but also the skills and availability of training needed to sustain that model.*

PB: To give you an example, there are about 30 countries in Africa that don't have a single radiotherapy machine. There are groups and people with foundations and governments with money that could buy radiotherapy machines for these countries, but it's not the simple fact of having a radiotherapy machine.

To make a radiotherapy machine effective, to make a linear accelerator useful, you really need a stable electricity supply. You need radiotherapy technicians as well as radiotherapists. You need maintenance contracts. You need people who've got the skills to do the maintenance of the sources and the machines.

So it's not just the machine that comes in. It's not just the initial capital cost. It's to have the human expertise and funding for the running costs to maintain

these machines. So there is a huge educational need, there's a huge training need that is absolutely vital if we're going to give radiotherapy machines, or whatever equipment or whatever medications—you need the expertise to deliver them correctly and make sure it can continue to be delivered. It's not a simple situation.

MO: *Right. So it sounds like an entire infrastructure needs to be in place for all this to be successful in the first place.*

PB: You need the infrastructure, but you also need the trained human resources to work with that, and you also need the money available to continue the maintenance and development of the resources.

MO: *Speaking of us needing to help these countries—on the federal front, what has NCI done, and what can NCI do?*

PB: NCI has started to reorient their international program. It's changed quite dramatically, and it's really looking quite impressive at the present time, I must say. [NCI Director] Harold Varmus has ordered a major reshaping of the program creating a much more practical international program, which I admire very much.

Dr. [Edward] Trimble [director of the NCI Center for Global Health] is leading that on the cancer side, and he's actually started to implement programs, resources and training, which is going to pay off in the years to come. It's fantastic to see that leadership.

But the thing is that not even a country as rich as the U.S. can do everything that's needed. What we need now—using all my experience, and knowing all the failures in the past—I think we need a huge international, private-public partnership that's dedicated to making sure that we've got short-term needs, the hardware needs, the infrastructure needs, and the continuing necessity for education and maintenance. The human capital training is extraordinarily important, as is the continuing sustainability of the program.

I think the current model for global cancer control, one could say, is broken, and we need to reorganize and look at ourselves again. The public sector we know wants to be involved. They know a lot about delivering cancer care, delivering what's necessary, but the private sector also needs to be involved.

They just can't piggyback on the work of the public sector and then sell things; make a lot of profit out of it. They've got to be involved in financing the basics from the start. I think we need a radical change in the model of approach to this.

MO: *It sounds like we need someone to spearhead the entire effort. Who's going to start it, and what do we have right now?*

Cancer Site	Low Income	Lower Middle Income	Upper Middle Income	High Income
Breast	56.3	44.0	38.7	23.9
Cervix	68.4	58.6	48.2	32.6
Colorectal	70.5	62.4	60.1	42.4
Lung	91.3	87.1	92.5	82.2
Oral Cavity	55.4	54.2	47.6	27.7
Stomach	82.0	80.1	81.3	59.1
Hodgkin's Lymphoma	53.3	42.6	41.3	17.4
Testicular cancer	41.4	37.5	24.1	5.1

Source: IPRI

PB: One of the great things that has surfaced in the last 20 years is the AIDS movement. Resources become available for AIDS, and a huge movement takes the resources and decides what's the priority to spend them, more or less.

There is no such cancer movement. There's no movement in chronic disease. It's a number of disparate organizations and groups who are fighting for their own corner. If we're going to do something, we need a cohesive approach.

Personally, I don't think we should go alone on the cancer front. I think the problems that the lower-resource countries are facing—in diabetes in 20 years for example—are probably going to be greater than the cancer situation. The cardiovascular disease situation is also getting worse in lower-resource countries.

There are a lot of factors in common: there is a great need for training, need for resources, need for human capital in these three areas. And the thing that may be worthwhile to try is to consider packaging the whole thing up, and try to keep it as a chronic disease movement rather than just a simple cancer movement, which would be difficult to get together and is a lot of work.

To have a chronic disease movement, would be, in my opinion, incredibly useful for the lower-resource

countries. I think there is need for a new model that gets together all the groups in the public sector who want to work together in good faith, get the private sector involved and come up with a coherent plan for dealing with the terrible situation of chronic disease in lower-resource countries.

MO: *Is it possible to bring down the price of cancer treatments, new and old for some markets in the world? That would be one factor to consider, right?*

PB: I think the major drug companies are susceptible to the arguments of pricing drugs. It's not only drugs, it's providing surgical equipment, providing radiotherapy machines, providing all the infrastructure, the machines, all the hardwired things that you need for cancer treatment.

I think there's a willingness to provide that at the cost that markets will tolerate. That tree needs to be shaken a little, and there's no reason why in a perfect world, you shouldn't be selling drugs and equipment to lower-resource countries at prices that the country and its health service can afford.

There are several big problems and hurdles in the way. One of them is the fact that sometimes, necessary drugs that are sent at a cheaper price to one country, are diverted to another country where they are sold at a higher price. I'm not talking about the issues now with generics, but the issues of the illegal copying of drugs and passing on essential drugs for cancer treatment—not only diluting injectables, but just selling drugs illegally.

So there are issues to do with illegal activities that would really need to be sorted out in a big way by the international community, as well. It's not just the price.

MO: *To summarize a good part of that, how would you prioritize what needs to be done, moving forward?*

PB: OK. Listen, you give me a $1 trillion a year and I'll come up with a plan on how to spend that appropriately. I really think there's got to be action from the private and the public sector to sit down and work together and work out how they can create feasible plans. These plans have got to be feasible, practical, affordable, and sustainable.

You need to start creating this movement and actually do something rather than talk about it. I'm very pleased, I'm very positive about the new direction that NCI is going in, and I hope that that's something that could continue—that other groups will join with—and we can get this concerted effort of the public and the private sectors to actually go and make a difference.

MO: *And would you say that that is the ultimate end goal of what you would hope to achieve with the report?*

PB: Well this report is just to provide the groundwork. I was very touched by some of the chapters that we got from individual countries. We didn't have any game plan about what they should write, it wasn't like there was a request where there were section areas I want to cover—we just said, "OK, write something. Tell me about the state of oncology in your country."

And the variation in what they were saying, I think, was quite dramatic. The chapter from Guinea, for example, tells you there's no cancer service outside the capital city, and the government created a national cancer program to solve the cancer problem with $100,000. We could spend that money in a morning.

There are these remarkable differences. The group from Nepal who was very excited about tobacco control, which is very good, and they're also excited because they got Gleevec free. The difference between Bangladesh and Pakistan is quite dramatic, and we're working currently on the situation in India and the surrounding countries, but also in China, where we're doing an individual report, which we will make available in about four months.

Where would I start? I honestly don't know. But I think if we all sit down for the next 20 years or so, and ask where is the best place to start I think we will make no progress. I think we have just got to do something.

Another lesson from PEPFAR: PEPFAR did not try to do it in every country and every region of every country, but started to do it in places where the task was feasible and where they identified a group or an individual who could be trusted to do what was necessary. PEPFAR then empowered the local resources to make it a success.

I think that's a model that we've really got to look very closely at for chronic disease.

State of the Union

President Calls For Reversing Cuts to Basic Research Budget

In his state of the union address to Congress Jan. 28, President Barack Obama called for reversing the cuts made to basic research in the federal budget.

"Congress should undo the damage done by last year's cuts to basic research so we can unleash the next great American discovery—whether it's vaccines that stay ahead of drug-resistant bacteria, or paper-thin material that's stronger than steel," he said.

The Federation of American Societies for Experimental Biology applauded the president for his support of federal investments in research and development.

"Scientific and technological advances keep our nation internationally competitive and spur the innovation ecosystem fueling economic growth, but we have lost ground in recent years, due to research appropriations that have not kept pace with rising costs or international competition," FASEB President Margaret Offermann said in a statement.

House Speaker John Boehner (R-Ohio) invited representatives from Teen Cancer America, a non-profit charity focusing on teenagers and young adults with cancer, to be his guests at the president's speech, among others.

Established in 2011, Teen Cancer America is the U.S. arm of the United Kingdom organization Teenage Cancer Trust. Chairman Rebecca Rothstein, executive director Simon Davies, and his wife Geraldine Lee represented the charity.

In a video response to the president's address, American Cancer Society Cancer Action Network Vice President Dick Woodruff said that Obama "gave a rousing defense of the Affordable Care Act…cancer patients [are no longer] being discriminated against because of their pre-existing condition."

"No longer are people going to be bankrupted and lose everything they own if they have a cancer diagnosis and have to undergo treatment," Woodruff continued.

In responding to the president's call to make 2014 "a year of action," Woodruff cited the need to increase taxes on tobacco products and to pass quality of life legislation for cancer patients.

Drasga, Einhorn Make Appeal For Single-Payer Healthcare

By Conor Hale

In a feature article published in the Journal of Oncology Practice, oncologists Ray Drasga and Lawrence Einhorn called for their colleagues to endorse single-payer healthcare.

The journal is published by the American Society for Clinical Oncology.

The authors appealed to fellow oncologists and society members to support a fundamental shift in the U.S. healthcare system, in the face of rising costs of cancer care. The program the two endorse is described as "an improved Medicare for all."

Drasga, the lead author, is a community-based oncologist who founded a free clinic in Crown Point, Ind.

Einhorn is a distinguished professor of medicine at the Indiana University School of Medicine, and is known for his research in testicular cancer, as well as treating Lance Armstrong. He is also a past president of ASCO.

People with cancer "are burdened not only physically but also financially," Drasga said in a statement. "They delay or do not receive care due to their inability to pay.

"The crisis in health care is much more pronounced in cancer due to the high costs of drugs, tests, and procedures," he said. "For example, the cost of a new cancer drug has increased to a median price of $10,000 per month since 2010, and some drugs cost much more."

The authors say they do not believe that the Affordable Care Act will be able to solve the health care crisis that cancer patients face, including a lack of insurance, insufficient coverage, and rising costs overall.

"Cancer care accounts for at least 5 percent of total health care spending," Drasga and Einhorn wrote. "One survey showed one third of nonelderly insured patients with incomes of less than $75,000 did not have enough money to pay for medical care."

According to the Census Bureau, 48.6 million people did not have health insurance in 2011, though the Affordable Care Act is expected to reduce that number. "The Congressional Budget Office estimates that the law will nevertheless leave 31 million Americans uninsured in 2023," they wrote.

"Having no insurance is associated with a 1.40

hazard ratio for mortality compared with those with insurance," they wrote. "Uninsured patients with cancer are 1.6 times more likely to die within 5 years than their insured counterparts, according to a 2008 study by American Cancer Society researchers."

The system they propose would provide universal, comprehensive coverage with a free choice of providers, covering provider visits, hospital care, prescription drugs and rehabilitation. The public agency running the program would have the ability to negotiate drug and supply prices. The system would be funded by a mix of payroll and income taxes.

"Several fiscal studies of single-payer national health insurance have shown that any increased tax burden on U.S. households would be more than offset by the elimination of insurance premiums and out-of-pocket costs for health care," Drasga and Einhorn wrote.

"With ACA now the law of the land, and its retention of the private insurance industry at the center of the health system, the trend toward high-deductible health plans, underinsurance, and cost shifting to patients will almost certainly worsen," they wrote.

"We call on the American Society of Clinical Oncology to advocate for a single-payer national health insurance program," they wrote. "Oncologists are in a unique position to champion the cause of improving access to care for patients with cancer and easing the financial burden they and their families face."

"The journal does not take a stance one way or another," said John Cox, editor-in-chief of the Journal of Oncology Practice. "We provide a forum where perspectives on policy can be discussed."

"Many of us look at these issues in our daily practice," he said to The Cancer Letter. "As wonderful as the legacy of fee-for-service is, many people realize there must be some kind of change."

ACS, SU2C Commit $20 Million For Lung Cancer Dream Team

The American Cancer Society and Stand Up To Cancer announced a collaboration to fund translational research and advocacy programs.

The collaboration's first project will be a three-year, $20 million research Dream Team focused on developing new therapies for lung cancer. ACS and SU2C will split funding equally. Bristol-Myers Squibb will also provide $5 million to support the dream team.

"This alliance marries the society's comprehensive cancer-fighting mission with SU2C's high-impact funding model," ACS CEO John Seffrin said in a statement.

"Lung cancer is the leading cause of cancer mortality in the United States," said Phillip Sharp, Nobel laureate and institute professor at the Massachusetts Institute of Technology and Koch Institute for Integrative Cancer Research, who is chairman of SU2C's Scientific Advisory Committee. "More work is urgently needed to address the many unanswered questions about lung cancer and guide new directions in treatment."

The collaboration will also include an advocacy component, led by the American Cancer Society Cancer Action Network and SU2C.

Later this year, the American Association for Cancer Research, SU2C's scientific partner, will issue a call for research proposals. The selection process will be conducted by a joint scientific advisory committee composed of an equal number of experts nominated by SU2C and ACS. The team itself will be announced in 2015.

In Brief

IU Cancer Center To Receive $15 Million for Breast Cancer

(Continued from page 1)

completed in November 2013 and will continue to fund the Vera Bradley Foundation for Breast Cancer Research Laboratories.

The gift will also establish the Vera Bradley Foundation Scholars Program to train scientists and physicians in breast cancer research and care.

THE HOPE FUNDS FOR CANCER RESEARCH announced the creation of the **James D. Watson Award**, with Nobel laureate **James Watson** being the first recipient.

The award honors Watson for his contributions to the field of biology and cancer research and will be awarded to scientists who make comparable seminal discoveries. The award will be presented at the organization's annual awards dinner on April 24 in New York City.

Watson is best known as a co-discoverer of the structure of DNA in 1953 with Francis Crick. He was awarded the 1962 Nobel Prize in Physiology or Medicine along with Crick and Maurice Wilkins.

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THE DEPARTMENT OF DEFENSE will offer over $580 million in the 2014 fiscal year through its office of **Congressionally Directed Medical Research Programs**.

Comprehensive program announcements will be released during the year. The announcements will include detailed descriptions of funding mechanisms, evaluation criteria, submission requirements, and deadlines. Each announcement may be downloaded from the Grants.gov website, or the CDMRP website upon its release. Requests for e-mail notification of the program announcement releases may be sent to help@cdmrp.org.

The programs and their amounts include:

- Amyotrophic Lateral Sclerosis Research Program - $7.5 million
- Autism Research Program - $6.0 million
- Bone Marrow Failure Research Program - $3.2 million
- Breast Cancer Research Program - $120.0 million
- Duchenne Muscular Dystrophy Research Program - $3.2 million
- Gulf War Illness Research Program - $20.0 million
- Lung Cancer Research Program - $10.5 million
- Multiple Sclerosis Research Program - $5.0 million
- Neurofibromatosis Research Program - $15.0 million
- Ovarian Cancer Research Program - $20.0 million
- Peer Reviewed Cancer Research Program - $25.0 million
- Peer Reviewed Medical Research Program - $200.0 million
- Peer Reviewed Orthopaedic Research Program - $30.0 million
- Prostate Cancer Research Program - $80.0 million
- Spinal Cord Injury Research Program - $30.0 million
- Tuberous Sclerosis Complex Research Program - $6.0 million

JUSTIN KLAMERUS was named chief quality officer and executive vice president for community-based programs at the **Barbara Ann Karmanos Cancer Institute**.

Prior to his appointment, Klamerus served as president and medical director of the McLaren Cancer Institute. Karmanos recently joined McLaren Health Care, which creates Michigan's largest oncology provider network with more than 12,000 new cancer cases per year.

With more than 30 active medical oncology protocols, Klamerus serves as the principal investigator of cancer research at McLaren. His independent research has focused on upper aerodigestive cancers, health policy, and health care disparities.

He also has worked as program director of cancer services from 2011-2012 and assistant medical director for quality and program development at McLaren Northern Michigan from 2009-2011.

Klamerus is a member of the American Society of Clinical Oncology and sits on the Clinical Practice Committee of ASCO. He is also chair of the Pathways Steering Committee of Blue Cross Blue Shield of Michigan, the Michigan Oncology Quality Consortium, the Michigan Cancer Consortium, the Health Management Academy's Oncology Forum and the American College of Physician Executives.

ANGELA DAVIES was appointed chief medical officer of **Champions Oncology**.

Davies most recently served as chief medical officer of Novocure, where she was responsible for the company's global clinical development and medical safety programs, and worked closely with the global commercialization team in launching a newly approved medical device for recurrent glioblastoma.

Previously, she was chief medical officer of OSI Pharmaceuticals where she led the clinical development program for Tarceva (erlotinib), as well as other products, until the company's acquisition by Astellas Pharma.

She also served as an associate professor of medicine at the University of California, Davis, where she practiced as a medical oncologist and was a principal investigator, specializing in thoracic malignancies and development therapeutics.

THE UNIVERSITY OF CALIFORNIA, SAN FRANCISCO and **Quest Diagnostics** formed a collaboration to research advanced diagnostics in the field of precision medicine. Initial clinical areas of focus include autism, oncology, neurology and women's health.

The organizations will focus on diagnostics to advance precision medicine. Quest Diagnostics will independently develop and validate any lab-developed tests for clinical use that emerge from the collaboration's research.

Researchers will utilize diagnostics, imaging procedures, and population analysis based on Quest's national Health Trends database, the largest private clinical database in the U.S., based on more than 1.5 billion patient encounters.

The alliance is the first master agreement that UCSF's Office of Innovation, Technology and Alliances

has signed with a clinical laboratory testing company.

The collaboration is launching with two specific projects already underway. One project involves Quest's national database of molecular testing data to facilitate participation in research and development efforts related to genetic variations of autism, based on Quest's CGH microarray ClariSure technology, which can help identify genetic mutations associated with autism and other developmental disorders.

The second project aims to identify biomarkers to determine which children with glioma brain tumors may benefit from a drug that is currently available to treat the disease. That project will integrate molecular biomarker testing with MRI imaging technologies.

JOHN PORTER, former member of Congress, partner in the law firm Hogan Lovells, and chair of Research!America, was named the recipient of **the 2014 Public Welfare Medal** by the **National Academy of Sciences**. The medal will be presented April 27 during the academy's 151st annual meeting.

First elected to Congress in 1980, Porter served Illinois' 10th district in the House of Representatives for 21 years. As a member and then chair of a House Appropriations subcommittee, he played a key role in overseeing budget appropriations for all federal health and education agencies. In 1995, Porter launched a campaign that led to the largest funding increase in NIH history, doubling the agency's budget over five years despite efforts to cut government spending.

As a partner at Hogan Lovells, Porter specializes in health legislation and political law compliance. He also serves as chair of Research!America, a nonprofit public education and advocacy alliance dedicated to making health research a higher national priority, and as vice chair of the Foundation for the National Institutes of Health.

In recognition of Porter's leadership in furthering biomedical research, the congressionally mandated John Edward Porter Neuroscience Research Center was recently completed on the NIH campus and will bring together scientists from seven NIH institutes.

Porter was elected to the Institute of Medicine in 2007 and has served on many study committees of the IOM and National Research Council. He is also a member of the boards of the PBS Foundation, the Council on Foreign Relations, and the Bretton Woods Committee. Previously, he was chairman of PBS and served on the boards of RAND Corp., the American Heart Association, the Brookings Institution, and the Population Resource Center.

FDA News

FDA Lifts Clinical Hold On CTI's Tosedostat

FDA notified Cell Therapeutics Inc. that the partial clinical hold on **tosedostat (IND 075503)** has been removed and all studies underway may continue.

Tosedostat is an oral selective inhibitor of aminopeptidases, which provide amino acids necessary for growth and tumor cell survival, and is under development for the treatment of blood-related cancers.

Tosedostat is currently being studied in the U.S. and the European Union in investigator-sponsored and cooperative group-sponsored phase II trials in elderly patients with newly diagnosed and relapsed acute myeloid leukemia and high-risk myelodysplastic syndromes.

The National Institute for Health and Care Excellence in the U.K. issued a Final Appraisal Determination for **Pixuvri (pixantrone)**, sponsored by Cell Therapeutics Inc

The positive draft guidance determines Pixuvri is cost effective and recommends funding the treatment as a monotherapy for the treatment of adult patients with multiply relapsed or refractory aggressive B-cell non-Hodgkin lymphoma, including diffuse large B-cell lymphoma.

The NICE Appraisal Committee recommended the treatment as an option for certain people with histologically confirmed aggressive B-cell NHL who have previously received rituximab and are receiving Pixuvri as a third- or fourth-line treatment.

The determination forms the basis of the final guidance to the NHS in England and Wales and is expected to be published in February 2014. Once the final guidance is published, the NHS must fully implement it within 90 days.

Pixuvri is an aza-anthracenedione that forms stable DNA adducts and in preclinical models. It is structurally designed so that it cannot bind iron and perpetuate oxygen radical production, or form a long-lived hydroxyl metabolite—both of which are the putative mechanisms for anthracycline induced acute and chronic cardiotoxicity.

In May 2012, the European Commission granted conditional marketing authorization for Pixuvri as a monotherapy for the treatment of adult patients with multiply relapsed or refractory aggressive NHL.

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