The gutting of the NIH and the capitalist assault on public health

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A recent report by the *New York Times* reveals that spending on new medical research by the National Institutes of Health (NIH) has fallen roughly $1 billion behind its historical pace during the second year of the Trump administration. Between October and late March, the NIH awarded only about 1,900 new and competitive grants. This figure represents less than half the number of grants typically approved by this point in the fiscal year under the previous administration.

The severe contraction in grant-making has been deliberately driven by a renewed effort to screen grants using a computational text analysis tool introduced to employees in December of last year. Designed to formalize a reactionary campaign against so-called "woke science" that was led by Elon Musk's Department of Government Efficiency, the algorithm scans proposals and existing projects for roughly 235 flagged terms, including "racism," "gender," "inequities," "minority" and "vaccination refusal."

Within certain divisions, the tool flags up to half of all grants, ensnaring vital research on cancer, diabetes, heart disease and Alzheimer's disease. These grants are frequently flagged simply because they examine inequities in access to care or identify minority groups disproportionately suffering from specific diseases. Staff scientists are then forced to extensively justify or rewrite their proposals, creating immense bottlenecks where a biological science grant can be stalled for weeks, if not indefinitely.

The severe contraction in grant-making is not solely the result of such ideological screening, but is driven by a deliberate assault on both the personnel at and operational funding for the NIH. Over the past year, the agency has lost nearly 3,000 employees, which accounts for approximately 14 percent of its total workforce. This systematic gutting of the scientific infrastructure was kicked off on April 1, 2025, when sweeping layoffs led to the mass termination of roughly 1,200 to 1,300 staff members.

Concurrently, the Trump administration has engineered severe operational funding bottlenecks. In July 2025, the White House Office of Management and Budget mandated that the agency pay the full cost of approved multiyear grants upfront rather than in annual installments, drastically shrinking the pool of capital available for new research. Furthermore, the Trump administration took the unprecedented step of canceling or freezing over 5,400 active agency grants throughout the year.

These efforts by President Donald Trump and Health and Human Services Secretary Robert F. Kennedy Jr. have caused a catastrophic hollowing out of the medical pipeline. The NIH is the primary public engine of biomedical research in the United States. Consequently, the severe drop in awarded grants directly translates into fewer laboratory hires, delayed scientific projects, weaker clinical response and far fewer discoveries moving into actual medical practice.

In 2025, new grants for Alzheimer's disease and aging research were cut by more than half, dropping from 369 awards to just 177. During the same period, funding for mental health research plummeted by 47 percent and new cancer research grants fell by 23 percent. The National Cancer Institute provides a stark example of this operational paralysis. By late March 2026, the institute had earmarked only $72 million for new and competitive research grants, representing less than one-third of the nearly $250 million it typically committed by that time in previous years. And to ensure this contraction becomes permanent, Kennedy terminated 49 scientific advisory committees at the NIH in 2025 and dismissed every member of the high-level Advisory Committee to the Director.

Censorship at the CDC

The consequence of this deliberate starvation of scientific funding threatens to permanently stall vital research projects. Furthermore, this structural sabotage of the scientific research pipeline sets the stage for the administration's parallel assault on the Centers for Disease Control and Prevention (CDC), where the attack shifts from blocking future cures to dismantling present-day disease surveillance and prevention.

Perhaps more insidiously, the science that does manage to survive is now subject to blatant political censorship. Recent reports in the *Washington Post* and the *New York Times* reveal that Dr. Jay Bhattacharya, the acting director of the CDC, blocked the publication of a critical study demonstrating that COVID vaccines cut emergency room visits by 50 percent and hospitalizations by 55 percent last winter.

The study had already cleared internal scientific review and was scheduled for publication in the agency's flagship journal, *The Morbidity and Mortality Weekly Report*. Because the research employed the exact same methodology as an influenza report published without objection just one week prior, the intervention by leadership was entirely political rather than methodological.

The suppression of such data exposes how federal health agencies are being transformed into ideological gatekeepers by subordinating scientific publication to the reactionary political preferences of the administration. This further and purposefully undermines public trust and eviscerates evidence-based decision-making. This act of censorship is not an isolated event. It represents a calculated component of a much broader restructuring of CDC authority and the national governance of vaccines.

The suppression of the vaccine effectiveness study directly parallels the sweeping rollback of the childhood immunization schedule and the deliberate weakening of foundational advisory structures. The starkest expression of this assault was the firing of all 17 independent experts on the Advisory Committee on Immunization Practices in June 2025 by Kennedy, who replaced them with anti-vaccine loyalists.

This captured committee was then used to strip universal recommendation status from vaccines protecting against diseases like influenza, COVID, hepatitis B and rotavirus, arbitrarily reducing the childhood schedule from 17 preventable diseases to just 11. The entire

vaccine system is being undermined.

While a recent preliminary injunction by a federal judge has stayed the appointments of Kennedy's new committee members and halted the implementation of this reduced schedule, this legal block must be viewed as merely a temporary setback for the administration. The courts remain an unreliable bulwark for public health, and a reactionary Supreme Court stands ready to ultimately protect this anti-science agenda upon appeal.

The impact of Long COVID

The systematic dismantling of public health infrastructure finds its most devastating expression in the ongoing crisis of Long COVID, which serves as the ultimate bridge between public health and the economy, transforming a viral event into a permanent labor crisis.

Research from the University of Florida demonstrates that lost wages from employee sick time alone conservatively totaled $12.7 billion in a single year. However, this is merely a fraction of the real social and economic burden. Broader estimates, including those by Harvard economists, place the total economic cost of Long COVID at a staggering $3.7 trillion in the United States alone, with the condition erasing approximately $1 trillion annually from the global economy. This is not a niche clinical issue as Bhattacharya and company attempt to frame it. It is a massive, ongoing disaster that has permanently sidelined between 2 million and 4 million working-age Americans.

The economic consequences of this mass disabling event are catastrophic for the working class. Long COVID drastically reduces the labor supply and drives up rates of disability and absenteeism. Furthermore, millions of chronically ill individuals remain employed but operate at significantly reduced productivity due to debilitating fatigue and cognitive impairment. This burden is immense on an individual level, with Long COVID imposing between $4,098 and $11,641 in excess medical costs annually per person, representing an average of roughly $9,000 in additional yearly healthcare spending per patient.

In the United Kingdom, Cambridge Econometrics estimates that Long COVID reduces the gross domestic product by £1.5 billion annually through workforce inactivity alone. However, when accounting for informal care and wider societal costs, this burden swells to nearly £20 billion per year. The individual productivity loss per patient averages £931 per month. The Office for National Statistics confirmed that there are 2 million affected individuals in the country, with 381,000 citizens reporting that their daily activities are severely limited. The Trades Union Congress reported that one in seven workers with Long COVID lost their jobs entirely, exposing the brutal reality for workers who can no longer meet the physical demands of their employers.

Across the Eurozone, the condition has reduced the total labor supply by between 0.3 percent and 0.5 percent, disproportionately impacting the healthcare and education sectors where physical and cognitive demands are high. A recent report by the Organization for Economic Cooperation and Development estimates that Long COVID could cost its member nations $135 billion, or almost €116 billion, every year over the next decade. This staggering figure is comparable to the entire annual health budget of the Netherlands or Spain. In Germany alone, Long COVID and related post-viral syndromes cost the economy €63.1 billion in 2024, representing roughly 1.5 percent of its gross domestic product.

Similarly, analysis from 2024 reveals that Long COVID cost the Australian economy AU$9.6 billion in a single year, shaving 0.5 percent off the national gross domestic product. This contraction was driven by the loss of over 100 million labor hours, a massive deficit that neither immigration nor automation has been able to offset for the ruling class.

While the macroeconomic drag of Long COVID is part of the global capitalist crisis, in the United States, this mass disabling event intersects with a uniquely brutal, market-driven healthcare system that was already failing the working class. Healthcare spending now consumes 18 percent of the Gross Domestic Product, reaching a staggering $5.3 trillion in 2024, or $15,474 per person. For the working class, this translates into an unbearable and escalating financial weight. The average employer-sponsored family premium hit $26,993 in 2025, with workers forced to pay $6,850 of that cost directly out of their own paychecks. Out-of-pocket expenses have also surged, compounding the economic strain on households.

Approximately 100 million Americans currently carry some form of medical debt, a crisis that contributes to roughly 530,000 personal bankruptcies every year. Nearly a third of the country is forced to make desperate material sacrifices just to afford healthcare, including cutting back on utilities, skipping meals and delaying vital medical treatments. As the Roosevelt Institute correctly noted, medical debt is not an individual financial failure but a "medical debt crisis [as a] result of a wholly broken health-care system that burdens patients, employers, and health-care providers alike for the benefit of a handful of insurance corporations, pharmaceutical companies, and pharmacy benefit managers." In other words, it becomes the institutionalized transfer of medical costs from the capitalist healthcare system directly onto the backs of the working class.

This systemic crisis is now being aggressively weaponized to dismantle the foundational social safety nets of Medicare and Medicaid. The political logic driving this assault was starkly articulated by President Donald Trump during a private Easter luncheon on March 31, 2026. Trump explicitly stated that because of the growing demands on the war machine of American imperialism, it is "not possible for us to take care of day care, Medicaid, Medicare" at the federal level, insisting instead that the government must focus on "one thing: military protection" and that citizens must "let states take care of them."

This statement must be treated as a programmatic declaration of the ruling class rather than a mere throwaway remark. It makes the brutal priorities of American capitalism completely explicit: the financing of global imperialist war and the servicing of a massive national debt take absolute precedence over the health and survival of the population. With net interest on the national debt projected to hit $1 trillion in fiscal year 2026, surpassing both defense and Medicaid spending, the state is actively stripping the social wage to fund its military apparatus and enrich its creditors.

Public health in the post-World War II period

To fully grasp the magnitude of the current destruction, the National Institutes of Health must be understood not as a peripheral government agency but as the historical product of the post-World War II settlement between the working class and the capitalist state

The architecture of modern American science was decisively shaped by Vannevar Bush's 1945 report, *Science, the Endless Frontier*. Bush argued that government-funded basic research at universities and medical schools was the essential precondition for disease control, economic growth and national security. His report recognized that the relentless pressure of commercial necessity within private industry was incapable of sustaining the foundational scientific research required to ensure public health and prosperity. Operating within this postwar compact, the NIH evolved into the critical backbone of the American biomedical research enterprise. By linking vast sums of public funding to university laboratories, the agency built an immense public infrastructure that downstream pharmaceutical

innovation has entirely relied upon. Research funded by the NIH was linked to every single drug approved by the Food and Drug Administration between 2010 and 2019, representing a massive $187 billion public investment in foundational science.

This arrangement operated on a specifically capitalist logic, where public science subsidized private corporate profits while providing partial health benefits to the working class. Nevertheless, it created an infrastructure that yielded vital therapies and catalyzed the entire biotechnology sector. The current operational slowdown and funding freeze therefore represent a reversal of the very architecture that made modern biomedical science possible. The institution currently being sabotaged is not peripheral; it is the central engine of medical discovery.

The present crisis is not merely another partisan budget dispute. It signifies a profound historical break with the political logic that underwrote the US scientific infrastructure after World War II. The ruling class is systematically dismantling the postwar settlement under which public investment in science and medicine was justified as a necessary concession to societal needs. By abandoning this framework, the administration is deliberately triggering a collapse in future training, innovation and public health capacity.

Reductions in NIH funding immediately choke off the pipeline of graduate students and postdoctoral researchers, permanently destroying the human capital required to sustain laboratory momentum. As universities are forced to freeze hiring and scale back projects, early-career researchers are driven out of the field or out of the country. Once these laboratories close and research teams disperse, the expertise is lost and cannot be easily reconstructed. This historical rupture guarantees a future where vital medical treatments are delayed or never discovered, leaving the working class increasingly defenseless against the inevitable resurgence of disease.

Rudolf Virchow and the politics of public health

The historical context of this assault extends beyond the postwar period and requires a return to the very foundations of social medicine. To fully understand the systematic destruction of the scientific pipeline, one must look to the German physician Rudolf Virchow.

Born in 1821 and widely recognized as the father of modern pathology, Virchow was commissioned by the government in Berlin in 1848 to investigate a devastating typhus epidemic among the impoverished peasants of Silesia. He concluded that the outbreak was not merely a biological event, but a profound social problem rooted in abject poverty, malnutrition and squalid living conditions. This realization led to his famous formulation that medicine is a social science, and politics is nothing but medicine on a grand scale.

Virchow demonstrated that public health has always been an inherently political domain, arguing that epidemics could only be eradicated through the equitable distribution of society’s resources and the elimination of social inequality. The current crisis facing the NIH and the broader medical system is a brutal demonstration of the class organization of life and death.

The brain drain currently underway in the United States is a direct result of the enacted policy changes, and both China and Europe are aggressively taking advantage of this scientific exodus. A recent survey found that 75 percent of researchers based in the United States are considering moving abroad. The European Union has allocated €500 million specifically to recruit scientists, while countries including France, Austria and Germany have launched active recruitment programs explicitly targeting American talent. Applications from US-based scientists for early-career grants to the European Research Council nearly tripled from 60 in 2024 to 169 in 2026. During this same period, applications from senior American researchers surged from 23 to 114.

Simultaneously, China is capitalizing on the crisis by launching a new K visa to attract scientific talent, and in 2024, China officially surpassed the United States in research and development spending, investing $1.03 trillion compared to the $1.01 trillion spent by the United States.

The structural sabotage of public health and scientific research is driven by a massive reallocation of resources toward militarism and the servicing of federal debt. While the NIH faces a proposed 40 percent budget cut and essential health programs are starved, the state has allocated nearly $1 trillion for the Pentagon and spent between $31 billion and $34 billion (equivalent to the cuts in the NIH budget) on military operations in the Middle East alone since late 2023. A war-centered state is fundamentally incompatible with universal social care, rendering public health collateral damage in the competition for resources.

Ultimately, the operational slowdown at the NIH, the blatant political censorship at the CDC, the mass disabling event of Long COVID, surging healthcare costs, the rollback of Medicaid and Medicare, the ballooning war budget and the unprecedented scientific brain drain are not isolated phenomena. They are all interconnected manifestations of a single systemic social crisis. Public health is being systematically dismantled because it stands in direct opposition to a ruling class project organized entirely around imperialist war, massive debt accumulation, privatization and deepening class division. The crisis in public health is therefore not a mere side effect of reactionary politics. It is a central arena of the international class struggle, requiring the independent political mobilization of the working class to defend human life against the dictates of the capitalist system.