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National Institutes of Health  
9000 Rockville Pike  
Bethesda, Maryland 20892

Submitted via email ([nihstrategicplan@od.nih.gov](mailto:nihstrategicplan@od.nih.gov))  
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### **Priority 1: Research Areas**

Metabolic health should be a top NIH research priority. Metabolic health reflects how effectively the body converts food and oxygen into energy while maintaining healthy blood sugar, blood pressure, cholesterol, and inflammation levels. When these systems break down, both physical and mental health deteriorate. Only about [7%](#) of U.S. adults meet criteria for optimal metabolic health, meaning 93% fall somewhere along a spectrum of dysfunction. Roughly [three in four](#) U.S. adults live with at least one chronic disease, and [two in five](#) have prediabetes. The United States spends [nearly \\$5 trillion](#) annually on health care, the majority directed toward managing rather than preventing chronic disease.

The *Dietary Guidelines for Americans, 2025-2030* reflect a meaningful shift toward foods that promote metabolic health, but also highlight persistent unresolved questions in nutrition science. Meaningful change will not come from the Guidelines alone, but from the research investments and clinical translation that follow. The MAHA Strategy calls on NIH to expand high-quality nutrition research in partnership with the FDA and USDA, and the FY26 Labor-HHS-Education appropriations report urges large-scale clinical trials and accelerated biomarker discovery aimed at developing best practice clinical guidelines. We strongly support these directions and urge NIH to prioritize them in its FY27-31 strategic plan.

We recommend that NIH convene a broad-scale scientific effort, supported by clinical trials and real-world implementation research focused on the root drivers of chronic disease, including:

- The mechanistic links between insulin resistance and chronic disease
- Dietary patterns that best support metabolic health
- The relationship between metabolic dysfunction and conditions that may share common metabolic roots, including cardiovascular disease and psychiatric illness

NIH should elevate insulin resistance as a foundational signal of disease and prioritize research capable of resolving long-standing scientific disagreements and improving reproducibility.

Prevention should be a central organizing principle of NIH's research agenda, with expanded investment across the life course from maternal and early-life metabolic health to childhood obesity to elderly dementia. Evidence increasingly suggests that targeted metabolic interventions, including therapeutic low-carbohydrate approaches, may not only prevent progression to [type 2 diabetes](#), [cardiovascular disease](#), and [metabolic dysfunction-associated steatotic liver disease \(MASLD\)](#), also known as fatty liver disease, but in some cases [reverse chronic disease trajectories](#) and [improve serious mental health conditions](#) and gynecologic conditions like [polyendocrine metabolic ovarian syndrome](#) (formerly polycystic ovary syndrome). This requires NIH investment in large-scale randomized controlled trials and real-world implementation studies to evaluate outcomes such as disease remission, medication reduction, and cost-effectiveness across diverse populations.

### **Priority 2: Research Capacity**

Expanding the nation's metabolic health research capacity will require building a more interdisciplinary scientific workforce and research ecosystem. Nutrition and metabolic health cut across virtually every layer of biology and every major disease area, yet the field remains fragmented across disciplines, institutions, and funding pathways. The NIH Office of Nutrition Research (ONR) is uniquely positioned to serve as a coordinating hub, but only if it is adequately resourced to do it right. We recommend the following priorities:

- NIH should strengthen the ONR as the central coordinating hub for cross-Institute nutrition and metabolic health research, including by:
  - Expanding ONR's authority, resources, and staffing to support NIH-wide coordination and priority-setting
  - Establishing mechanisms to incentivize co-investment across NIH through jointly developed initiatives and matched funding
  - Leveraging and expanding existing infrastructure such as the Precision Nutrition for Health Initiative
  - Addressing gaps in shared protocols, outcome measures, and data-sharing systems.
- NIH should foster collaboration across nutrition science, metabolism, cardiology, endocrinology, psychiatry, neurology, and women's health, and actively engage researchers conducting real-world metabolic interventions who may sit outside traditional NIH funding pathways.
- NIH should use structured scientific convenings to bring together diverse, credible scientific perspectives, reduce fragmentation across differing frameworks, and surface the most decision-relevant research questions to inform future funding priorities.
- NIH should also expand support for real-world measurement tools such as continuous glucose and ketone monitoring, decentralized clinical trial platforms, and longitudinal metabolic phenotyping systems. These tools are essential to capturing how metabolic interventions perform outside controlled settings and across diverse populations. Partnerships with community health systems, Federally Qualified Health Centers (FQHCs), and VA hospitals will be essential to improving access and scalability.
- NIH should establish a national metabolic health registry to centralize data across mechanistic, clinical, and real-world research. A shared, well-governed data infrastructure would enable pattern recognition across populations, reduce duplication across studies, and build a foundation for precision metabolic medicine that no single study or institution could achieve alone.

### **Priority 3: Research Operations**

NIH can strengthen how priorities are identified, coordinated, and funded by using structured scientific convenings to surface high-value research questions; strengthening ONR's coordinating role; emphasizing rigor, reproducibility, and clinically meaningful endpoints; and improving coordination with FDA, USDA, CMS, and the VA so that NIH-funded evidence translates efficiently into clinical guidelines and coverage decisions.



The funding to act on these priorities already exists. NIH has approximately \$9 billion in FY26 funding available for new competing grants. Allocating just 20% to a coordinated nutrition initiative would provide roughly \$1 billion for new research without affecting existing commitments. Real-world evidence suggests meaningful returns: participation in individualized nutrition therapy programs has been [associated with](#) significant reductions in healthcare costs and medication use. NIH should apply the same funding scale and scientific rigor to nutrition and metabolic therapies as it does to pharmacologic interventions.

Public trust in science depends on transparency and rigor. NIH should bring diverse scientific perspectives into structured dialogue; clearly distinguish areas of consensus, disagreement, and uncertainty; and communicate priorities in ways that are accessible and tied to public health impact.

By elevating metabolic health as a cross-cutting priority and strengthening coordination and scientific stewardship, NIH can accelerate progress toward more effective prevention and treatment while ensuring research investments deliver meaningful public health impact.