Endocrine Society comments in response to NOT-OD-26-047, "Request for Information (RFI): Inviting Comments and Suggestions on a Framework for the NIH-Wide Strategic Plan for Fiscal Years 2027-2031".

Response was informed by members of the Research Affairs Core Committee (RACC).

Comments were submitted electronically via online submission form on May 26, 2026.

Priority 1: Research Areas

For the NIH to fulfil its mission to "enhance human health, lengthen life and reduce illness and disability" it must support foundational discoveries encompassing the breadth of human physiology including hormonal changes and responses to these changes across the lifespan, and support discoveries in how variables, such as environmental exposures and dietary factors, affect human physiology and health. Under-researched physiological changes such as pregnancy, aging, or menopause/andropause, and homeostatic perturbations, such as allostatic load, must be included in NIH-wide research that spans all Institutes and Centers (ICs) to address gaps in knowledge and improve our understanding of the totality of human biology. Physiological or hormonal mechanisms are, by definition, systemic as they include inter-tissue signaling through the endocrine system, immune system, and metabolic system and cut across the mission of multiple ICs that focus on specific tissues and disease types. Additionally, NIH must think beyond the health of humans today and support research to understand how transgenerational programming impacts physiological systems. Finally, the NIH must continue its stated goal of supporting rigorous research by enforcing policies meant to help all Americans, including the Sex as a Biological Variable (SABV) policy. Research must include sex variables and consider these as a fundamental good laboratory or clinical practice which will reveal truths about physiology and improve human health. NIH must support research that considers the health of all individuals to increase public trust; it is essential that all Americans, including those from populations often understudied, can see themselves as participants in, and therefore beneficiaries of progress in medical research.

Research that bridges molecular and physiological mechanisms with population science and epidemiology will enhance NIH's ability to generate findings that can be translated into meaningful improvements in health outcomes across the translational science spectrum. Better integration of these research domains, along with increased support for real-world data, longitudinal cohort studies, and community-engaged research, will help ensure that foundational discoveries ultimately inform strategies that improve population health. NIH should also continue to invest in implementation science to understand how evidence-based interventions can be effectively adopted across the wide range of clinical and community settings, ensuring that research funding ultimately results in measurable improvements in health with clear assessments of costs and return on investment.

Priority 2: Research Capacity

Building and maintaining the research workforce is imperative for the continuity of biomedical research. This requires strengthening not only basic and clinical research pathways but also the public health workforce through partnerships with other federal agencies that enable translation of discovery into improved patient care and population health. The instability of the current funding environment does not build confidence or support for the next generation of researchers and will create a deficit of talent and labor that will take decades to recover from, allowing other countries to surpass our current leadership in biomedical research. Program grants and trainee fellowships need to be awarded to provide sufficient support for researchers in training to cover the rising cost of living. We note that the number of NRSA Post-Doctoral Fellowships awarded dropped by 10% from FY 24 to FY 25, with a 7% decline in success rates, while the number of Predoctoral awards declined by ~20% over the same period with a 4% decline in success rate.

To support the translation of scientific discoveries into real-world impacts, training programs should consider introducing fields such as epidemiology, implementation science, data science, artificial intelligence, and health economics to biomedical and clinical researchers. To build the infrastructure and programs necessary to compete for larger training grants, NIH should consider providing smaller training awards to institutions to establish new activities and programs. Bolstering an institution's ability to provide professional development for graduate students and postdoctoral researchers can help elevate the institution's competitiveness for more substantial training awards while also improving the training experience for trainees.

We note that the ability to recruit and retain specialized researchers as part of multi-disciplinary teams is both a research operations and workforce capacity issue. Research capacity also depends on supporting staff scientists, data specialists, biostatisticians, laboratory managers, and core-facility personnel. These individuals ensure that research infrastructure is maintained, that data are managed responsibly, and that collaborative, multi-investigator work can continue efficiently. Staff scientists also have training responsibilities. Longitudinal investments in staff scientist positions, including dedicated funding, should be established by NIH to maintain these essential, highly trained, and experienced staff. Additionally, introducing metrics for performance-determined salary support would promote growth and establishment of a vibrant and active cohort of research scientists and trainees.

Our membership, which includes basic scientists, translational scientists, clinical scientists, and implementation scientists, appreciates the importance of having broad expertise to advance biomedical research that will eventually improve patient care and outcomes. NIH must invest in the training and development of clinical researchers to maintain the connection between translational research and applied clinical care, and to increase patient participation in clinical research and trials for new therapies and interventions.

Priority 3: Research Operations

The peer review process is critical for good scientific stewardship and awarding grants responsibly. Study section reviewers are recognized as leaders in their field and provide critical expertise for grant review. They dedicate a considerable amount of time reviewing grant applications as part of their commitment to scientific stewardship. Because of the consolidation of grant reviews within CSR and elimination of IC-specific review panels, chartered study section members are evaluating increasing numbers of grants while seeking funding for their own research. To ensure that these investigators are not significantly disadvantaged due to their study section service, NIH should consider reversing the termination of the Continuous Submission policy, which offered deadline flexibility for reviewers to submit their own grant applications. Virtual study section meetings limit the attention of the panel and minimize valuable networking opportunities with individuals in their discipline; NIH should consider bringing back hybrid and in-person study section participation. While we understand the rationale for temporary changes to the peer review process where only the top third of grant applications are reviewed, we are concerned that this change limits the review panel's opportunity to address concerns and misinterpretations of grants that could impact a grant's score. Additionally, funding decisions made by political appointees and at other agencies to control the distribution of NIH grants undermines the service and expertise of the scientific review committee. We are also concerned about persistent vacancies on NIH advisory councils that may impact the final layer of review for meritorious grant applications. Together, these changes create instability, introduce disruptions, reduce efficacy of this process, and are not in line with good stewardship and responsibility to taxpayers by supporting rigorous science.

We also encourage NIH to integrate evaluation and continuous quality improvement practices across programs. This includes routine assessment of the distribution of research investments across the country, supporting innovative methodologies, and producing findings that are adopted in clinical and public health settings. Strengthening NIH's partnerships with health systems, public health agencies, community organizations, and other federal partners will help ensure that research is responsive to real-world needs and has impact. Partnerships with agencies such as the Agency for Healthcare Research and Quality (AHRQ) can strengthen training for health services researchers and implementation scientists. This will help ensure that evidence-based therapies are delivered to the right patients at the right time, ensuring impact on a population level and across health care delivery contexts.

Public trust in science depends on transparency, not only in data sharing, but in how evidence is generated, communicated, and translated into policy and practice. NIH can continue to lead by promoting open-science platforms and improving usability and analytics of real-world data and research databases. Enhancing community and stakeholder engagement throughout the research process will strengthen public trust in NIH-supported science.