I am delighted that I can report to the House of Representatives an agreement among the House and Senate conferees on the 1960 appropriations for the Department of Labor and the Department of Health, Education, and Welfare -- an agreement that I am convinced represents a responsible blend of concern for the public interest and concern for the Nation's economy.

Many days of hearings and many hours of committee deliberations, extending over a period of several months, have preceded the establishment of the final appropriation levels on which we ask your endorsement today. There has been a thoughtful, detailed analysis of the programs of both Departments, based on the presentations of Departmental officials, the testimony of non-Federal witnesses, and special materials developed by and for the committee and its staff. It is as the result of such consideration, focused on the demonstrable needs of the individual programs and the opportunities they represent to serve the American people, that our action has been taken.

An agreement reached in conference between the House and Senate is often called a compromise. This is a term that I believe should not be applied to the bill that is before you, which represents rather an unwillingness to compromise on matters that so vitally affect the well-being and

indeed the very lives of the people we represent and serve. What we have done, through democratic processes, is to seek a strong consensus on what the level of these appropriations should be. And if it has turned out that the consensus requires setting certain of the appropriations well above and certain others below the levels initially proposed by the Administration, this fact has nothing to do with either compromise or partisan politics, but is merely the result of bringing new and different points of view to bear on questions which must ultimately be decided, under the law, by the Congress of the United States.

Among the many and diverse activities contained within the Departments whose 1960 programs are financed by this bill, there are two in which the Congress found itself in substantial disagreement with the Administration. The degree of that disagreement is to a large extent reflected in the difference between the President's budget proposals for these two Departments and the appropriation levels contained in the bill that is now before you. The two activities to which I refer are medical research and the construction of hospitals.

The medical research items relate primarily to the nine appropriations which finance the Public Health Service's research programs that are located administratively at the National Institutes of Health in Bethesda, Maryland. I say "located administratively" because more than 80 percent of the funds appropriated to the National Institutes of Health are not spent in Bethesda but are used for grants and awards to scientists

and research institutions across the Nation. And 96 percent of the increases over the President's Budget carried in the conferees recommendation is for expenditures that relate to NIH's support of research and training rather than to direct operations.

I shall not take the time here to recapitulate the intense professional and public interest that has been centered on these programs in recent years, interest that has consistently been reflected in Congressional action. The members of the House of Representatives know that they are fine programs, splendidly administered, highly productive, and broadly supported by all segments of our society.

My colleagues here in the House of Representatives will recall that the committee I am privileged to chair was faced with an awkward situation on the budgets for medical research when hearings opened on the Labor-HEW appropriations early this spring. The President's 1960 Budget for the National Institutes of Health, exclusive of construction, was $294 million -- the same dollar level as the amount appropriated by the Congress for these activities in 1959, and well below the actual 1959 program level because of increased costs and other factors. Moreover, funds for medical research construction grants were cut by one-third as compared with 1959.

Both the President and the Secretary of Health, Education, and Welfare, Dr. Arthur G. Flemming, indicated that they were not altogether happy with the medical research proposals in the President's Budget and also indicated that they were being kept under study and that they might

come back with an amendment at a later date. Unfortunately, they were not able to reach agreement on an amendment, and we were forced to hold our initial hearings on the basis of the inadequate information at hand.

We developed our own information in committee, including the fact that the NIH's own request for 1960 had been for $335 million plus $16 million for an increase in overhead on research grants -- a total increase of $57 million over the President's Budget -- and a figure which, incidentally, has been widely misrepresented as being all the NIH thought it could effectively spend. In point of fact, our committee elicited the information that such a program would finance only half of the meritorious new research grant applications expected to be received and approved in 1960, and would permit expansion of training activities in only two of the eight programs.

Our committee, as you recall, set an initial level of $344 million on these programs, with overhead on research grants at 15 percent, and the full committee and the House confirmed our action.

Our sister committee in the Senate, chaired by the distinguished and able Senator from Alabama, Senator Hill, received extensive testimony from outside witnesses and concluded that there were still further needs to be met and opportunities to be exploited in Federal programs in support of medical research. As a result, the Senate, by an overwhelming majority, voted out a bill which increased the House figure on the NIH appropriations by $136 million, to a total of $480 million.

Those who were named conferees to resolve the differences between the House and Senate bills spent many hours in discussion of the medical research appropriations, with full and frank exchange of points of view. It was gratifying indeed to take part in these meetings and see how the members of the conference committee put aside their differences on matters of fiscal policy or when the public interest was so clearly at stake.

The conferees have agreed to accept a figure of $400 million for the 1960 NIH appropriations--well under half of the Senate's initial increases over the House, and $106 million over the Administration's admittedly inadequate proposal submitted as part of the President's Budget last January.

The general premises on which agreement was reached among the conferees were: first, that all meritorious research projects now being supported, on the basis of recommendations by the NIH's scientific advisors, should continue to be supported; second, that there should be ample funds to give support to new projects, representing scientists new to the program, new ideas, and perhaps research institutions that are just joining the Nation's concerted research attack on disease; and third, that at the same time as full support is provided for today's medical research effort, we must also invest significantly in resources for the future -- in research and related training, in research construction, and in starting the development of certain kinds of specialized research facilities which are required as resources for tomorrow's medical research effort.

There are those who will argue against these increases by saying that we can't afford to spend any more money, even on programs that have such a direct and long-range bearing on the people's health, and besides, that there aren't enough scientists to use the additional money effectively without damaging medical teaching and medical care services. The first of these points is false economy; the second is

based on errors in fact.

Medical Research and the National Economy

There are two reasons why investment in medical research is not inflationary in terms of the national economy: first, the product of medical research is a progressive decrease in expenditures for the ravages of disease; and second, the product of medical research is a progressive increase in the productivity of our people.

Expenditures for medical research, therefore, are investments that pay dividends of a kind that can be realized in few, if any, of the other ways of putting money to work for long-term gain. For they are investments in life itself. Yet in total the national investment in medical research this year is only about half of the amount of tax funds that will be spent this year to care for the victims of only one of the major disease of today -- mental illness. On a relative scale, the investment is small in comparison with the potential economic benefits that will accrue as, step by step, medical research achieves new knowledge that is bringing and will bring the killing and disabling diseases progressively under control.

I wonder who among us would hesitate if he were weighing whether to spend some money now to protect the health and possibly the lives of his own loved ones? That seems like a foolish question. But that is what those who propose standing still or cutting back on these medical research programs would have us do for the Nation as a whole.

This is not a cold, statistical problem that is governed solely by fiscal consideration. Human lives and human health are involved, and we must be less concerned with giving the appearance of a balanced budget now and more concerned with the long-term economic stability of our Nation -- stability that is determined in large part by our productive capacity which in turn is in large part dependent upon the health and happiness and well-being of our people.

One of the standard arguments raised by those who seek to rationalize failure to move forward in medical research is that little is being accomplished and that the support for medical research comes from a limited number of emotionally charged individuals who expect miracles. It is my conviction that it is the rank and file of the American people who want better health, are willing to pay for it, and believe medical research is essential if progress is to be made. They know, for example:

....that one cancer patient out of three can now be saved, as compared with one out of four in 1938, which means that there are now 800,000 persons living in the United States who have been saved from cancer.

....that advances in research now permit significant reduction in disability and premature death among those who suffer from heart attacks and high blood pressure.

....that thousands of individuals born with heart defects, once doomed to invalidism and early death, are leading useful and productive lives because of advances in heart surgery.

.... that progress in the infectious and communicable diseases

has revolutionized medical and public health practice in these fields, as illustrated by recent advances against tuberculosis, poliomyelitis, and rheumatic fever.

....that because of new medical and surgical treatment now available, approximately 80 percent of all people with epilepsy are capable of regular productive employment in a wide range of jobs.

....that research has led to methods that can reduce tooth decay by 50 percent.

....that a major cause of blindness among infants has been discovered and eliminated.

....that with new drugs and methods of treatment and diagnosis, it is possible to prevent crippling in 70 percent of patients suffering from rheumatic disease.

....that for the first time discharges from mental hospitals have outnumbered admissions, based on new methods of treatment resulting from research.

These are illustrative. They bespeak progress in human terms. In addition, however, I hold that a strong and sustained medical research effort is sound national economics, and that the twin burdens of large expenditure for medical care and lost productivity because of illness and premature death can be reduced through the application in medical and public health practice of new knowledge derived from research.

Medical Research and Scientific Manpower

There are some who seek to convey the impression that there is not and will not be enough professional medical research manpower to use increased funds for medical research effectively.

There are so many answers to that argument that I shall have to select only a few of them.

In the first place, the same argument was used last year when Congress increased these same appropriations some $83 million. Yet the increase was used, and used effectively in the eyes of the Nation's scientists, who are perhaps better able than anybody else to judge the quality of scientific projects. It is true that a total of some $8 million was not spent by NIH last year in certain of its appropriations, but this was not a manpower question -- as evidenced by the fact that they also had some $10 million in recommended applications that remained unpaid at the end of the year because of lack of funds in certain other appropriation categories.

Moreover, the manpower critics fail to take into account the evidence that the number of sound research grant applications continues to increase steadily . . . . that large numbers of trained scientists continue to result from NIH and other research training programs in that potential medical research manpower are drawn from a larger pool than simply the Ph.D.'s and M.D.'s. . . and that a great deal of the proposed increase, if inacted and signed into law, will be used for activities that do not drain, but enhance scientific resources.

A corollary line of challenge is that if medical research grows, it will be at the expense of other essential health activities -- and

that a strengthened medical research effort "steals" manpower from medical teaching and medical practice. I find it fallacious to the point of being ludicrous to assume that the way to progress is for one to stand still so that the others can catch up. In the first place, there is no evidence that any special effort is being made by the Administration to help medical and medical services "catch up," if indeed they are behind. In the second place, it is the rôle of medical research to change the pattern of medical care, hospital practice and so on -- not to stay "in balance" with them.

I think everyone would agree that the period 1951-59 was a time of rapid growth in medical research. During that time, it is interesting to note, the medical school faculties roughly doubled, with no significant increase in student enrollment. Thus an expanded medical research program enriched rather than detracted from the teaching process. In the same way, giving physicians in hospitals a rôle in clinical investigations doesn't decrease his services to patients and may even enhance them.

The argument that medical research steals from other health fields is a piece of sophistry that has no basis in fact.

The Bayne-Jones Report

Two years ago, working with data that was a year older, a group of outstanding scientists, scientific administrators, and laymen were called together by the Secretary of Health, Education, and Welfare to study and make recommendations on the Department's medical research activities. Very ably chaired by Dr. Stanhope Bayne-Jones, the group of consultants worked over a period of nine months and produced a very fine report.

This report, generally referred to as the Bayne-Jones Report, is being so badly misinterpreted that I feel compelled to comment on it.

The real issues the Report posed were three in number. It says:

1. That the expansion of medical research and education required in the national interest will be costly and should not be restricted by lack of funds.

2. That to meet the health needs of a rapidly growing population we must expand the output of physicians and improve the quality of medical education.

3. That it is essential in the long run to provide rewarding and stable career opportunities in medical research.

I have seen no evidence that any one of these three major points is being acted upon by the Department of Health, Education, and Welfare.

But the Department and its fiscal hierarchy are acting on one thing in the Report.

The consultants, as a preliminary to more fundamental considerations, attempted to assess the probable direction and possible magnitude in the growth of medical research expenditures in the Nation. It was clear that this projection was not intended as an absolute determinant of national or Federal medical research levels for any given year. The consultants labeled the projection conservative, concluding only that the growth of medical research would be upward, continuous, and substantial. They then went on to consideration of substantive questions such as the terms and conditions for medical research support and the plight of medical education.

It is tragic indeed that the only thing in this stimulating and provocative Report that has been raised as a national issue is the projection of growth, which is being used and abused in an effort to restrain growth and progress in the Nation's medical research effort.

Unfortunately, the projection -- although the consultants said it was designed only "to indicate possible orders of magnitude" -- grossly underestimates the present and probable future growth of medical research. It understates economic conditions, fails to take

into account social interests and pressures, sets a rigid balance between public and private support, and deals with dollars of constant value. Already the Nation is well beyond the Bayne-Jones projection, and the Department and the Bureau of the Budget would do well to abandon their efforts to adhere to that projection and instead think through the meaning of the programs they support in terms of the people's health.

Conferee Agreement

The elements of the conference agreement on the NIH appropriations can be quite simply stated as compared with the levels to which we agreed in April when the Labor-HEW bill was passed in the House.

$ 25.8 million is provided for the further support of research in nonfederal institutions. This means that the total amount of this item will provide support for essentially all of the research grant applications that NIH estimates will be received and recommended for approval and payment. This includes new projects as well as continuation of existing projects, and also provides for 20 percent above the new grant estimate to make sure that no worthwhile new project may have to go unsupported for lack of funds.

$ 13.9 million is provided for training grants and awards beyond the amount covered in the House bill. The bulk of this is applied to training in the sciences basic to medicine and in the fields

and disciplines of mental health, where acute shortages continue to exist or threaten. The additional funds are also provided so that the NIH can adjust the starting dates for as many training grants as possible in order to make the availability of funds coincide with the normal time when grantee institutions are engaged in planning and recruiting for the next academic year.

$ 2 million is provided to expand the fellowships program, with special emphasis on the senior research fellowships which serve such a useful purpose in helping the young investigator establish himself in a university medical research career.

$ 4 million is provided for ~~three~~ four fields of special interest and promise in the cancer field -- the search for ~~clinical~~ chemical agents to treat cancer, ~~the effort to find new ways to assist in early diagnosis of cancer and new uses for existing diagnostic techniques, and the intensification of the effort to find out if viruses cause cancer and, if so, whether a preventive agent can be devised.~~ these funds are specifically for research contracts with industry, which has much to contribute to the discovery and development of these agents, which are now being tested for anti-cancer activity at the rate of 40,000 compounds a year.

$ 3 million is provided for establishing on an experimental basis several specialized clinical investigative units in environments where they can serve a variety of purposes, including carefully controlled therapeutic and metabolic studies. I shall have more to say on these units in a moment, since they were the subject of considerable

attention on the Senate side.

$ 2 million is provided on a similar basis to undertake the establishment of one or more animal colonies designed for experimental work involving monkeys and the higher primates.

$ / million is for broadening the mechanisms for the review and approval of research projects supported by grants, and another $ / million for extensions in those programs of NIH related to the control of heart disease and cancer through public health programs.

$ 3 million is provided for the Bethesda operation, for such purposes as strengthening the central staffing and services for the nationwide collaborative program for study of the total range of influences on the unborn and just-born babies, seeking answers to such conditions as cerebral palsy and mental retardation.

I should point out in conclusion that there are two major respects in which the increases were not acceptable to the House conferees in the form and dimension in which they were presented.

One of these is the perennial question of the overhead or indirect costs of research supported by grants. We continue to be sympathetic to the needs of the medical schools and related institutions for general operating or fluid funds. But again the case has

not been well presented by inside or outside witnesses, and we are unwilling in the name of research to get involved in financing the more general parts of the operations of the medical, dental, and related schools.

A second aspect of the Senate bill which was modified to a major extent in conference was the heavy emphasis it placed on the creation of specialized resources for clinical research in cancer, heart disease, and other conditions. We felt this to be a major departure from established NIH programs, one for which there is no precedent as to cost, location, or operating relationships. We therefore advocated a cautious initial approach to these and the primate colonies also contained in the Senate bill, at the same time recognizing that if suitable groundwork can be laid in 1960, this program of Federal aid to the creation of regionally dispersed, specialized resources may grow significantly in the years ahead. For the new clinical facilities, the conferees believed that some construction might be involved during 1960 (although the primary need is for renovation of existing facilities, equipment, staffing, and operating funds). The conferees assume that the authorities of Section 433(A) -- under which Heart and Cancer research facilities were built in 1948-50 -- are still in force and can be used for the specialized construction needs related to the creation of these units.

Summary

In summary, I urge your favorable action on this agreement reached by the conferees of the House and Senate appropriations committees relative to the medical research appropriations for the National Institutes of Health. You can have confidence, as I have, that these programs are effectively administered in the public interest. And you can act with the knowledge that the meaning of your act will be found in the product of medical research: new knowledge that will protect the life and improve the health of man.

Finally, although this may be a bit unusual, I want to acknowledge the thoughtful, impartial, and creative contributions of the other members of the committee which I chair. Mr. Denton, Mr. Marshall, Mr. Laird, and Mr. Cederberg have been most helpful throughout this long and often difficult and frustrating experience. They have demonstrated good judgment, good will, and good leadership, recognizing and acting in the public interest, based on their own conviction of what is best for the people and the Nation. All of us, and all the people, are indebted to them.