In the last twelve months alone, America's medical bill went up eleven percent, from $63 to $70 billion. In the last ten years, it has climbed 170 percent, from the $26 billion level in 1960. Then we were spending 5.3 percent of our Gross National Product on health; today we devote almost 7% of our GNP to health expenditures.

This growing investment in health has been led by the Federal Government. In 1960, Washington spent $3.5 billion on medical needs—13 percent of the total. This year it will spend $21 billion—or about 30 percent of the nation's spending in this area.

But what are we getting for all this money?

For most Americans, the result of our expanded investment has been more medical care and care of higher quality. A profusion of impressive new techniques, powerful new drugs, and splendid new facilities has developed over the past decade. During that same time, there has been a six percent drop in the number of days each year that Americans are disabled. Clearly there is much that is right with American medicine.

But there is also much that is wrong.

One of the biggest problems is that fully 60 percent of the growth in medical expenditures in the last ten years has gone not for additional services but merely to meet price inflation. Since 1960, medical costs have gone up twice as fast as the cost of living. Hospital costs have risen five times as fast as other prices. For growing numbers of Americans, the cost of care is becoming prohibitive. And even those who can afford most care may find themselves impoverished by a catastrophic medical expenditure.
The shortcomings of our health care system are manifested in other ways as well. For some Americans—especially those who live in remote rural areas or in the inner city—care is simply not available. The quality of medicine varies widely with geography and income. Primary care physicians and outpatient facilities are in short supply in many areas and most of our people have trouble obtaining medical attention on short notice. Because we pay so little attention to preventing disease and treating it early, too many people get sick and need intensive treatment.

Our record, then, is not as good as it should be. Costs have skyrocketed but values have not kept pace. We are investing more of our nation's resources in the health of our people but we are not getting a full return on our investment.

BUILDING A NATIONAL HEALTH STRATEGY

Things do not have to be this way. We can change these conditions—indeed, we must change them if we are to fulfill our promise as a nation. Good health care should be readily available to all of our citizens.

It will not be easy for our nation to achieve this goal. It will be impossible to achieve it without a new sense of purpose and a new spirit of discipline. That is why I am calling today not only for new programs and not merely for more money but for something more—for a new approach which is equal to the complexity of our challenges. I am calling today for a new National Health Strategy that will marshal a variety of forces in a coordinated assault on a variety of problems.

This new strategy should be built on four basic principles.

1. Assuring Equal Access. Although the Federal Government should be viewed as only one of several partners in this reforming effort, it does bear a special responsibility to help all citizens achieve equal access to our health care system. Just as our National Government has moved to provide equal opportunity in areas such as education, employment and voting, so we must now work to expand the opportunity for all citizens to obtain a decent standard of medical care. We must do all we can to remove any racial, economic, social or geographic barriers which now prevent any of our citizens from obtaining adequate health protection. For without good health, no man can fully utilize his other opportunities.

2. Balancing Supply and Demand. It does little good, however, to increase the demand for care unless we also increase the supply. Helping more people pay for more care does little good unless more care is available. This axiom was ignored when Medicaid and Medicare were created—and the nation paid a high price for that error. The expectations of many beneficiaries were not met and a severe inflation in medical costs was compounded.

Rising demand should not be a source of anxiety in our country. It is, after all, a sign of our success in achieving equal opportunity, a measure of our effectiveness in reducing the barriers to care. But since the Federal Government is helping to remove those barriers, it also has a responsibility for what happens after they are reduced. We must see to it that our approach to health problems is a balanced approach. We must be sure that our health care system is ready and able to welcome its new clients.
3. Organizing for Efficiency. As we move toward these goals, we must recognize that we cannot simply buy our way to better medicine. We have already been trying that too long. We have been persuaded, too often, that the plan that costs the most will help the most and too often we have been disappointed.

We cannot be accused of having underfinanced our medical system—not by a long shot. We have, however, spent this money poorly—reinforcing inequities and rewarding inefficiencies and placing the burden of greater new demands on the same old system which could not meet the old ones.

The toughest question we face then is not how much we should spend but how we should spend it. It must be our goal not merely to finance a more expensive medical system but to organize a more efficient one.

There are two particularly useful ways of doing this:

A. Emphasizing Health Maintenance. In most cases our present medical system operates episodically—people come to it in moments of distress—when they require its most expensive services. Yet both the system and those it serves would be better off if less expensive services could be delivered on a more regular basis.

If more of our resources were invested in preventing sickness and accidents, fewer would have to be spent on costly cures. If we gave more attention to treating illness in its early stages, then we would be less troubled by acute disease. In short, we should build a true "health" system—and not a "sickness" system alone. We should work to maintain health and not merely to restore it.

B. Preserving Cost Consciousness. As we determine just who should bear the various costs of health care, we should remember that only as people are aware of those costs will they be motivated to reduce them. When consumers pay virtually nothing for services and when, at the same time, those who provide services know that all their costs will also be met, then neither the consumer nor the provider has an incentive to use the system efficiently. When that happens, unnecessary demand can multiply, scarce resources can be squandered and the shortage of services can become even more acute.

Those who are hurt the most by such developments are often those whose medical needs are most pressing. While costs should never be a barrier to providing needed care, it is important that we preserve some element of cost consciousness within our medical system.

4. Building on Strengths. We should also avoid holding the whole of our health care system responsible for failures in some of its parts. There is a natural temptation in dealing with any complex problem to say: "Let us wipe the slate clean and start from scratch." But to do this—to dismantle our entire health insurance system, for example—would be to ignore those important parts of the system which have provided useful service. While it would be wrong to ignore any weaknesses in our present system, it would be equally wrong to sacrifice its strengths.

One of those strengths is the diversity of our system—and the range of choice it therefore provides to doctors and patients alike. I believe the public
will always be better served by a pluralistic system than by a monolithic one, by a system which creates many effective centers of responsibility—both public and private—rather than one that concentrates authority in a single governmental source.

This does not mean that we must allow each part of the system to go its own independent way, with no sense of common purpose. We must encourage greater cooperation and build better coordination—but not by fostering uniformity and eliminating choice. One effective way of influencing the system is by structuring incentives which reward people for helping to achieve national goals without forcing their decisions or dictating the way they are carried out. The American people have always shown a unique capacity to move toward common goals in varied ways. Our efforts to reform health care in America will be more effective if they build on this strength.

These, then, are certain cardinal principles on which our National Health Strategy should be built. To implement this strategy, I now propose for the consideration of the Congress the following six point program. It begins with measures designed to increase and improve the supply of medical care and concludes with a program which will help people pay for the care they require.

A. Reorganizing the Delivery of Service

In recent years, a new method for delivering health services has achieved growing respect. This new approach has two essential attributes. It brings together a comprehensive range of medical services in a single organization so that a patient is assured of convenient access to all of them. And it provides needed services for a fixed contract fee which is paid in advance by all subscribers.

Such an organization can have a variety of forms and names and sponsors. One of the strengths of this new concept, in fact, is its great flexibility. The general term which has been applied to all of these units is “HMO”—Health Maintenance Organization.

The most important advantage of Health Maintenance Organizations is that they increase the value of the services a consumer receives for each health dollar. This happens, first, because such organizations provide a strong financial incentive for better preventive care and for greater efficiency.

Under traditional systems, doctors and hospitals are paid, in effect, on a piece work basis. The more illnesses they treat—and the more service they render—the more their income rises. This does not mean, of course, that they do any less than their very best to make people well. But it does mean that there is no economic incentive for them to concentrate on keeping people healthy.

A fixed-price contract for comprehensive care reverses this illogical incentive. Under this arrangement, income grows not with the number of days a person is sick but with the number of days he is well. HMO's therefore have a strong financial interest in preventing illness, or, failing that, in treating it in its early stages, promoting a thorough recovery and preventing any
reoccurrence. Like doctors in ancient China, they are paid to keep their clients healthy. For them, economic interests work to reenforce their professional interests.

At the same time, HMO’s are motivated to function more efficiently. When providers are paid retroactively for each of their services, inefficiencies can often be subsidized. Sometimes, in fact, inefficiency is rewarded—as when a patient who does not need to be hospitalized is treated in a hospital so that he can collect on his insurance. On the other hand, if an HMO is wasteful of time or talent or facilities, it cannot pass those extra costs on to the consumer or to an insurance company. Its budget for the year is determined in advance by the number of its subscribers. From that point on it is penalized for going over its budget and rewarded for staying under it.

In an HMO, in other words, cost consciousness is fostered. Such an organization cannot afford to waste resources—that costs more money in the short run. But neither can it afford to economize in ways which hurt patients—for that increases long-run expenses.

The HMO also organizes medical resources in a way that is more convenient for patients and more responsive to their needs. There was a time when every housewife had to go to a variety of shops and markets and pushcarts to buy her family’s groceries. Then along came the supermarket—making her shopping chores much easier and also giving her a wider range of choice and lower prices. The HMO provides similar advantages in the medical field. Rather than forcing the consumer to thread his way through a complex maze of separate services and specialists, it makes a full range of resources available through a single organization—often at a single stop—and makes it more likely that the right combination of resources will be utilized.

Because a team can often work more efficiently than isolated individuals, each doctor’s energies go further in a Health Maintenance Organization—twice as far according to some studies. At the same time, each patient retains the freedom to choose his own personal doctor. In addition, services can more easily be made available at night and on weekends in an HMO. Because many doctors often use the same facilities and equipment and can share the expense of medical assistants and business personnel, overhead costs can be sharply curtailed. Physicians benefit from the stimulation that comes from working with fellow professionals who can share their problems, appreciate their accomplishments and readily offer their counsel and assistance. HMO’s offer doctors other advantages as well, including a more regular work schedule, better opportunities for continuing education, lesser financial risks upon first entering practice, and generally lower rates for malpractice insurance.

Some seven million Americans are now enrolled in HMO’s—and the number is growing. Studies show that they are receiving high quality care at a significantly lower cost—as much as one-fourth to one-third lower than traditional care in some areas. They go to hospitals less often and they spend less time there when they go. Days spent in the hospital each year for those who belong to HMO’s are only three-fourths of the national average.

Patients and practitioners alike are enthusiastic about this organizational
concept. So is this Administration. That is why we proposed legislation last March to enable Medicare recipients to join such programs. That is why I am now making the following additional recommendations:

1. We should require public and private health insurance plans to allow beneficiaries to use their plan to purchase membership in a Health Maintenance Organization when one is available. When, for example, a union and an employer negotiate a contract which includes health insurance for all workers, each worker should have the right to apply the actuarial value of his coverage toward the purchase of a fixed-price, health maintenance program. Similarly, both Medicare and the new Family Health Insurance Plan for the poor which I will set out later in this message should provide an HMO option.

2. To help new HMO's get started—an expensive and complicated task—we should establish a new $23 million program of planning grants to aid potential sponsors—in both the private and public sector.

3. At the same time, we should provide additional support to help sponsors raise the necessary capital, construct needed facilities, and sustain initial operating deficits until they achieve an enrollment which allows them to pay their own way. For this purpose, I propose a program of Federal loan guarantees which will enable private sponsors to raise some $300 million in private loans during the first year of the program.

4. Other barriers to the development of HMO's include archaic laws in 22 States which prohibit or limit the group practice of medicine and laws in most States which prevent doctors from delegating certain responsibilities (like giving injections) to their assistants. To help remove such barriers, I am instructing the Secretary of Health, Education and Welfare to develop a model statute which the States themselves can adopt to correct these anomalies. In addition, the Federal Government will facilitate the development of HMO's in all States by entering into contracts with them to provide service to Medicare recipients and other Federal beneficiaries who elect such programs. Under the supremacy clause of the Constitution, these contracts will operate to preempt any inconsistent State statutes.

Our program to promote the use of HMO's is only one of the efforts we will be making to encourage a more efficient organization of our health care system. We will take other steps in this direction, including stronger efforts to capitalize on new technological developments.

In recent years medical scientists, engineers, industrialists, and management experts have developed many new techniques for improving the efficiency and effectiveness of health care. These advances include automated devices for measuring and recording body functions such as blood flow and the electrical activity of the heart, for performing laboratory tests and making the results readily available to the doctor, and for reducing the time required to obtain a patient's medical history. Methods have also been devised for using computers in diagnosing diseases, for monitoring and diagnosing patients from remote locations, for keeping medical records and generally for restructuring the layout and administration of hospitals and other care centers. The results of early tests for such techniques have been
most promising. If new developments can be widely implemented, they can help us deliver more effective, more efficient care at lower prices.

The hospital and outpatient clinic of tomorrow may well bear little resemblance to today's facility. We must make every effort to see that its full promise is realized. I am therefore directing the Secretary of Health, Education and Welfare to focus research in the field of health care services on new techniques for improving the productivity of our medical system. The Department will establish pilot experiments and demonstration projects in this area, disseminate the results of this work, and encourage the health industry and the medical profession to bring such techniques into full and effective use in the health care centers of the nation.

B. Meeting the Special Needs of Scarcity Areas

Americans who live in remote rural areas or in urban poverty neighborhoods often have special difficulty obtaining adequate medical care. On the average, there is now one doctor for every 630 persons in America. But in over one-third of our counties the number of doctors per capita is less than one-third that high. In over 130 counties, comprising over eight percent of our land area, there are no private doctors at all—and the number of such counties is growing.

A similar problem exists in our center cities. In some areas of New York for example, there is one private doctor for every 200 persons but in other areas the ratio is one to 12,000. Chicago's inner city neighborhoods have some 1700 fewer physicians today than they had ten years ago.

How can we attract more doctors—and better facilities—into these scarcity areas? I propose the following actions:

1. We should encourage Health Maintenance Organizations to locate in scarcity areas. To this end, I propose a $22 million program of direct Federal grants and loans to help offset the special risks and special costs which such projects would entail.

2. When necessary, the Federal Government should supplement these efforts by supporting out-patient clinics in areas which still are underserved. These units can build on the experience of the Neighborhood Health Centers experiment which has now been operating for several years. These facilities would serve as a base on which full HMO's—operating under other public or private direction—could later be established.

I have also asked the Administrator of Veterans Affairs and the Secretary of Health, Education, and Welfare to develop ways in which the Veterans Administration medical system can be used to supplement local medical resources in scarcity areas.

3. A series of new area Health Education Centers should also be established in places which are medically underserved—as the Carnegie Commission on Higher Education has recommended. These centers would be satellites of existing medical and other health science schools; typically, they could be built around a community hospital, a clinic or an HMO which is already in existence. Each would provide a valuable teaching center for new health
professionals, a focal point for the continuing education of experienced personnel, and a base for providing sophisticated medical services which would not otherwise be available in these areas. I am requesting that up to $40 million be made available for this program in Fiscal Year 1972.

4. We should also find ways of compensating—and even rewarding—doctors and nurses who move to scarcity areas, despite disadvantages such as lower income and poorer facilities.

As one important step in this direction, I am proposing that our expanding loan programs for medical students include a new forgiveness provision for graduates who practice in a scarcity area, especially those who specialize in primary care skills that are in short supply.

In addition, I will request $10 million to implement the Emergency Health Personnel Act. Such funds will enable us to mobilize a new National Health Service Corps, made up largely of dedicated and public-spirited young health professionals who will serve in areas which are now plagued by critical manpower shortages.

Meeting the Personnel Needs of our Growing Medical System

Our proposals for encouraging HMO's and for serving scarcity areas will help us use medical manpower more effectively. But it is also important that we produce more health professionals and that we educate more of them to perform critically needed services. I am recommending a number of measures to accomplish these purposes.

1. First, we must use new methods for helping to finance medical education. In the past year, over half of the nation's medical schools have declared that they are in "financial distress" and have applied for special Federal assistance to meet operating deficits.

More money is needed—but it is also important that this money be spent in new ways. Rather than treating the symptoms of distress in a piecemeal and erratic fashion, we must rationalize our system of financial aid for medical education so that the schools can make intelligent plans for regaining a sound financial position.

I am recommending, therefore, that much of our present aid to schools of medicine, dentistry and osteopathy—along with $60 million in new money—be provided in the form of so-called "capitation grants," the size of which would be determined by the number of students the school graduates. I recommend that the capitation grant level be set at $6,000 per graduate.

A capitation grant system would mean that a school would know in advance how much Federal money it could count on. It would allow an institution to make its own long-range plans as to how it would use these monies. It would mean that we could eventually phase out our emergency assistance programs.

By rewarding output—rather than subsidizing input—this new aid system would encourage schools to educate more students and to educate them more efficiently. Unlike formulas which are geared to the annual number of enrollees, capitation grants would provide a strong incentive for schools to shorten their curriculum from four years to three—in line with another sound
recommendation of the Carnegie Commission on Higher Education. For then, the same sized school would qualify for as much as one-third more money each year, since each of its graduating classes would be one-third larger.

This capitation grant program should be supplemented by a program of special project grants to help achieve special goals. These grants would support efforts such as improving planning and management, shortening curriculums, expanding enrollments, team training of physicians and allied health personnel, and starting HMO's for local populations.

In addition, I believe that Federal support dollars for the construction of medical education facilities can be used more effectively. I recommend that the five current programs in this area be consolidated into a single, more flexible grant authority and that a new program of guaranteed loans and other financial aids be made available to generate over $500 million in private construction loans in the coming Fiscal Year—five times the level of our current construction grant program.

Altogether, these efforts to encourage and facilitate the expansion of our medical schools should produce a 50 percent increase in medical school graduates by 1975. We must set that as our goal and we must see that it is accomplished.

2. The Federal Government should also establish special support programs to help low income students enter medical and dental schools. I propose that our scholarship grant program for these students be almost doubled—from $15 to $29 million. At the same time, this Administration would modify its proposed student loan programs better to meet the needs of medical students. To help alleviate the concern of low income students that such a loan might become an impossible burden if they fail to graduate from medical school, we will request authority to forgive loans where such action is appropriate.

3. One of the most promising ways to expand the supply of medical care and to reduce its costs is through a greater use of allied health personnel, especially those who work as physicians' and dentists' assistants, nurse pediatric practitioners, and nurse midwives. Such persons are trained to perform tasks which must otherwise be performed by doctors themselves, even though they do not require the skills of a doctor. Such assistance frees a physician to focus his skills where they are most needed and often allows him to treat many additional patients.

I recommend that our allied health personnel training programs be expanded by 50% over 1971 levels, to $29 million, and that $15 million of this amount be devoted to training physicians' assistants. We will also encourage medical schools to train future doctors in the proper use of such assistants and we will take the steps I described earlier to eliminate barriers to their use in the laws of certain States.

In addition, this administration will expand nationwide the current MEDIHC program—an experimental effort to encourage servicemen and women with medical training to enter civilian medical professions when they leave military duty. Of the more than 30,000 such persons who leave military service each year, two-thirds express an interest in staying in the health field but only about one-third finally do so. Our goal is to increase the number who enter
civilian health employment by 2,500 per year for the next five years. At the same time, the Veterans Administration will expand the number of health trainees in VA facilities from 49,000 in 1970 to over 53,000 in 1972.

D. A Special Problem: Malpractice Suits and Malpractice Insurance

One reason consumers must pay more for health care and health insurance these days is the fact that most doctors are paying much more for the insurance they must buy to protect themselves against claims of malpractice. For the past five years, malpractice insurance rates have gone up an average of 10 percent a year—a fact which reflects both the growing number of malpractice claims and the growing size of settlements. Many doctors are having trouble obtaining any malpractice insurance.

The climate of fear which is created by the growing menace of malpractice suits also affects the quality of medical treatment. Often it forces doctors to practice inefficient, defensive medicine—ordering unnecessary tests and treatments solely for the sake of appearance. It discourages the use of physicians' assistants, inhibits that free discussion of cases which can contribute so much to better care, and makes it harder to establish a relationship of trust between doctors and patients.

The consequences of the malpractice problem are profound. It must be confronted soon and it must be confronted effectively—but that will be no simple matter. For one thing, we need to know far more than we presently do about this complex problem.

I am therefore directing—as a first step in dealing with this danger—that the Secretary of Health, Education and Welfare promptly appoint and convene a Commission on Medical Malpractice to undertake an intensive program of research and analysis in this area. The Commission memberships should represent the health professions and health institutions, the legal profession, the insurance industry, and the general public. Its report—which should include specific recommendations for dealing with this problem—should be submitted by March 1, 1972.

E. New Actions to Prevent Illnesses and Accidents

We often invest our medical resources as if an ounce of cure were worth a pound of prevention. We spend vast sums to treat illnesses and accidents that could be avoided for a fraction of those expenditures. We focus our attention on making people well rather than keeping people well, and—as a result—both our health and our pocketbooks are poorer. A new National Health Strategy should assign a much higher priority to the work of prevention.

As we have already seen, Health Maintenance Organizations can do a great deal to help in this effort. In addition to encouraging their growth, I am also recommending a number of further measures through which we can take the offensive against the long-range causes of illnesses and accidents.

1. To begin with, we must reaffirm—and expand—the Federal commitment to biomedical research. Our approach to research support should be balanced—with strong efforts in a variety of fields. Two critical areas, however, deserve special attention.

The first of these is cancer. In the next year alone, 650,000 new cases of
cancer will be diagnosed in this country and 340,000 of our people will die of this disease. Incredible as it may seem, one out of every four Americans who are now alive will someday develop cancer unless we can reduce the present rates of incidence.

In the last seven years we spent more than 30 billion dollars on space research and technology and about one-twenty-fifth of that amount to find a cure for cancer. The time has now come to put more of our resources into cancer research and—learning an important lesson from our space program—to organize those resources as effectively as possible.

When we began our space program we were fairly confident that our goals could be reached if only we made a great enough effort. The challenge was technological; it did not require new theoretical breakthroughs. Unfortunately, this is not the case in most biomedical research at the present time; scientific breakthroughs are still required and they often cannot be forced—no matter how much money and energy is expended.

We should not forget this caution. At the same time, we should recognize that of all our research endeavors, cancer research may now be in the best position to benefit from a great infusion of resources. For there are moments in biomedical research when problems begin to break open and results begin to pour in, opening many new lines of inquiry and many new opportunities for breakthrough.

We believe that cancer research has reached such a point. This Administration is therefore requesting an additional $100 million for cancer research in its new budget. And—as I said in my State of the Union Message—"I will ask later for whatever additional funds can effectively be used" in this effort.

Because this project will require the coordination of scientists in many fields—drawing on many projects now in existence but cutting across established organizational lines—I am directing the Secretary of Health, Education and Welfare to establish a new Cancer Conquest Program in the Office of the Director of the National Institutes of Health. This program will operate under its own Director who will be appointed by the Secretary and supported by a new management group. To advise that group in establishing priorities and allocating funds—and to advise other officials, including me, concerning this effort—I will also establish a new Advisory Committee on the Conquest of Cancer.

A second targeted disease for concentrated research should be sickle cell anemia—a most serious childhood disease which almost always occurs in the black population. It is estimated that one out of every 500 black babies actually develops sickle cell disease.

It is a sad and shameful fact that the causes of this disease have been largely neglected throughout our history. We cannot rewrite this record of neglect, but we can reverse it. To this end, this Administration is increasing its budget for research and treatment of sickle cell disease fivefold, to a new total of $6 million.

2. A second major area of emphasis should be that of health education.

In the final analysis, each individual bears the major responsibility for his own health. Unfortunately, too many of us fail to meet that responsibility.
Too many Americans eat too much, drink too much, work too hard, and exercise too little. Too many are careless drivers.

These are personal questions, to be sure, but they are also public questions. For the whole society has a stake in the health of the individual. Ultimately, everyone shares in the cost of his illnesses or accidents. Through tax payments and through insurance premiums, the careful subsidize the careless, the nonsmokers subsidize those who smoke, the physically fit subsidize the rundown and the overweight, the knowledgeable subsidize the ignorant and vulnerable.

It is in the interest of our entire country, therefore, to educate and encourage each of our citizens to develop sensible health practices. Yet we have given remarkably little attention to the health education of our people. Most of our current efforts in this area are fragmented and haphazard—a public service advertisement one week, a newspaper article another, a short lecture now and then from the doctor. There is no national instrument, no central force to stimulate and coordinate a comprehensive health education program.

I have therefore been working to create such an instrument. It will be called the National Health Education Foundation. It will be a private, non-profit group which will receive no Federal money. Its membership will include representatives of business, labor, the medical profession, the insurance industry, health and welfare organizations, and various governmental units. Leaders from these fields have already agreed to proceed with such an organization and are well on the way toward reaching an initial goal of $1 million in pledges for its budget.

This independent project will be complemented by other Federal efforts to promote health education. For example, expenditures to provide family planning assistance have been increased, rising fourfold since 1969. And I am asking that the great potential of our nation's day care centers to provide health education be better utilized.

3. We should also expand Federal programs to help prevent accidents—the leading cause of death between the ages of one and 37 and the fourth leading cause of death for persons of all ages.

Our highway death toll—50,000 fatalities last year—is a tragedy and an outrage of unspeakable proportions. It is all the more shameful since half these deaths involved drivers or pedestrians under the influence of alcohol. We have therefore increased funding for the Department of Transportation's auto accident and alcohol program from $8 million in Fiscal Year 1971 to $35 million in Fiscal Year 1972. I am also requesting that the budget for alcoholism programs be doubled, from $7 million to $14 million. This will permit an expansion of our research efforts into better ways of treating this disease.

I am also requesting a supplemental appropriation of $5 million this year and an addition of $8 million over amounts already in the 1972 budget to implement aggressively the new Occupational Safety and Health Act I signed last December. We must begin immediately to cut down on the 14,000 deaths and more than two million disabling injuries which result each year from occupational illnesses and accidents.
The conditions which affect health are almost unlimited. A man's income, his daily diet, the place he lives, the quality of his air and water—all of these factors have a greater impact on his physical well-being than does the family doctor. When we talk about our health program, therefore, we should not forget our efforts to protect the nation's food and drug supply, to control narcotics, to restore and renew the environment, to build better housing and transportation systems, to end hunger in America, and—above all—to place a floor under the income of every family with children. In a sense this special message on health is one of many health messages which this Administration is sending to the Congress.

F. A National Health Insurance Partnership

In my State of the Union message, I pledged to present a program "to ensure that no American family will be prevented from obtaining basic medical care by inability to pay." I am announcing that program today. It is a comprehensive national health insurance program, one in which the public and the private sectors would join in a new partnership to provide adequate health insurance for the American people.

In the last twenty years, the segment of our population owning health insurance has grown from 50 percent to 87 percent and the portion of medical bills paid for by insurance has gone from 35 percent to 60 percent. But despite this impressive growth, there are still serious gaps in present health insurance coverage. Four such gaps deserve particular attention.

First—too many health insurance policies focus on hospital and surgical costs and leave critical outpatient services uncovered. While some 80 percent of our people have some hospitalization insurance, for example, only about half are covered for outpatient and laboratory services and less than half are insured for treatment in the physician's office or the home. Because demand goes where the dollars are, the result is an unnecessary—and expensive—overutilization of acute care facilities. The average hospital stay today is a full day longer than it was eight years ago. Studies show that over one-fourth of hospital beds in some areas are occupied by patients who do not really need them and could have received equivalent or better care outside the hospital.

A second problem is the failure of most private insurance policies to protect against the catastrophic costs of major illnesses and accidents. Only 40 percent of our people have catastrophic cost insurance of any sort and most of that insurance has upper limits of $10,000 or $15,000. This means that insurance often runs out while expenses are still mounting. For many of our families, the anguish of a serious illness is thus compounded by acute financial anxiety. Even the joy of recovery can often be clouded by the burden of debt—and even by the threat of bankruptcy.

A third problem with much of our insurance at the present time is that it cannot be applied to membership in a Health Maintenance Organization—and thus effectively precludes such membership. No employee will pay to join such a plan, no matter how attractive it might seem to him, when deductions from his paycheck—along with contributions from his employer—are being used to purchase another health insurance policy.

The fourth deficiency we must correct in present insurance coverage is its
failure to help the poor gain sufficient access to our medical system. Just one index of this failure is the fact that fifty percent of poor children are not even immunized against common childhood diseases. The disability rate for families below the poverty line is at least 50 percent higher than for families with incomes above $10,000.

Those who need care most often get care least. And even when the poor do get service, it is often second rate. A vicious cycle is thus reinforced—poverty breeds illness and illness breeds greater poverty. This situation will be corrected only when the poor have sufficient purchasing power to enter the medical marketplace on equal terms with those who are more affluent.

Our National Health Insurance Partnership is designed to correct these inadequacies—not by destroying our present insurance system but by improving it. Rather than giving up on a system which has been developing impressively, we should work to bring about further growth which will fill in the gaps we have identified. To this end, I am recommending the following combination of public and private efforts.

1. I am proposing that a National Health Insurance Standards Act be adopted which will require employers to provide basic health insurance coverage for their employees.

   In the past, we have taken similar actions to assure workers a minimum wage, to provide them with disability and retirement benefits, and to set occupational health and safety standards. Now we should go one step further and guarantee that all workers will receive adequate health insurance protection.

   The minimum program we would require under this law would pay for hospital services, for physicians' services—both in the hospital and outside of it, for full maternity care, well-baby care (including immunizations), laboratory services and certain other medical expenses. To protect against catastrophic costs, benefits would have to include not less than $50,000 in coverage for each family member during the life of the policy contract. The minimum package would include certain deductible and coinsurance features. As an alternative to paying separate fees for separate services, workers could use this program to purchase membership in a Health Maintenance Organization.

   The Federal Government would pay nothing for this program; the costs would be shared by employers and employees, much as they are today under most collective bargaining agreements. A ceiling on how much employees could be asked to contribute would be set at 35 percent during the first two and one-half years of operation and 25 percent thereafter. To give each employer time to plan for this additional cost of doing business—a cost which would be shared, of course, by all of his competitors—this program would not go into effect until July 1, 1973. This schedule would also allow time for expanding and reorganizing our health system to handle the new requirements.

   As the number of enrollees rises under this plan, the costs per enrollee can be expected to fall. The fact that employees and unions will have an even higher stake in the system will add additional pressures to keep quality up and costs down. And since the range within which benefits can vary will be
somewhat narrower than it has been, competition between insurance companies will be more likely to focus on the overall price at which the contract is offered. This means that insurance companies will themselves have a greater motivation to keep medical costs from soaring.

I am still considering what further legislative steps may be desirable for regulating private health insurance, including the introduction of sufficient disincentive measures to reinforce the objective of creating cost consciousness on the part of consumers and providers. I will make such recommendations to the Congress at a later time.

2. I am also proposing that a new Family Health Insurance Plan be established to meet the special needs of poor families who would not be covered by the proposed National Health Insurance Standards Act headed by unemployed, intermittently employed or self-employed persons.

The Medicaid program was designed to help these people, but—for many reasons—it has not accomplished its goals. Because it is not a truly national program, its benefits vary widely from State to State. Sixteen States now get 80 percent of all Medicaid money and two States, California and New York, get 30 percent of Federal funds though they have only 20 percent of the poverty population. Two States have no Medicaid program at all.

In addition, Medicaid suffers from other defects that now plague our failing welfare system. It largely excludes the working poor—which means that all benefits can suddenly be cut off when family income rises ever so slightly—from just under the eligibility barrier to just over it. Coverage is provided when husbands desert their families, but is often eliminated when they come back home and work. The program thus provides an incentive for poor families to stay on the welfare rolls.

Some of these problems would be corrected by my proposal to require employers to offer adequate insurance coverage to their employees. No longer, for example, would a workingman receive poorer insurance coverage than a welfare client—a condition which exists today in many States. But we also need an additional program for much of the welfare population.

Accordingly, I propose that the part of Medicaid which covers most welfare families be eliminated. The new Family Health Insurance Plan that takes its place would be fully financed and administered by the Federal Government. It would provide health insurance to all poor families with children headed by self-employed or unemployed persons whose income is below a certain level. For a family of four persons, the eligibility ceiling would be $5,000.

For the poorest of eligible families, this program would make no charges and would pay for basic medical costs. As family income increased beyond a certain level ($3,000 in the case of a four-person family) the family itself would begin to assume a greater share of the costs—through a graduated schedule of premium charges, deductibles, and coinsurance payments. This provision would induce some cost consciousness as income rises. But unlike Medicaid—with its abrupt cutoff of benefits when family income reaches a certain point—this arrangement would provide an incentive for families to improve their economic position.
The Family Health Insurance Plan would also go into effect on July 1, 1973. In its first full year of operation, it would cost approximately $1.2 billion in additional Federal funds—assuming that all eligible families participate. Since States would no longer bear any share of this cost, they would be relieved of a considerable burden. In order to encourage States to use part of these savings to supplement Federal benefits, the Federal Government would agree to bear the costs of administering a consolidated Federal-State benefit package. The Federal Government would also contract with local committees—to review local practices and to ensure that adequate care is being provided in exchange for Federal payments. Private insurers, unions and employees would be invited to use these same committees to review the utilization of their benefits if they wished to do so.

This, then, is how the National Health Insurance Partnership would work: The Family Health Insurance Plan would meet the needs of most welfare families—though Medicaid would continue for the aged poor, the blind and the disabled. The National Health Insurance Standards Act would help the working population. Members of the Armed Forces and civilian Federal employees would continue to have their own insurance programs and our older citizens would continue to have Medicare.

Our program would also require the establishment in each State of special insurance pools which would offer insurance at reasonable group rates to people who did not qualify for other programs: the self-employed, for example, and poor risk individuals who often cannot get insurance.

I also urge the Congress to take further steps to improve Medicare. For one thing, beneficiaries should be allowed to use the program to join Health Maintenance Organizations. In addition, we should consolidate the financing of Part A of Medicare—which pays for hospital care—and Part B—which pays for outpatient services, provided the elderly person himself pays a monthly fee to qualify for this protection. I propose that this charge—which is scheduled to rise to $5.60 per month in July of this year—be paid for instead by increasing the Social Security wage base. Removing this admission cost will save our older citizens some $1.3 billion annually and will give them greater access to preventive and ambulatory services.

WHY IS A NATIONAL HEALTH INSURANCE PARTNERSHIP BETTER THAN NATIONALIZED HEALTH INSURANCE?

I believe that our government and our people, business and labor, the insurance industry and the health profession can work together in a national partnership to achieve our health objectives. I do not believe that the achievement of these objectives requires the nationalization of our health insurance industry.

To begin with, there simply is no need to eliminate an entire segment of our private economy and at the same time add a multibillion dollar responsibility to the Federal budget. Such a step should not be taken unless all other steps have failed.

More than that, such action would be dangerous. It would deny people the right to choose how they will pay for their health care. It would remove
competition from the insurance system—and with it an incentive to experiment and innovate.

Under a nationalized system, only the Federal Government would lose when inefficiency crept in or when prices escalated; neither the consumer himself, nor his employer, nor his union, nor his insurance company would have any further stake in controlling prices. The only way that utilization could be effectively regulated and costs effectively restrained, therefore, would be if the Federal Government made a forceful, tenacious effort to do so. This would mean—as proponents of a nationalized insurance program have admitted—that Federal personnel would inevitably be approving the budgets of local hospitals, setting fee schedules for local doctors, and taking other steps which could easily lead to the complete Federal domination of all of American medicine. That is an enormous risk—and there is no need for us to take it. There is a better way—a more practical, more effective, less expensive, and less dangerous way—to reform and renew our nation’s health system.

CONFRONTING A DEEPENING CRISIS

"It is health which is real wealth," said Ghandi, "and not pieces of gold and silver." That statement applies not only to the lives of men but also to the life of nations. And nations, like men, are judged in the end by the things they hold most valuable.

Not only is health more important than economic wealth, it is also its foundation. It has been estimated, for example, that ten percent of our country’s economic growth in the past half century has come because a declining death rate has produced an expanded labor force.

Our entire society, then, has a direct stake in the health of every member. In carrying out its responsibilities in this field, a nation serves its own best interests, even as it demonstrates the breadth of its spirit and the depth of its compassion.

Yet we cannot truly carry out these responsibilities unless the ultimate focus of our concern is the personal health of the individual human being. We dare not get so caught up in our systems and our strategies that we lose sight of his needs or compromise his interests. We can build an effective National Health Strategy only if we remember the central truth that the only way to serve our people well is to better serve each person.

Nineteen months ago I said that America’s medical system faced a “massive crisis.” Since that statement was made, that crisis has deepened. All of us must now join together in a common effort to meet this crisis—each doing his own part to mobilize more effectively the enormous potential of our health care system.

THE WHITE HOUSE

February 18, 1971.

RICHARD NIXON