

Guest Opinion

Should Disease Prevalence Determine NIH Fund Allocations?

Yes. Federal funding for medical research is skewed, failing to focus on diseases that cause the most suffering and death. Something is wrong when NIH funds research at the rate of \$1,129 per heart disease death, \$723 per stroke death, \$4,995 per diabetes death, \$4,525 per cancer death, but \$31,381 per HIV/AIDS death.

NIH priorities respond well to the political and media attention focused upon AIDS and HIV. But its priorities fall short on diseases that cause the most death or suffering. NIH allocates \$2,100 per year for each HIV/AIDS patient (600,000 to 700,000), \$200 per breast cancer patient (2 million), \$338 per overall cancer patient (8 million), \$40 per heart disease patient (22 million), and \$20 per diabetes patient (16 million). Of the 43 percent of its budget that NIH spends on disease-specific research, heart disease receives \$903 million (16.5 percent), diabetes \$316 million (5.8 percent), pneumonia and influenza \$64 million (1.2 percent), stroke \$127 million (2.3 percent) and HIV/AIDS \$1.5 billion (27.5 percent). Cardiovascular disease is America's number-one killer, nearing a million deaths a year, or 22 times more than AIDS (number eight). Cancer kills 13 times more persons than AIDS, and

No. There is a serious and growing threat to biomedical research within Congress. It is a well-intended but ill-advised effort to allocate specific amounts for research into specific diseases. This practice, known as earmarking, substitutes political decisions for scientific judgment.

Congress' role is not micromanagement of disease research. We are responsible for determining how much we can allocate to the NIH's 18 separate institutes and related centers in any given year. We do not—nor does the NIH—fund by disease. Once funds have been allocated by institute, proposals seeking funding are considered for scientific merit by professional peer-review groups. NIH also consults with a large number of advisory groups, including patient, health advocacy and research organizations.

It's important to remember that this is basic research, not necessarily targeted toward a particular disease—which is why the distribution of funds is usually an inadequate measure of support for a specific disease. Research aimed in one direction often provides benefits in an unexpected way. Secondly, explicit directives may slow research by keeping funds from areas of the greatest scientific opportunity.

Earmarking research funds leads us in another harmful direction. Imagine the

stroke four times as many. But NIH's \$1.5 billion in AIDS research is second only to cancer's \$2.7 billion. Although AIDS is the leading cause of death for males ages 25 to 44, this selected segment is only 15 percent of the entire population.

Congress gives too much discretion over specific research-funding allocation to NIH and its institute directors. We should provide significant funding for AIDS research, but not to the detriment of other deadly diseases.

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Subcommittee on Labor, Health &
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debate on an amendment to move funding from breast cancer research to Alzheimer's, or to transfer funding for juvenile diabetes to spinal injuries. Who could possibly "win"? We should not provide the greatest funding to combat the disease that has the strongest lobby or the most popular support at the moment. Science, not politics, should direct biomedical research.

**Rep. John E. Porter (R-Ill.)
Chairman, House Appropriation
Subcommittee on Labor, Health &
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Return to FASEB Newsletter, October 1998 [Table of Contents](#)