William Hait â?? Chief Scientific Advisor, American Association for Cancer Research

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13.03.2026

Tags:

USA, AACR, Oncology, R&D, Clinical Trials

William Hait, Chief Scientific Advisor of the American Association for Cancer Research (AACR) and Chair of AACRâ??s Scientific Advisory Council, highlights the societyâ??s position within the global oncology ecosystem as a trusted, unbiased leader facilitating progress from discovery to community impact. Hait details AACRâ??s focus on prioritizing prevention, early detection, and interception, while addressing the need to reduce disparities in access to care. Pulling from his industry perspective as former Chief External Innovation and Medical Officer of Johnson & Johnson, he

goes on to examine the evolving dynamics of global clinical trials and emphasizes why basic research funding is the essential foundation for driving innovation.

Walk us through AACRâ??s role within the greater oncology ecosystem, and how the organisation goes about translating basic science and innovation into real world impact.

The AACR is one of the pillars of the cancer research community. Established in 1907, it is the first and arguably most prestigious cancer research society in the world. Over the years, it has expanded enormously and continues to grow at a faster pace than ever. Today, we have more than 62,600 members across 143 countries and territories; over a third of AACR members are located outside the U.S., and our annual meeting brings together over 22,000 cancer experts from around the world. This global scale is partially supported by a publishing arm of ten scientific journals, including *Cancer*

Research and *Cancer Discovery*, the latter of which has become one of the highest impact publications in the cancer field.

What differentiates the AACR from other societies is its comprehensive scope. We are uniquely positioned at the intersection of fundamental discovery science and its clinical application. In many ways, the AACR was one of the original propagators of the term â??translational research.â?• We serve as a direct conduit for our membership, identifying which scientific frontiers need to be addressed, and which innovations must be promulgated to the wider community.

An example of this influence was our push for an epigenetics task force at the National Institute of Health (NIH), which successfully led to the funding of global epigenetics mapping. Because the AACR is highly respected as a voice without bias or conflicts of interest, we occupy a position of unique authority. In my view, it is the most trusted voice in cancer research.

From your perspective, how have the emerging areas of precision and personalised medicine shaped the AACR priorities?

To understand our current priorities, we must look back to the National Cancer Act of 1971. That legislation created the National Cancer Institute (NCI) and catalyzed an investment of billions of dollars annually into cancer research. The resulting explosion of knowledge regarding cancer biology, genetics, and molecular alterations ushered in the era of precision medicine. If you look at university campuses today, almost all of them host a dedicated cancer center. This is the legacy of that original national commitment to cancer patients, which established a level of funding and focus that has outpaced other critical areas like neurodegenerative or cardiovascular disease without the same national commitment.

To define where we go next, the AACR recently chartered a Scientific Advisory Council (SAC), composed of 49 of the worldâ??s leading cancer researchers, to identify the research areas and methods most likely to accelerate progress. At the top of the list was Prevention, Early Detection, and Interception. We must not wait until a patient has cancer to intervene if we want to fundamentally shift the morbid trajectory of this disease.

Also high on the list was the necessity of protecting basic, curiosity-driven research. This is the basis of knowledge generation that underpins progress. You cannot translate knowledge that does not yet exist. While pharmaceutical companies excel at drug discovery, development, regulatory science, and commercialization, they focus less on basic science. Therefore, it is essential that basic research continues to be supported in the broadest, most fundamental way.

AACR is also addressing cancer disparities and getting â??to the last mileâ?• to markedly improve health equity**.** We see significantly poorer outcomes in low- and middle-income countries as well as in rural and frontier areas in the US, where access to care is more limited. For populations that cannot afford expensive, late-stage treatment, prevention, early detection, and interception become the most effective tools.

Scientifically, the tumor microenvironment continues to be an important focus area. We now understand that cancer isnâ??t just about the tumor cells; itâ??s about the cells of the immune system, the tumor stroma, and the vasculature. A focus on immunobiology is what continues to drive the great advances in immunotherapeutics. AACR is also deeply interested in tumor initiation and evolution. If we can understand the earliest moments of cancer initiationâ??or even the conditions that precede it, such as hepatitis C, HPV, or metabolic dysfunctions related to obesityâ??we can intercept the disease before itâ??s too late. For instance, studying if treating obesity with incretins

like GLP-1s could have a profound impact on future cancer incidence could reveal important new directions.

Finally, we are also facing a demographic challenge. With an aging global population, it is estimated that by 2050, we will see 35 million new cancer cases and 18 million deaths annually. If we do not stop people from getting cancer in the first place, we will not affect incidence, and if we donâ??t affect incidence, it becomes much more difficult to reduce mortality.

What is the AACRâ??s role in advancing innovative perspectives, whether precision or prevention practices, into the community setting?

The AACR has convened the majority of NCI-designated and some community cancer centers to form a new initiative, the AACR Cancer Centers Alliance. These centers sought to work with AACR on large-scale projects. The NCI expects cancer centers to impact cancer across their entire catchment areas as part of the review of the coveted NCI Comprehensive Cancer Center designation. As a result, this has catalyzed more collaboration on clinical and population studies conducted outside of the main academic campuses.

The AACR has strong relationships with the pharmaceutical industry and the U.S. FDA that recognize AACRâ??s convening, influencing, and implementing power. Simultaneously, the organisation has a historical reach among advocates and survivors, allowing us to hear directly what they are seeing in their communities and what they would like to see improved.

The AACR is uniquely positioned to touch all these aspects and serve as a trusted voice to transmit accurate information, whether we are writing white papers or testifying before Congress. An example of this leadership are our Cancer Progress Reports, including a recent one on pediatric cancers, which serve to inform both the scientific community and policymakers.

Having spent 17 years in the pharmaceutical industry, what are your thoughts on the possible conditions that have led to an increase in oncology clinical trials shifting outside of the U.S.?

When selecting trial sites, industry partners prioritize four variables: the ability to accrue eligible patients, the speed of enrollment, the quality of the data, and costs. In the U.S., the landscape is shaped by a variety of factors. We have seen the rise of private Phase 1 businesses with first-rate medical oncologists who focus exclusively on early-phase studies. They are highly efficient at accruing patients and delivering clean data, which has been a very positive development.

However, shifts in academic medicine have created significant barriers. There are increased demands on academic physicians to devote more time to clinical practice to a point where, in some cases, there is less time devoted to clinical research. Consequently, even in cancer centers with a first-rate clinical trial infrastructure, the process tends to be slower and more expensive than in countries outside the U.S. Furthermore, many excellent oncologists practicing outside of these large centers often lack access to clinical studies altogether. Discussing a trial with a patient rather than prescribing a standard treatment requires the time and infrastructure that a busy practitioner simply may not have.

Compare this to the environment in China. Over the years, they have developed the sophistication to host large-scale pharmaceutical studies, supported by the modernization of the Chinese FDA. There is also access to patient populations at a scale that allows for rapid accrual at lower costs. These

centers understand that if they do not deliver high-quality data, industry partners will not return.

When you combine a clinical focus that is dedicated nearly 100 percent to research with robust infrastructure and a large patient population and competitive pricing, you have the formula that has led many companies to look outside the U.S. There are also scientific reasons. If you intend to market a drug globally, one must understand how it performs across diverse populations.

Ultimately, in my view, we should move away from considering clinical trials as a commodity. We should be turning our attention to supporting the most sophisticated and innovative science, which is the strength of U.S. investigators. What is next is a wave of truly innovative, complex trials for next-generation therapies. This is an area where AACR can take the lead and patients will achieve the most benefit.

Whatâ??s your perspective on the long-term implications of continuing to fund basic scientific research and how that impacts the competitiveness of the U.S. in research and innovation?

It begins with public support and public awareness. This year, rather than cutting the NIH budget, Congress increased it by USD 400 million and increased the NCI budget by USD 128 million. The long-term federal investment in biomedical research has been an economic driver for the U.S. It spawned the biotechnology industry and the entire ecosystem surrounding it, from early diagnostics to the utilization of artificial intelligence.

It is absolutely essential that, for both our nationâ??s health and our economic well-being, we remember it takes capital to conduct research and innovation to build these economic powerhouses. It would be a national tragedy to cut back on that investment. There is nothing more important than peopleâ??s health, and you simply cannot maintain it without a sustained commitment to health research.

Is there a final closing message that you would like to deliver on behalf of the AACR?

For many years, I have been an advocate for disease prevention. I often say that a century from now, people will look back at this era and find it hard to believe that we waited until we got a disease before doing something about it. This is where the influencing power of the AACR comes in. We have the ability to promote prevention, early detection, and interception through a deeper understanding of cancer causation, allowing us to reach a point where we can stop cancer from occurring or catching cancer at its earliest, most curable stage.

I am incredibly proud to be part of the AACR. Working alongside our CEO Dr. Marge Foti, the members of our Scientific Advisory Council, our dedicated SAC staff led by Dr. Yixian (John) Zhang, and the entire AACR team, has been a true honor. There were moments in the past year when I, like many Americans, was concerned about the general direction of funding for scientific research, but the current momentum appears to be moving in a positive direction. When you witness the enthusiasm of the thousands of young people joining the AACR and see the collective commitment of the AACR members and cancer community advancing research for the benefit of patients everywhere, it makes me optimistic.

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