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PRESIDENT'S MESSAGE ON HEALTH CARE SYSTEM

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

RELATIVE TO HIS HEALTH CARE PROGRAM

MARCH 2, 1972.—Message and accompanying papers referred to the Committee of the Whole House on the State of the Union and ordered to be printed

To the Congress of the United States:

An all-directions reform of our health care system—so that every citizen will be able to get quality health care at reasonable cost regardless of income and regardless of area of residence—remains an item of highest priority on my unfinished agenda for America in the 1970s.

In the ultimate sense, the general good health of our people is the foundation of our national strength, as well as being the truest wealth that individuals can possess.

Nothing should impede us from doing whatever is necessary to bring the best possible health care to those who do not now have it—while improving health care quality for everyone—at the earliest possible time.

In 1971, I submitted to the Congress my new National Health Strategy which would produce the kind of health care Americans desire and deserve, at costs we all can afford.

Since that time, a great national debate over health care has taken place. And both branches of the Congress have conducted searching examinations of our health needs, receiving and studying testimony from all segments of our society.

The Congress has acted on measures advancing certain parts of my National Health Strategy:

—The Comprehensive Health Manpower Training Act of 1971 and the Nurse Training Act of 1971, which I signed last November, will spur the greatest effort in our history to expand the supply of health personnel. Additionally and importantly, it will attract them to the areas of health care shortages, helping to close one of the most glaring gaps in our present system.

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—The Congress also passed the National Cancer Act which I proposed last year. This action opens the way for a high-intensity effort to defeat the No. 2 killer and disabler of our time, an effort fueled by an additional $100 million in the last year. A total of $430 million is budgeted for cancer programs in fiscal year 1973, compared to $185 million in fiscal year 1969.

—The Congress responded to my statement of early 1970 on needed improvements in veterans medical care by authorizing increased funds in 1971 and 1972, increases which have brought the VA hospital-to-patient ratios to an all-time high and have provided many additional specialty and medical services, including increased medical manpower training.

—The Congress also created a National Health Service Corps of young professionals to serve the many rural areas and inner city neighborhoods which are critically short on health care. By midsummer, more than 100 communities around the Nation will be benefiting from these teams.

These are important steps, without doubt, but we still must lay the bedrock foundations for a new national health care system for all our people.

The need for action is critical for far too many of our citizens.

The time for action is now.

I therefore again urge the Congress to act on the many parts of my health care program which are still pending so that we can end—at the earliest possible time—the individual anguishes, the needless neglects and the family financial fears caused by the gaps, inequities and maldistributions of the present system.

The United States now spends more than $75 billion annually on health care—and for most people, relatively good service results.

Yet, despite this huge annual national outlay, millions of citizens do not have adequate access to health care. Our record in this field does not live up to our national potential.

That sobering fact should summon us to prompt but effective action to reform and reorganize health care practices, while simultaneously resisting the relentless inflation of health care costs.

MORE THAN MONEY IS NEEDED

When the subject of health care improvements is mentioned, as is the case with so many other problems, too many people and too many institutions think first and solely of money—bills, payments, premiums, coverages, grants, subsidies and appropriations.

But far more than money is involved in our current health care crisis.

More money is important—but any attempted health care solution based primarily on money is simply not going to do the job.

In health care as in so many other areas, the most expensive remedy is not necessarily the most effective one.

One basic shortcoming of a solution to health care problems which depends entirely on spending more money, can be seen in the Medicare and Medicaid programs. Medicare and Medicaid did deliver needed dollars to the health care problems of the elderly and the poor. But at

the same time, little was done to alter the existing supply and distribution of doctors, nurses, hopsitals and other health resources. Our health care supply, in short, remained largely the same while massive new demands were loaded onto it.

The predictable result was an acute price inflation, one basic cause of our health economic quandary of the past 11 years.

In this period, national health expenditures rose by 188 percent, from $26 billion in fiscal 1960 to $75 billion in fiscal 1971. But a large part of this enormous increase in the Nation's health expenditure went, not for more and better health care, but merely to meet price inflation.

If we do not lessen this trend, all other reform efforts may be in vain.

That is why my National Health Strategy was designed with built-in incentives to encourage sensible economies—in the use of health facilities, in direct cost-control procedures, and through more efficient ways to bring health care to people at the community level. That is also why we have given careful attention to medical prices in Phase II of the Economic Stabilization Program.

Several months ago, the Price Commission ruled that increases in physician fees must be kept to within 2½ percent. Rules also were issued to hold down runaway price increases among hospitals, nursing homes and other health care institutions. All of these efforts were directed toward our goal of reducing the previous 7.7 percent annual price increase in total health care costs to half of that level, 3.85 percent this year.

These actions should buy us some time. But they are, at best, a temporary tourniquet on health care price inflation.

We must now direct our energies, attentions and action to the long-range factors affecting the cost, the quality and the availability of medical care.

My overall program, of course, is one that would improve health care for everyone. But it is worthy of special note that these recommendations have a particular importance and a high value for older Americans, whose health care needs usually rise just as their incomes are declining.

WE SHOULD BUILD ON PRESENT STRENGTHS

When we examine the status of health care in America, we always must be careful to recognize its strengths. For most Americans, more care of higher quality has been the result of our rising national investment in health, both governmental and private.

We lead the world in medical science, research, and development. We have obliterated some major diseases and drastically reduced the incidence of others. New institutions, new treatments and new drugs abound. There has been a marked and steady gain in the number of people covered by some form of health insurance to 84 percent of those under 65, and coverages have been expanding. Life expectancy has risen by 3.4 percent since 1950 and the maternal death rate has declined 66 percent. Days lost from work in the same period are down 3.5 percent and days lost from school have declined 7.5 percent—both excellent measures of the general good state of our health.

All of this is progress—real progress.

It would be folly to raze the structure that produced this progress—and start from scratch on some entirely new basis—in order to repair shortcomings and redirect and revitalize the thrust of our health system.

To nationalize health care as some have proposed, and thus federalize medical personnel, institutions and procedures—eventually if not at the start—also would amount to a stunning new financial burden for every American taxpayer.

The average household would pay more than $1,000 a year as its share of the required new Federal expenditure of more than $80 billion each and every year. Such a massive new Federal budget item would run counter to the temper of the American taxpayer.

Also, such a massive new Federal budget item would run counter to the efforts of this Administration to decentralize programs and revenues, rather than bring new responsibilities to Washington.

And, finally, such a massive new Federal budget requirement would dim our efforts to bring needed Federal actions in many new areas—some of which bear directly on health, such as environmental protection.

Clearly we must find a better answer to the deficiencies in our health care system. Unfortunately, such deficiencies are not difficult to identify:

—In inner cities and in many rural areas, there is an acute shortage of physicians. Health screening under various government programs has found that appalling percentages of young people, mostly from deprived areas, have not seen a doctor since early childhood, have never seen a dentist and have never received any preventive care.

—General practitioners are scarce in many areas and many people, regardless of income or location, have difficulty obtaining needed medical attention on short notice.

—Our medical schools must turn away qualified applicants.

—While we emphasize preventive maintenance for our automobiles and appliances, we do not do the same for our bodies. The private health insurance system, good as it is, operates largely as standby emergency equipment, not coming into use until we are stricken and admitted to the most expensive facility, a hospital.

—Relative affluence is no ultimate protection against health care costs. A single catastrophic illness can wipe out the financial security of almost any family under most present health insurance policies.

To remedy these problems, however, will require far more than the efforts of the Federal Government—although the Federal role is vital and will be met by this Administration.

It is going to take the complementing efforts of many other units of government at the State and local levels; of educational and health organizations and institutions of all kinds; of physicians and other medical personnel of all varieties; of private enterprise and of individual citizens.

My National Health Strategy is designed to enlist all those creative talents into a truly national effort, coordinated but not regimented by four guiding principles:

Capitalizing on existing strengths: We resolve to preserve the best in our existing health care system, building upon those strong elements the new programs need to correct existing deficiencies.

Equal access for all to health care: We must do all we can to end any racial, economic, social or geographical barriers which may prevent any citizen from obtaining adequate health protection.

Balanced supply and demand: It makes little sense to expand the demand for health care without also making certain that proper increases take place in the numbers of available physicians and other medical personnel, in hospitals and in other kinds of medical facilities.

Efficient organization: We must bring basic reorganizations to our health care system so that we can cease reinforcing inequities and relying on inefficiencies. The exact same system which has failed us in many cases in the past certainly will not be able to serve properly the increased demands of the future.

MAJOR ACTIONS AWAITED

Three major programs, now awaiting action in the Congress after substantial hearings and study, would give life to these principles.

The National Health Insurance Partnership Act, The Health Maintenance Organization Assistance Act, and H.R. 1, my welfare reform bill which also would amend Medicare and Medicaid in several significant ways.

The National Health Insurance Partnership Act

This proposal for a comprehensive national health insurance program, in which the public and private sector would join, would guarantee that no American family would have to forego needed medical attention because of inability to pay.

My plan would fill gaps in our present health insurance coverage. But, beyond that, it would redirect our entire system to better and more efficient ways of bringing health care to our people.

There are two critical parts of this Act:

1. *The National Health Insurance Standards Act* would require employers to provide adequate health insurance for their employees, who would share in underwriting its costs. This approach follows precedents of long-standing under which personal security—and thus national economic progress—has been enhanced by requiring employers to provide minimum wages and disability and retirement benefits and to observe occupational health and safety standards.

Required coverages would include not less than $50,000 protection against catastrophic costs for each family member; hospital services; physician services both in and out of a hospital; maternity care; well-baby care (including immunizations); laboratory expenses and certain other costs.

The proposed package would include certain deductibles and coinsurance features, which would help keep costs down by encouraging the use of more efficient health care procedures.

It would permit many workers, as an alternative to paying separate fees for services, to purchase instead memberships in a Health Maintenance Organization. The fact that workers and unions would have a direct economic stake in the program would serve as an addi-

tional built-in incentive for avoiding unnecessary costs and yet maintaining high quality.

The national standards prescribed, moreover, would necessarily limit the range within which benefits could vary. This provision would serve to sharpen competition and cost-consciousness among insurance companies seeking to provide coverage at the lowest overall cost.

Any time the Federal Government, in effect, prescribes and guarantees certain things it must take the necessary follow-through steps to assure that the interests of consumers and taxpayers are fully protected.

Accordingly, legislative proposals have been submitted to the Congress within recent weeks for regulating private health insurance companies, in order to assure that they can and will do the job, and that insurance will be offered at reasonable rates. In addition, States would be required to provide group-rate coverage for people such as the self-employed and special groups who do not qualify for other plans.

2. Another vital step in my proposed program is the *Family Health Insurance Plan (FHIP)* which would meet the needs of poor families not covered by the National Health Insurance Standards Act because they are headed by unemployed or self-employed persons whose income is below certain levels. For a family of four, the ceiling for eligibility would be an annual income of $5,000. FHIP would replace that portion of Medicaid designed to help such families. Medicaid would remain for the aged poor, the blind, the disabled and some children.

Health Maintenance Organizations

Beyond filling gaps in insurance coverage, we must also turn our attention to how the money thus provided will be spent—on what kind of services and in what kind of institutions. This is why the Health Maintenance Organization concept is such a central feature of my National Health Strategy.

The HMO is a method for financing and providing health care that has won growing respect. It brings together into a single organization the physician, the hospital, the laboratory and the clinic, so that patients can get the right care at the right moment.

HMO's utilize a method of payment that encourages the prevention of illness and promotes the efficient use of doctors and hospitals. Unlike traditional fee-for-service billing, the HMO contracts to provide its comprehensive care for a fixed annual sum that is determined in advance.

Under this financial arrangement, the doctors' and hospitals' incomes are determined not by how much the patient is sick, but by how much he is well. HMO's thus have the strongest possible incentive for keeping well members from becoming ill and for curing sick members as quickly as possible.

I do not believe that HMO's should or will entirely replace fee-for-service financing. But I do believe that they ought to be everywhere available so that families will have a choice between these methods. The HMO is no mere drawing-board concept—more than 7 million Americans are now HMO subscribers and that number is growing.

Several pieces of major legislation now before the Congress would give powerful stimulus to the development of HMO's:

1. *The Health Maintenance Organization Assistance Act* would provide technical and financial aid to help new HMO's get started, and would spell out standards of operation;

2. *The National Health Insurance Partnership Act* described above requires that individuals be given a choice between fee-for-service or HMO payment plans;

3. H.R. 1 contains one provision allowing HMO-type reimbursement for Medicare patients and another that would increase the Federal share of payments made to HMO's under State Medicaid programs.

I urge that the Congress give early consideration to these three measures, in order to hasten the development of this efficient method for low-cost, one-stop health service. Meantime, the Administration has moved forward in this area on its own under existing legislative authorities.

Last year, while HMO legislation was being prepared, I directed the Department of Health, Education, and Welfare to focus existing funds and staff on an early HMO development effort. This effort has already achieved payoffs:

To date, 110 planning and development grants and contracts have been let to potential HMO sponsors and some 200,000 Medicaid patients are now enrolled in HMO-type plans. Also, in a few months, 10 Family Health Centers will be operating with federally-supported funds to provide prepaid health care to persons living in underserved areas. Each of these Centers can develop into a full-service HMO. I have requested funds in 1973 to expand this support.

To keep this momentum going, I have included in the fiscal year 1972 supplemental budget $27 million for HMO development, and requested $60 million for this purpose in fiscal year 1973.

I will also propose amendments to the pending HMO Assistance Act that would authorize the establishment of an HMO loan fund.

The National Need for H.R. 1

One of the greatest hazards to life and health is poverty. Death and illness rates among the poor are many times those for the rest of the Nation. The steady elimination of poverty would in itself improve the health of millions of Americans.

H.R. 1's main purpose is to help people lift themselves free of poverty's grip by providing them with jobs, job training, income supplements for the working poor and child care centers for mothers seeking work.

For this reason alone, enactment of H.R. 1 must be considered centerpiece legislation in the building of a National Health Strategy.

But H.R. 1 also includes the following measures to extend health care to more Americans—especially older Americans—and to control costs:

Additional Persons Covered:

—Persons eligible for Part A of Medicare (hospital care) would be automatically enrolled in Part B (physician's care).

—Medicare (both Parts A and B) would be extended to many disabled persons not now covered.

H.R. 1 as it now stands, however, would still require monthly premium payments to cover the costs of Part B. I have recommended that the Congress eliminate this $5.80 monthly premium payment and finance Medicare coverage of physician services through the social security payroll tax. This can be done within the Medicare tax rate now included in H.R. 1. If enacted, this change would save $1.5 billion annually for older Americans and would be equivalent to a 5 percent increase in social security cash benefits.

Cost Control Features:

—Medicare and Medicaid reimbursement would be denied any hospital or other institution for interest, depreciation and service charges on any construction disapproved by local or regional health planning agencies. Moreover, to strengthen local and regional health planning agencies, my fiscal year 1973 budget would increase the Federal matching share. In addition, grants to establish 100 new local and 20 new State planning agencies would bring health planning to more than 80 percent of the Nation's population.

—Reviews of claim samples and utilization patterns, which have saved much money in the Medicare program, would be applied to Medicaid.

—The efficiency of Medicaid hospitals and health facilities would be improved by testing various alternative methods of reimbursing them.

—Cost sharing would be introduced after 30 days of hospitalization under Medicare.

—Federal Medicaid matching rates would decline one-third after the first 60 days of care.

—Federal Medicaid matching rates would be increased 25 percent for services for which the States contract with HMO's or other comprehensive health care facilities.

These latter three revisions are aimed at minimizing inefficient institutional care and encouraging more effective modes of treatment.

RESEARCH AND PREVENTION PROGRAMS

My overall health program encompasses actions on three levels: 1) improving protection against health care costs; 2) improving the health care system itself; and 3) working creatively on research and prevention efforts, to eradicate health menaces and to hold down the incidence of illnesses.

A truly effective national health strategy requires that a significant share of Federal research funds be concentrated on major health threats, particularly when research advances indicate the possibility of breakthrough progress.

Potentially high payoff health research and prevention programs include:

Heart Disease

If current rates of incidence continue, some 12 million Americans will suffer heart attacks in the next 10 years.

I shortly will assign a panel of distinguished professional experts to guide us in determining why heart disease is so prevalent and what

we should be doing to combat it. In the meantime, the fiscal year 1973 budget provides funds for exploring:

—the development of new medical devices to assist blood circulation and improved instruments for the early detection of heart disease; and

—tests to explore the relationship of such high-risk factors as smoking, high blood pressure and high blood fats to the onset and progression of heart disease.

Cancer

The National Cancer Act I signed into law December 23, 1971, creates the authority for organizing an all-out attack on this dread disease. The new cancer program it creates will be directly responsive to the President's direction.

This new program's work will be given further momentum by my decision last October to convert the former biological warfare facility at Fort Detrick, Maryland into a cancer research center.

To finance this all-out research effort, I have requested that an additional $93 million be allocated for cancer research in fiscal year 1973, bringing the total funding available that year to $430 million.

In the past two and one-half years, we have more than doubled the funding for cancer research, reflecting this Administration's strong commitment to defeat this dread killer as soon as humanly possible.

Alcoholism

One tragic and costly illness which touches every community in our land is alcoholism. There are more than 9 million alcoholics and alcohol abusers in our Nation.

The human cost of this condition is incalculable—broken homes, broken lives and the tragedy of 28,000 victims of alcohol-related highway deaths every year.

The recently established National Institute of Alcohol Abuse and Alcoholism will soon launch an intensive public education program through television and radio and will continue to support model treatment projects from which States and communities will be able to pattern programs to fight this enemy.

Meanwhile, the Department of Health, Education, and Welfare and the Department of Transportation are funding projects in 35 States to demonstrate the value of highway safety, enforcement and education efforts among drinking drivers. The Veterans Administration will increase the number of its Alcohol Dependence Treatment Units by more than one-third, to 56 units in fiscal year 1973.

Drug Abuse

Drug abuse now constitutes a national emergency.

In response to this threat and to the need for coordination of Federal programs aimed at drug abuse, I established the Special Action Office for Drug Abuse Prevention within the Executive Office of the President. Its special areas of action are programs for treating and rehabilitating the drug abuser and for alerting our young people to the dangers of drug abuse.

I have proposed legislation to the Congress which would extend and clarify the authority of this Office. I am hopeful that Senate and House conferees will soon be able to resolve differences in the versions

passed by the two branches and emerge with a single bill responsive to the Nation's needs.

The new Special Action Office, however, has not been idly awaiting this legislation. It has been vigorously setting about the task of identifying the areas of greatest need and channelling Federal resources into these areas.

The Department of Defense, for example, working in close coordination with the Special Action Office, has instituted drug abuse identification, education, and treatment programs which effectively combatted last year's heroin problem among our troops in South Vietnam. Indications are that the corner has been turned on this threat and that the incidents of drug dependence among our troops is declining.

The Veterans Administration, again in coordination with the Special Action Office, has accomplished more than a six-fold increase in the number of drug dependency treatment centers in fiscal year 1972, with an increase to 44 centers proposed in fiscal year 1973.

In fiscal year 1972, I have increased funds available for the prevention of drug abuse by more than 130 percent. For fiscal year 1973, I have requested over $365 million to treat the drug abuser and prevent the spread of the affliction of drug abuse.

This is more than eight times as much as was being spent for this purpose when this Administration took office.

Sickle Cell Disease

About one out of every 500 black infants falls victim to the painful, life-shortening disease called sickle cell anemia. This inherited disease trait is carried by about two million black Americans.

In fiscal year 1972, $10 million was allocated to attack this problem and an advisory committee of prominent black leaders was organized to help direct the effort. This committee's recommendations are in hand and an aggressive action program is ready to start.

To underwrite this effort, I am proposing to increase the new budget for sickle cell disease from $10 million in fiscal 1972 to $15 million in fiscal 1973.

The Veterans Administration's medical care system also can be counted on to make an important contribution to the fight against sickle cell anemia.

Eight separate research projects concerning sickle cell anemia are underway in VA hospitals and more will be started this year. All 166 VA hospitals will launch a broad screening, treatment and educational effort to combat this disease.

On any given day, about 17,000 black veterans are in VA hospitals and some 116,000 are treated annually.

All these expanded efforts will lead to a better and longer life for thousands of black Americans.

Family Planning Services

Nearly three years ago, I called for a program that would provide family planning services to all who wanted them but could not afford their cost. The timetable for achieving this goal was five years.

To meet that schedule, funding for services administered by the National Center for Family Planning for this program has been steadily increased from $39 million in fiscal year 1971 to $91 million in fiscal year 1972. I am requesting $139 million for this Center in fiscal year 1973.

Total Federal support for family planning services and research in fiscal 1973 will rise to $240 million, a threefold increase since fiscal year 1969.

Venereal Disease

Last year, more than 2.5 million venereal disease cases were detected in the United States. Two-thirds of the victims were under 25.

A concentrated program to find persons with infectious cases and treat them is needed to bring this disease under control. I am, therefore, recommending that $31 million be allocated for this purpose in fiscal year 1973, more than two and one-half times the level of support for VD programs in 1971.

Health Education

Aside from formal treatment programs, public and private, the general health of individuals depends very much on their own informed actions and practices.

Last year, I proposed that a National Health Education Foundation be established to coordinate a nationwide program to alert people on ways in which they could protect their own health. Since that time, a number of public meetings have been held by a committee I established then to gather views on all aspects of health education. The report of this committee will be sent to me this year.

The committee hopes to define more explicitly the Nation's need for health education programs and to determine ways of rallying all the resources of our society to meet this need.

Consumer Safety

More than a half century has passed since basic legislation was enacted to ensure the safety of the foods and drugs which Americans consume. Since then, industrial and agricultural revolutions have generated an endless variety of new products, food additives, industrial compounds, cosmetics, synthetic fabrics and other materials which are employed to feed, clothe, medicate and adorn the American consumer.

These revolutions created an entirely new man-made environment—and we must make absolutely certain that this new environment does not bring harmful side-effects which outweigh its evident benefits.

The only way to ensure that goal is met is to give the agency charged with that responsibility the resources it needs to meet the challenge.

My budget request for the Food and Drug Administration for fiscal year 1973 represents the largest single-year expansion in the history of this agency—70 percent. I believe this expansion is amply justified by the magnitude of the task this agency faces.

In the past year, the foundations for a modern program of consumer protection have been laid. The FDA has begun a detailed review of the thousands of non-prescription drug products now marketed. The pharmaceutical industry has been asked to cooperate in compiling a complete inventory of every drug available to the consumer.

Meanwhile, I have proposed the following legislation to ensure more effective protection for consumers:

—A wholesome fish and fish products bill which provides for the expansion of inspections of fish handlers and greater authority to assure the safety of fish products.

—A Consumer Product Safety bill which would authorize the Federal Government to establish and enforce new standards for product safety.

—Medical device legislation which would not only authorize the establishment of safety standards for these products, but would also provide for premarketing scientific review when warranted.

—A drug identification bill now before the Congress would provide a method for quickly and accurately identifying any pill or tablet. This provision would reduce the risk of error in taking medicines and allow prompt treatment following accidental ingestion.

—The Toxic Substances Control Act that I proposed last year also awaits action by the Congress. This legislation would require any company developing a new chemical that may see widespread use to test it thoroughly beforehand for possible toxic effects.

Nursing Homes

If there is one place to begin upgrading the quality of health care, it is in the nursing homes that care for older Americans. Many homes provide excellent care and concern, but far too many others are callous, understaffed, unsanitary and downright dangerous.

Last August I announced an eight-point program to upgrade the quality of life and the standards of care in American nursing homes. The Federal interest and responsibility in this field is clear, since Federal programs including Medicare and Medicaid provide some 40 percent of total nursing home income nationally.

That HEW effort is well underway now:

Federal field teams have surveyed every State nursing home inspection program, and as a result 38 of 39 States found to have deficiencies have corrected them. The 39th is acting to meet Federal standards. To help States upgrade nursing homes, I have proposed legislation to pay 100 percent of the costs of inspecting these facilities.

Meanwhile, at my direction, a Federally-funded program to train 2,000 State nursing home inspectors and to train 41,000 nursing home employees is also underway. The Federal field force for assisting nursing homes is being augmented and fire, safety and health codes have been strengthened.

One way to measure the results of these efforts is to learn how patients in nursing homes feel about the care they are given. We have therefore also begun a program to monitor the complaints and suggestions of nursing home residents.

Applying Science and Technology

In my State of the Union message, I proposed a new Federal partnership with the private sector to stimulate civilian technological research and development. One of the most vital areas where we can focus this partnership—perhaps utilizing engineers and scientists displaced from other jobs—is in improving human health. Opportunities in this field include:

1. *Emergency Medical Services:* By using new technologies to improve emergency care systems and by using more and better trained people to run those systems, we can save the lives of many heart attack victims and many victims of auto accidents every year. The

loss to the Nation represented by these unnecessary deaths cannot be calculated. I have already allocated $8 million in fiscal year 1972 to develop model systems and training programs and my budget proposes that $15 million be invested for additional demonstrations in fiscal year 1973.

2. *Blood:* Blood is a unique national resource. An adequate system for collecting and delivering blood at its time and place of need can save many lives. Yet we do not have a nationwide system to meet this need and we need to draw upon the skills of modern management and technology to develop one. I have therefore directed the Department of Health, Education, and Welfare to make an intensive study and to recommend to me as soon as possible a plan for developing a safe, fast and efficient nationwide blood collection and distribution system.

3. *Health Information Systems:* Each physician, hospital and clinic today is virtually an information island unto itself. Records and billings are not kept on the same basis everywhere, laboratory tests are often needlessly repeated and vital patient data can get lost. All of these problems have been accentuated because our population is constantly on the move. The technology exists to end this chaos and improve the quality of care. I have therefore asked the Secretary of Health, Education, and Welfare to plan a series of projects to demonstrate the feasibility of developing integrated and uniform systems of health information.

4. *Handicapping Conditions:* In America today there are half a million blind. 850,000 deaf and 15 million suffering paralysis and loss of limbs. So far, the major responses to their need to gain self-sufficiency, have been vocational rehabilitation and welfare progams. Now the skills that took us to the moon and back need to be put to work developing devices to help the blind see, the deaf hear and the crippled move.

TOWARD A BETTER HEALTH CARE SYSTEM

Working together, this Administration and the Congress already have taken some significant strides in our mutual determination to provide the best, and the most widely available, health care system the world has even known.

The time now has come to take the final steps to reorganize, to revitalize and to redirect American health care—to build on its historic accomplishments, to close its gaps and to provide it with the incentives and sustenance to move toward a more perfect mission of human compassion.

I believe that the health care resources of America in 1972, if strengthened and expanded as I have proposed in this Message, will be more than sufficient to move us significantly toward that great goal.

If the Administration and the Congress continue to act together—and act on the major proposals this year, as I strongly again urge—then the 1970s will be remembered as an era in which the United States took the historic step of making the health of the entire population not only a great goal but a practical objective.

RICHARD NIXON.

THE WHITE HOUSE, *March 2, 1972.*

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