Response to the NIH-Wide Strategic Plan for Fiscal Years 2027–2031

Priority 1: Research Areas (483/500 words)

The Society of General Internal Medicine (SGIM), a member-based medical association of more than 3,300 academic general internal medicine physicians, appreciates the opportunity to provide comments on the NIH Strategic Plan framework.

The most consequential health challenges facing Americans today — multimorbidity, aging, care transitions, and the widening gap between biomedical discovery and real-world clinical benefit — do not respect the boundaries of traditional disease categories or medical specialties. Addressing them demands an organizational and scientific posture from NIH that elevates cross-disciplinary inquiry, rewards integration across body systems, and commits sustained resources to the infrastructure of translation and implementation.

NIH's next strategic plan should therefore articulate a clear and durable commitment to interdisciplinary research ecosystems — not as a supplement to foundational biomedical science, but as an equal and essential pillar of the agency's mission.

General internal medicine (GIM) research — broadly understood as the scientific study of how to prevent, diagnose, and manage illness in the whole patient across the lifespan — sits at the center of American healthcare yet at the periphery of NIH's institutional structure. Evidence supporting the practice of GIM sits behind what your primary care doctor does every day. It asks how patients with multiple chronic conditions are best managed together, how preventive care can be delivered more consistently, and how the healthcare system itself can be organized to produce better outcomes at lower cost.

These questions are not narrowly clinical — they are simultaneously biological, behavioral, economic, and organizational. They require the integration of health services research, implementation science, population health science, and clinical expertise in ways that no single existing NIH institute is positioned to champion. The result has been chronic underinvestment in a domain that is central to the health and well-being of Americans across the lifespan.

Biomedical innovation generates enormous potential value — but that value is only realized when discoveries reach patients in clinical settings. Understanding the barriers and facilitators to effective and efficient implementation in hospitals and clinics is not a peripheral concern; it is where the return on NIH's entire research portfolio is ultimately determined. Sustained investment in implementation science and health services research is therefore not optional — it is the mechanism by which NIH maximizes the impact of every dollar invested in upstream discovery.

NIH should affirm its commitment to funding meritorious and rigorous science through transparent, open, and merit-based processes. While high-risk, high-reward research increasingly finds a natural home at ARPA-H, NIH's comparative strength lies in building cumulative scientific knowledge through sustained, peer-reviewed inquiry. NIH should preserve and protect that strength while creating dedicated pathways for generalist and primary care research that has long lacked an institutional home within the NIH portfolio.

Fulfilling NIH's mission in 2027–2031 requires more than accelerating biomedical discovery. It requires building the scientific infrastructure to ensure those discoveries improve real lives. A renewed commitment to interdisciplinary, generalist, and implementation-focused research is not a departure from NIH's core purpose — it is its completion.

Priority 2: Research Capacity (489/500 words)

A thriving biomedical research enterprise depends not only on scientific ideas, but on the people and infrastructure that make rigorous inquiry possible. NIH's next strategic plan must therefore treat workforce development and research infrastructure not as administrative concerns, but as scientific priorities — particularly for interdisciplinary and generalist researchers who have historically operated without a clear institutional home within the NIH portfolio.

NIH's training programs — including T32 institutional training grants, career development (K) awards, and individual fellowships (F awards) — form the backbone of the research pipeline. Yet these mechanisms have not kept pace with the realities facing today's trainees and early-career investigators. T32 programs, while indispensable to many institutions, frequently leave trainees with insufficient protected time and resources for genuine career development activities, as overhead costs absorb a disproportionate share of available funds. NIH should revisit funding structures within training mechanisms to ensure that dollars dedicated to career development actually reach trainees.

K and F awards have grown extraordinarily competitive, creating a bottleneck that drives attrition from the research workforce at precisely the moment when young investigators are most vulnerable. This problem is especially acute in fields — such as general internal medicine, health services research, and implementation science — that lack a dedicated NIH institute to advocate for their trainees and sustain their pipeline. NIH should expand funding opportunities in these areas and explore targeted mechanisms to support early-career researchers in cross-disciplinary and generalist fields.

Reforms to NIH funding structures, while often well-intentioned, carry real risks for workforce continuity. A sudden shift to multi-year funding, for example, reduced the number of awards supported last year, making the already highly competitive funding environment even more so and putting trainees and junior scientists at risk of losing funding. Any movement toward multi-year funding models must be implemented gradually and deliberately, with explicit strategies to protect junior scientists, trainees, and smaller research programs that are disproportionately vulnerable to funding discontinuities. Otherwise, we will risk losing highly trained researchers who cannot sustain their programs during the transition. Anticipating these second-order effects is not a bureaucratic concern — it is a scientific imperative.

Clinical and Translational Science Awards (CTSAs) have served as critical nodes of research capacity across the country, supporting the infrastructure that enables clinical trials, community engagement, and translational research at academic medical centers. Proposed reductions in the number of CTSA sites are therefore a cause for serious concern, particularly as the field works to strengthen the last-mile connection between discovery and clinical practice. NIH should carefully evaluate the downstream consequences of CTSA consolidation on institutional

research capacity, especially at institutions serving as training hubs for generalist and cross-disciplinary investigators.

On the positive side, NIH's recent decision to remove the prior approval requirement for R01 applications requesting $500,000 or more in direct costs is a meaningful step toward reducing administrative burden and aligning resources with the real costs of conducting rigorous research in an inflationary environment. This kind of streamlining should be extended wherever possible.

Priority 3: Research Operations (497/500 words)

Effective research operations are the foundation upon which scientific credibility and public trust are built. NIH's strategic plan for 2027–2031 must therefore reaffirm two interdependent principles: that funding decisions are driven by scientific merit, and that efforts to improve transparency do not inadvertently create new barriers to participation in the research enterprise. Both goals are undermined when policy diverges from stated principles, as demonstrated by the unintended consequences of recent operational decisions.

NIH's core mission is to fund the highest-quality science, wherever it originates. Any effort to distribute research funding based on geographic or institutional considerations — rather than scientific merit — represents a departure from that mission and risks eroding the public's confidence in the integrity of NIH's peer review and award processes. While there are legitimate arguments for strengthening research capacity in historically underfunded regions, those goals are best pursued through dedicated capacity-building mechanisms, not by adjusting the merit standards that govern competitive grant awards.

Scientific stewardship means protecting the integrity of the funding process from political influence. As NIH navigates an increasingly complex policy environment, its strategic plan should explicitly affirm that award decisions will remain grounded in transparent, peer-reviewed scientific evaluation. NIH's strength has always derived from the trust that the scientific community and the American public place in its processes; that trust must be actively protected, not passively assumed.

NIH's Public Access Policy, requiring that all funded research results be made immediately and publicly available through PubMed Central (PMC) upon publication, reflects a genuine and important commitment to open science. Broad public access to federally funded research accelerates discovery, reduces duplication, and strengthens the social contract between science and society.

However, the current implementation of the Public Access Policy is creating a significant and underappreciated problem. NIH has stated that compliance with public access does not require payment of an open access fee, consistent with the federal purpose license at 2 CFR 200.315, which grants NIH the irrevocable right to make author-accepted manuscripts publicly available in PMC, before any copyright transfer. Despite this, some publishers have conflated public access with open access, requiring that NIH-funded authors pay open access article processing charges (APCs) in order to deposit author-accepted manuscripts in PMC.

These fees can range from several hundred to several thousand dollars per article and create substantial financial burdens for researchers—particularly early-career scientists, those at under-resourced institutions, and investigators in fields with modest grant budgets. NIH's proposed APC cap of $2,000 per publication may fail to cover the actual cost at many journals, further exacerbating these inequities. The result is a troubling irony: a policy designed to democratize access to science is instead creating a two-tiered system in which the ability to publish in leading venues is increasingly determined by financial resources rather than scientific quality. NIH should revisit its APC cap, explore institutional or consortium-level publishing agreements, develop dedicated support mechanisms for investigators, and publicly reinforce its position that authors can deposit author-accepted manuscripts in PMC without paying open access fees.