NIH: Should All the Institutes Be One?

A couple of years ago, when the National Cancer Institute (NCI) was on its way to gaining special status within the National Institutes of Health (NIH) and it was apparent that the heart institute was next in line for favored-institute status, a lot of people worried about what effect the exuberant crusades against cancer and heart disease would have on NIH and, therefore, on U.S. biomedical research as a whole. At the time, it seemed clear that the best, if not the only, way to get research money in large amounts was to publicize one's cause. Public visibility and political clout were what counted. Bills to create individual institutes for virtually every disease one can think of filled congressional hoppers, and there was fear that, in the end, a proliferation of institutes would ruin NIH.

In those days, which seem longer ago than they really are, a prophetic, if somewhat listless, joke was going around the NIH campus. "Someday," quipped countless would-be comedians, "someone will think of creating a single NIH."

Well, someone has.

In a jealously guarded internal memo, Health, Education, and Welfare (HEW) officials, with the blessing of the Office of Management and Budget (OMB), have proposed to consolidate the now separate budgets of the individual institutes into a single NIH appropriation. Only the cancer institute, which, by law, sends its budget requests directly to the President himself, is excepted from the proposed consolidation. No one really expects the Administration's plan to win the approval of the Congress and the NIH leadership without a fight, but at least some of the combatants were hoping not to have to slug it out in public.

At the moment, one of the difficulties in assessing the idea of a single NIH appropriation is that no one is quite sure what it means or precisely how it would work. There is still a lot of negotiating to be done, and the present proposal seems genuinely to be in only an embryonic stage.

It is not clear what is behind the proposal for a consolidated budget; nor is it certain that it has equally enthusiastic backing in all quarters of the Administration. In keeping with the idea that this country needs a national research strategy, which has been expressed by everybody from HEW Secretary Caspar Weinberger on down (*Science*, 27 July), there are those who would like to see a change in the budget-making process that involves more than administrative niceties. One possibility, therefore, is that as the details of this proposal are put in place, there may evolve a system of distinguishing funds for basic and clinical research. As one official said, "If this just means that money will go to the institutes as they now exist through a single funnel rather than many, I'm not sure I'm for it."

Generally, most of the scientists who are aware of the proposal are not sure they are for it, either, though their reasons are somewhat different. As they envision it, a consolidated budget would simply place more power in the hands of an Administration with which they feel little rapport. So, they are skeptical.

The manner in which the proposal for consolidation first came to the attention of NIH leaders has also contributed to a certain wariness about the way the present Administration conducts its affairs. In current Potomac jargon, the proposal first "surfaced" at the top levels of NIH a couple of months ago with the arrival of a pair of memos. Each is dated 2 August. One is signed by Rupert Moure, the other by John C. Droke. Both men are responsible to the assistant secretary for health, Charles C. Edwards.

The Moure memo is an outline of proposed changes in the organization and budget procedures of several health agencies, of which NIH is only one. Even so, it is singled out for special comment. Moure says "It is recommended," without saying by whom, that the changes in line for NIH be set aside until the preparation of the fiscal 1976 budget begins next spring in order to allow more time for discussion within HEW and NIH and on Capitol Hill. "The proposal could have intense political sensitivity . . ." he notes.

It is the Droke memo, however, that is revealing about the relationship that currently exists between HEW and NIH. He wrote:

> Although no formal discussions were held with NIH, their financial management liaison person was asked to comment on several alternative plans which we had developed. He indicated that the plan proposed in this memorandum would probably be most acceptable to NIH if the biomedical research institutes, except for the cancer institute, had to be consolidated. We consider the biomedical institutes consolidation a necessary first step in the reduction of the number of NIH appropriations.

Officials of NIH, with no slight intended to their "financial management liaison person," otherwise known simply as the chief budget officer, are bewildered as to why they were not consulted on such an important question *before* one of various alternative plans was hit upon. The rest of that paragraph suggests there was some contact, although reportedly the situation was not considered in detail with NIH administrators.

> The deferment of the changes proposed in NIH appropriations to 1976 is in accordance with my understanding of Dr. Edwards' promise to NIH to keep the current NIH appropriations for 1975. However, NIH may go along in 1975 with some changes in their activity structure to reflect more programmatic functions similar to our proposed subactivities.

Translated, that last sentence means there might be more "goal-oriented," or "targeted," work than there is now. Research falls under the heading of an "activity," while a specific effort to combat cancer, or any other problem, is a "program."

If the proposal to consolidate the NIH budget goes through, it will force some major changes in the present system of doing business.

Consider what happens now. An institute director prepares his budget, asking for what he needs plus a little more, all the while knowing he'll never get it all. As his budget goes through NIH and HEW channels, it is trimmed —sometimes a little, sometimes a lot. During the months that this is going on, there is activity on Capitol Hill too. Individual scientists may be pressing the case for their specialty with receptive members of the House or Senate. The voluntary health agencies, such as the American Heart Association,

are also going around the Hill, spreading the word that there must be more money for heart disease or dental research or studies on aging, or whatever. Lobbying, pressure, politics.

Under the present structure, each institute's budget is what is known as a "line item," which means that it must receive specific Congressional approval. So, each institute chief goes once a year to Congress to defend his budget—the one the Administration approved—at appropriations hearings. It gives each institute and the research areas it represents a measure of independence and a visibility before Congress that would inevitably be lost if the NIH budget were to be consolidated to a single line item. That, almost certainly, is one of the things that the Administration wants.

The Administration would like to do business with as little interference from lobbyists and Congress as possible. Ironically, until now most scientists felt the same way, although probably for different reasons. During the terrible fights over the fight against cancer, members of the biomedical community—and the leadership of NIH—rose up to declare that decisions about the funding of research should not be made in a political arena. Today, theoretically, most of them still believe that. But whether they are actually prepared to go along with that in practice under changed circumstances is something else.

The simple truth is that the scientific community does not trust this Administration. It is fearful, even intimidated, by the OMB. It is leary of Edwards, who has said quite plainly that he thinks there should be some centralization or coordination of health and research budgets (*Science*, 31 August). It does not yet know NIH director Robert S. Stone very well and does not know whether to trust him or not. There is a feeling that his "heart is in the right place"—meaning he is sympathetic to fundamental research—but no feeling that he wields much authority with HEW. Robert W. Berliner, former scientific director of NIH, who resigned to become dean of the Yale University School of Medicine and who was seen as a champion of fundamental research (*Science*, 29 June), has yet to be replaced. In this environment, the scientific community will not like being excluded from decision-making even more than it is now.

Administration officials and persons close to their way of thinking have

NIMH Put in New Agency

The National Institute of Mental Health (NIMH) has been wracked by budget cuts, stunned by the loss of major training and service programs, and consigned to what some consider temporary oblivion within the National Institutes of Health (NIH). Now, the NIMH has resurfaced, this time as part of a tripartite organization outside NIH.

In accordance with a 25 September executive order, it will be one of three coequal institutes in a new body called the Alcohol, Drug Abuse and Mental Health Administration, or ADAMHA (its detractors place the emphasis on the second syllable).

Assistant Secretary for Health Charles Edwards has appointed Roger O. Egeberg as temporary director until a permanent one is appointed, perhaps within the next few weeks. Egeberg, a former Assistant Secretary for Health, has been roving around Washington since he resigned that post acting as an elder statesman of health and as a special assistant to the Secretary of Health, Education, and Welfare on health policy.

The reorganization was recommended by Edwards after a study by a special task force, which couldn't decide between two alternatives. One was the ADAMHA idea; the other was to keep NIMH within NIH where it would have been divested of substantially all but its research functions, and to set up an autonomous "substance abuse" agency to cover both alcohol and drug abuse programs. This alternative was rejected amid frantic lobbying by mental health interests who were appalled at the prospect of NIMH losing its identity, and who believe that alcohol and drug problems properly belong within the scope of mental health.

Neither the mental health people, the alcohol people, nor the drug people are wild about the new organizational structure. All fear their missions will be choked if a heavy and domineering ADAMHA superstructure is set up.

The mental health people fear that in its new position the NIMH will still be emasculated. They also believe that the federal structure sets a bad precedent for the states. Some states have separate alcohol and drug agencies, but the most common arrangement is to integrate these services within their mental health agencies.

The alcohol people fear domination by the mental health people in the new administration. What they would really like is their own independent agency, with a prominence similar to that which the Nixon Administration has accorded drugs.

The drug people, similarly, would have preferred an autonomous agency.

The big questions now are who will head the new combine and what the structure will be around the administrator. Edwards has asked the Institute of Medicine to come up with a list of names. Among those under consideration will be the present heads of three institutes: Bertram Brown, head of NIMH; Morris Chafetz of the National Institute on Alcohol Abuse and Alcoholism; and Robert DuPont who heads the new National Institute for Drug Abuse as well as the President's Special Action Office for Drug Abuse Prevention, which is slated for dissolution, mission presumably accomplished, in mid-1975. Of these three, Brown is the obvious choice; but an HEW official says he may be passed over because mental health has a reputation as a "budget breaker" and Brown, while widely respected on Capitol Hill, is not a "White House favorite."

Brown, not unexpectedly, is unhappy with his new subordinate position in ADAMHA, and can probably be expected to leave unless he is assured of a prominent role. He has said publicly that he will stay as long as he can "make a major contribution to the national mental health program." If federal support for community mental health centers, NIMH's major service program, is not revived, and if Brown finds himself buried in an expanded bureaucracy, he will undoubtedly seek employment elsewhere.—C.H.

suggested that it is imperative to get the politicking out of scientific budget-making. But why the effect of a single appropriation would not be to merely change the theater of operation from the relative openness of the Congress to the inner sanctums of the Administration is not immediately apparent. Those scientists who know about the HEW proposal and have commented on it to *Science* feel safer with Congress.

There is no question that the idea of a single NIH appropriation has a ring of order and simplicity that is appealing to many. The dean of the Harvard Medical School has suggested that the institutes become one. In a May address to the elite Association of American Physicians, which was reprinted in the 16 August *New England Journal of Medicine*, Robert H. Ebert said, "In my view, there should be one National Institute of Health, which would support on a permanent basis both basic biologic research and clinical research. I suspect that such a reorganization would create a far healthier research environment than we have now."

Some of Ebert's colleagues have said recently that they wish he had kept still. Ebert, for his part, is not surprised that some people, who are used to the categorical or disease-by-disease approach to biomedical research, find the idea of centralization discomfiting.

Ebert, who had no knowledge of the Administration's budgetary proposal until informed of it by *Science*, says—without endorsing or rejecting it—that he thinks it certainly worth consideration. "If there is to be appropriate planning for biomedical research, it can't be done well unless it is done with a single budget. One must come to grips with this as a general policy matter," he said, indicating that policy should be made apart from one's view of particular individuals in any Administration.

The Administration's proposal to consolidate the NIH budget is part of a broader effort to reorganize HEW and make it more manageable. Thus, in addition to diffusing pressures for expanded research budgets, the consolidation would provide what some HEW officials see as "administrative flexibility." That is, with fewer dollars earmarked by Congress for specific programs, there would be greater leeway for deciding where money is needed most.

Again, the idea has a certain appeal, especially in view of the existing feeling that red tape is needlessly confining. But, again, it comes down to a matter of *who* exercises the promised flexibility when people express feelings on the subject. There is no reason to believe that either NIH officials or members of Congress really want to place the authority in the office of the assistant secretary for health, which is where it would probably go. On the other hand, if the scientific community believed that *it* would be able to divide the pie according to its own priorities, its reaction would doubtless be more favorable.

The present situation raises more general issues. Does it really matter whether or not the NIH budget is consolidated? "Yes," says one man who is involved. "It matters, not because some of us have doubts about the decisions this present Administration would make, but because it represents a subtle nibbling away at the independence of the scientist from the politicians in power, whoever they are. Gradually, the NIH is being dismantled and its strength diminished. That matters, and we must not let it creep up on us."

At issue too is what the relationship between the Executive branch of the government and the Congress should be. To be sure, since the question of the single appropriation has yet to be openly debated, it is not possible to pin down various points of view. Nevertheless, at this stage, one senses that a good deal of existing opposition to the scheme is founded on a distrust of this Administration. The presumption, which may have little foundation in fact, is that, with some other administration, things would be different, safer, less threatening.

What emerges is a question of whether any administration should assume almost total control of biomedical budget-making or whether it is best to leave things in the hands of Congress, chaotic and subject to pressures though they be. As one former official put it, "The burden of proof should be on the Administration to prove that their change would be better for biomedical research, not just for administrators." But then, again, no one seems to be very satisfied with things as they are and it is difficult, to say the least, to find anyone who believes that, today, biomedical research is as healthy as it might be.

—BARBARA J. CULLITON

RECENT DEATHS

Armand R. Collett, 78; professor emeritus of chemistry, West Virginia University; 17 June.

Harold S. Diehl, 81; former dean of medical sciences, University of Minnesota; 27 June.

Henry E. Garrett, 79; professor emeritus of psychology, Columbia University; 26 June.

David M. Harrison, 71; professor emeritus of economics, Ohio State University; 17 June.

Roger A. Harvey, 63; chairman, radiology department, University of Illinois College of Medicine; 17 July.

Arthur G. Hills, 58; professor of medicine, Ohio State University; 18 June.

G. Dabney Kerr, 80; former chairman, radiology department, University of Iowa; 3 July.

Bernard Levy, 47; professor of pharmacology, University of Texas Medical Branch; 31 March.

Ralph E. Lincoln, 61; chief, Developmental Research Laboratory, Frederick Cancer Research Center; 25 May.

Aleksei A. Lyapunov, 61; head, cybernetics department, Mathematics Institute, Siberian Science Center; 23 June.

Friedrich F. Nord, 83; professor emeritus of chemistry, Fordham University; 12 July.

Maurice Pardé, 79; professor of hydrology, University of Grenoble; 14 June.

Robert L. Platzman, 54; professor of chemistry and physics, University of Chicago; 2 July.

James S. Rising, 70; professor emeritus of engineering graphics, Iowa State University; 9 June.

Neill A. Rosser, 57; professor of education, University of North Carolina, Chapel Hill; 5 June.

Bunyan Y. Tyner, 90; professor emeritus of education, Meredith College; 22 June.

Ernest H. Wiegand, 86; professor emeritus of food science and technology, Oregon State University; 30 April.

Erratum: In an article on radioactive waste spills at Hanford, Washington (*Science*, 24 August, p. 730), an estimate that waste storage tanks might remain serviceable for 500 years was erroneously attributed to Herbert M. Parker, then manager of the Hanford Laboratories. The estimate should have been attributed to R. E. Tomlinson, then manager of advance process development at Hanford, who, with Parker, contributed to a formal statement on waste disposal practices prepared for the congressional Joint Committee on Atomic Energy in 1959.