# Tobacco money to pay for diabetes research

Diabetes research in the US received an unexpected and welcome boost last month when President Clinton signed the 1997 Balanced Budget Act into law. $150 million, to be collected from a 10–15 percent increase in tobacco taxes over the next five years, will fund research into the prevention and cure of type I diabetes. A further $150 million will go to diabetes screening and prevention in native Americans, who are three times more likely than the national average to suffer from the disease.

The money comes from a new diabetes grant program within the children's health insurance section of the Budget, and was created by an insertion of provisions by House-speaker Newt Gingrich. The revenue dramatically increases diabetes funding from the department of Health and Human Services.

There is wide speculation that the majority of the money for type I research will go to the National Institute for Diabetes and Digestive Kidney Diseases (NIDDK) at the National Institutes of Health (NIH). However, an NIDDK spokesperson insisted that it was premature to say how and where the money would be allocated.

In fact, extra funding for this organization would be especially welcome, since the NIDDK was one of only six NIH institutes set to receive less than the average 2.6 percent increase in President Clinton's 1998 NIH research budget proposals (*Nature Med.* 3, 589; 1997). Furthermore, the distribution of funding within the NIH is the subject of increasing scrutiny. Although diabetes is the nation's fourth leading cause of mortality, the NIH backs research into the disease at the rate of $4,995 per death compared with $31,381 per death which goes to the eighth-ranked killer, HIV/AIDS.

The Juvenile Diabetes Foundation (JDF) applauds the new funds. Type I diabetes, in which the insulin-producing beta cells of the pancreas are destroyed by auto-antibodies, affects around one million Americans and is also known as juvenile-onset diabetes because it strikes typically before 30 years of age. Robert Goldstein, vice president of research at the JDF, believes that it is an excellent disease model in which to invest research funds for two reasons.

First, new discoveries about type I pathogenesis may have broader implications for other autoimmune diseases, such as rheumatoid arthritis and multiple sclerosis. Second, the complications associated with diabetes in general, such as neuropathy and retinopathy, occur much sooner in type I diabetes but are identical to those seen in the more common type II diabetes.

Goldstein says that in addition to basic research, the JDF would like to see the money used to advance clinical trials such as those currently being run by the NIH to evaluate the ability of "mini-doses" of insulin to induce tolerance to the peptide in high-risk, non-symptomatic children.

The Budget diabetes package — which was highlighted by Clinton in a speech at Georgetown University Medical Center, Washington, on August 8 — also provides for a $2.1 billion expansion of the Medicare diabetes program over the next five years. This is in contrast to the overall cut in Medicare funding set out in the Budget Act.

It is estimated that three million seniors have diabetes, which takes up almost one quarter of the Medicare budget. While insulin and other medications will still not be reimbursed, the new funds will provide coverage for education outside the hospital setting for the first time. And whereas previous Medicare regulations restricted reimbursement to diabetics treated with insulin, the new funding means that those who control their disease with diet and exercise will also qualify for diet counseling and reimbursement on monitors and testing strips. These policies take effect on July 1, 1998.

Rounding off a high-profile week for diabetes, Clinton also announced a "groundbreaking initiative," led by the American Diabetes Association, which will set guidelines for the management of the disease. The Diabetes Quality Improvement Project comprises public and private sector organizations such as the Health Care Finance Administration, the National Committee for Quality Assurance and the Foundation for Accountability, and is charged with improving the diabetes care given by healthcare providers and plans.

The financial spotlight on diabetes comes in the wake of a major revision of guidelines for the disease by the American Diabetes Association (ADA), which is expected to increase the number of people diagnosed as having diabetes by two million to a total of ten million.

KAREN BIRMINGHAM

## Medicare cut may hurt teaching hospitals

The report in the August issue of *Journal of American Medical Association* that patients treated in teaching hospitals have a better outcome than those cared for in other hospitals, could hardly have been timed better.

It came one week after the signing of the Balanced Budget Act which delivered a significant blow to all hospitals, but particularly teaching hospitals, through its cuts to Medicare funding.

The Budget's goal of a 12 percent reduction in Medicare spending over five years is designed to save $115 billion, and will do so at the expense of Medicare payments to hospitals, doctors and other health providers.

However, teaching hospitals are a major recipient of Medicare subsidies which pay for graduate medical education, and many fear that this area will be hardest hit. Furthermore, the Indirect Medical Education (IME) funds that these hospitals receive in addition to Medicare subsidies (to support other educational costs) are also marked for reduction from 7.7 to 5.5 percent.

Whether the historically favored position of teaching hospitals will prevail in spite of these measures, or whether next years' Budget will relieve any of these issues, remains to be seen.

K.B.