The original documents are located in Box D31, folder "Department of School Nurses, National Education Association, Annual Convention, Detroit, MI, June 26, 1971" of the Ford Congressional Papers: Press Secretary and Speech File at the Gerald R. Ford Presidential Library.

KEYNOTE SPEECH AT THE OPENING SESSION OF THE DEPARTMENT OF SCHOOL NURSES, NATIONAL EDUCATION ASSOCIATION, ANNUAL CONVENTION, 9.30 A.M. SATURDAY, JUNE 26, 1971, IN DETROIT, MICHIGAN.

NURSING IS A NOBLE PROFESSION. TO CARE FOR THE SICK, TO NURSE THE SICK BACK TO HEALTH, REQUIRES NOT ONLY SKILL BUT THE FINEST OF HUMAN IMPULSES AND THE TENDEREST OF EMOTIONS.

IN THAT CONNECTION, I QUOTE MR. DOOLEY, OTHERWISE KNOWN AS FINLEY PETER DUNNE. SAID MR. DOOLEY: "I THINK THAT IF TH' CHRISTIAN SCIENTISTS HAD SOME SCIENCE AN' TH' DOCTORS MORE CHRISTIANITY, IT WUDDEN'T MAKE ANY DIFF'RENCE WHICH YE CALLED IN -- IF YE HAD A GOOD NURSE."

NOR DOES IT MATTER WHETHER THE

NURSE IS GOOD-LOOKING. I ONCE KNEW A NURSE WHO WAS VERY PRETTY. SHE WAS SO CONCEITED THAT EVERY TIME SHE TOOK A MAN'S PULSE SHE SUBTRACTED ABOUT 10 BEATS TO ALLOW FOR THE IMPACT OF HER PERSONALITY.

BUT THAT HAS NO BEARING ON THE KEYNOTE OF THIS CONVENTION. ~~AND IT IS A KEYNOTE I AM SUPPOSED TO BE SOUNDING.~~ ACTUALLY, THAT KEYNOTE IS CONTAINED IN THE ADVICE I RECEIVED WHEN I ASKED YOUR CONVENTION PLANNERS WHAT I SHOULD TALK ABOUT.

TELL US, THEY SAID, WHAT WE CAN DO TO PROMOTE LEGISLATION THAT WILL BRING ABOUT BETTER HEALTH SERVICE FOR ALL SCHOOL CHILDREN AND YOUTH.

FIRST OF ALL, I DON'T THINK WE SHOULD SEPARATE HEALTH SERVICE TO SCHOOL CHILDREN FROM HEALTH SERVICE TO ALL AMERICANS. IT IS BETTER FAMILY HEALTH

SERVICE THAT WE WANT -- AND THE KEY TO THAT IS REFORM. NOT A DOUBLING OF THE DOLLARS GOING INTO HEALTH CARE IN AMERICA, BUT REFORM IN THE WAY THAT HEALTH CARE IS DELIVERED.

AT THE RISK OF SOUNDING RADICAL, I HAVE TO TELL YOU THAT OUR HEALTH CARE DELIVERY SYSTEM ISN'T WORKING RIGHT. ~~UNLIKE THE RADICALS,~~ I AM BACKING A PLAN, A CONSTRUCTIVE PLAN, WHICH I THINK WILL GIVE AMERICA GOOD HEALTH CARE FOR ALL. AND WE CAN DO IT BY BUILDING, NOT BY TEARING SOMETHING DOWN.

BUT BEFORE WE TALK ABOUT THAT PLAN, LET'S TALK ABOUT WHAT WE HAVE NOW AND WHAT'S WRONG WITH IT. ~~YOU KNOW HOW IT IS WHEN YOURE IN A BIG BUILDING. THEY HAVE FLOOR MAPS AROUND WITH AN "X" THAT SAYS, "HERE IS WHERE YOU ARE."~~ YOU HAVE

TO KNOW WHERE YOU ARE IN ORDER TO GET WHERE YOU WANT TO GO.

WHERE ARE WE NOW IN TERMS OF HEALTH CARE? AS HEALTH IS MEASURED, THE UNITED STATES IS NOT DOING AS WELL AS OTHER ADVANCED NATIONS. WE RANK 13TH, FOR INSTANCE, IN INFANT MORTALITY. THAT IS RELATIVELY POOR. THE UNITED STATES SHOULD HAVE THE LOWEST INFANT DEATH RATE. ~~THERE IS NO REASON WHY WE SHOULD NOT BE ABLE TO ACHIEVE THAT RANK~~.

LET ME NOW IMMEDIATELY ENTER A DISCLAIMER. WHILE AMERICA IS BEHIND OTHER WESTERN COUNTRIES IN MANY ASPECTS OF HEALTH CARE, IT IS FAR AHEAD OF MOST IN THE OVERALL QUALITY OF ITS MEDICINE. THE TROUBLE IS THAT THE PERFORMANCE IS SPOTTY AND UNEVEN.

WE HAVE MADE A NUMBER OF ADVANCES.

A CHILD BORN TODAY CAN EXPECT TO LIVE 30 PER CENT LONGER ON THE AVERAGE THAN A CHILD BORN IN 1920.

NONWHITE CHILDREN, WHILE LAGGING BEHIND WHITE CHILDREN IN TOTAL LIFE EXPECTANCY, HAVE MADE THE GREATEST GAINS -- A THIRD MORE LIFE FOR NONWHITE MEN, AND MORE THAN A 50 PER CENT INCREASE IN LIFE SPAN FOR NONWHITE WOMEN.

INFANT DEATHS HAVE BEEN ON THE DECLINE FOR SOME TIME, AND MATERNAL DEATH RATES DROPPED BY 66 PER CENT BETWEEN 1950 AND 1967.

SO THE GROSS MEASURES OF HEALTH STATUS CLEARLY INDICATE THAT OUR HEALTH HAS BEEN IMPROVING, NOT WORSENING. YET THERE IS A CRISIS IN HEALTH CARE TODAY. WHAT IS THE NATURE OF THAT CRISIS? IT IS NOT TO BE FOUND IN THE GENERAL STATUS OF HEALTH

BUT IN THE UNEVEN DISTRIBUTION OF HEALTH CARE THROUGHOUT AMERICA.

I SPEAK OF THE FACT THAT THE POOR AND THE RACIAL MINORITIES HAVE BEEN SHORTCHANGED. THEIR LIVES ARE SHORTER. THEY HAVE MORE CHRONIC AND DEBILITATING DISEASES. THEIR INFANT AND MATERNAL DEATH RATES ARE HIGHER. THEIR PROTECTION AGAINST INFECTIOUS DISEASES, THROUGH IMMUNIZATION, IS FAR LOWER. THEY HAVE FAR LESS ACCESS TO HEALTH SERVICES -- AND THIS IS PARTICULARLY TRUE OF THE CHILDREN AMONG THE POOR AND NONWHITE MINORITIES. MILLIONS OF THESE CHILDREN RECEIVE LITTLE OR NO DENTAL OR PEDIATRIC CARE.

THIS IS PART OF THE HEALTH CRISIS.

ANOTHER PART HAS TO DO WITH OUR RURAL POPULATION AND OUR GHETTO RESIDENTS. THE FACT IS THAT THEY ARE POORLY SERVED WITH MEDICAL CARE.

THERE ARE, FOR EXAMPLE, LARGE GEOGRAPHIC VARIATIONS IN THE RATIO OF PHYSICIANS TO POPULATION. THERE ARE 82 ACTIVE PHYSICIANS PER 100,000 PEOPLE IN MISSISSIPPI, 141 IN MICHIGAN, AND 228 IN NEW YORK. A STUDY OF 1,500 CITIES AND TOWNS IN THE UPPER MIDWEST SHOWED 1,000 OF THEM WITHOUT A PHYSICIAN, AND 200 HAD ONLY ONE. LARGE METROPOLITAN AREAS AVERAGE 185 PHYSICIANS PER 100,000 PEOPLE, WHILE NON-METROPOLITAN AREAS AVERAGE 76. AND THE CITIES, PARTICULARLY THE GHETTOES, FARE FAR WORSE THAN THE SUBURBS IN THE RATIO OF PHYSICIANS TO POPULATION.

GEOGRAPHIC LOCATION OF DOCTORS IS NOT THE ONLY PROBLEM. THE OTHER IS THE SHORTAGE OF PRIMARY CARE PHYSICIANS -- GENERAL PRACTITIONERS, PEDIATRICIANS, AND INTERNISTS. THE DEMAND IS FOR PRIMARY CARE

PHYSICIANS. YET THE RELATIVE RATIO OF PRIMARY CARE PHYSICIANS TO POPULATION HAS BEEN DECLINING. IN 1931, ROUGHLY 117,000 PHYSICIANS OUT OF 156,000 WERE PRIMARY CARE PHYSICIANS -- 75 PER CENT OF THE TOTAL. IN 1967, THERE WERE ROUGHLY 115,000 PRIMARY CARE PHYSICIANS OUT OF 303,000 PHYSICIANS, OR ONLY 39 PER CENT. FROM 94 PRIMARY CARE PHYSICIANS PER 100,000 PEOPLE IN 1931, THE RATIO HAS DROPPED TO 73.

SO WE HAVE THE PROBLEM OF GEOGRAPHIC LOCATION OF PHYSICIANS AND THE PROBLEM OF TYPE OF MEDICAL PRACTICE.

STILL ANOTHER PROBLEM IS THE IMPROPER MANAGEMENT OF OUR HEALTH CARE RESOURCES.

THE JOINT COUNCIL OF NATIONAL PEDIATRIC SOCIETIES SAYS THAT 75 PER CENT

OF THE PEDIATRIC TASKS PERFORMED BY A PHYSICIAN COULD BE DONE BY A PROPERLY TRAINED CHILD HEALTH ASSISTANT. A SIGNIFICANT AMOUNT OF THE WORK DONE BY OBSTETRICIANS COULD BE PERFORMED BY NURSE-MIDWIVES. EX-MEDICAL CORPSMEN, OR COMPARABLY TRAINED INDIVIDUALS, WITH SOME ADDITIONAL TRAINING COULD ASSUME A LARGE NUMBER OF THE TASKS NOW PERFORMED BY GENERAL PRACTITIONERS.

IN EVERY STUDY OF HEALTH CARE FACILITIES, ONE FINDS VARYING PERCENTAGES OF PATIENTS WHO SHOULD BE USING MORE APPROPRIATE FACILITIES.

THE HEALTH-EDUCATION-WELFARE DEPARTMENT ESTIMATES THAT WITH JUST A 10 PER CENT IMPROVEMENT IN THE EFFICIENCY WITH WHICH OUR HEALTH RESOURCES ARE USED WE COULD ACHIEVE A SAVING OF MORE THAN $5 BILLION.

IT IS CLEAR THAT THE ORGANIZATION OF OUR HEALTH CARE DELIVERY SYSTEM NEEDS REFORMING.

WHAT ABOUT FINANCING?

EXPENDITURES ON PERSONAL HEALTH CARE AMOUNTED TO $58 BILLION IN FISCAL 1969. THE LARGEST PART -- ALMOST 63 PER CENT -- CAME FROM PRIVATE SOURCES, AND THE REST FROM PUBLIC SOURCES.

ABOUT 80 PER CENT OF THE POPULATION UNDER 65 HAS SOME PRIVATE HEALTH INSURANCE, MAINLY FOR HOSPITAL AND SURGICAL COVERAGE.

ABOUT 75 PER CENT OF THE WORKING POPULATION IS PROTECTED THROUGH EMPLOYER-EMPLOYE PLANS DEVELOPED UNDER COLLECTIVE BARGAINING AGREEMENTS.

MEDICARE PROVIDES PROTECTION FOR MORE THAN 95 PER CENT OF THE ELDERLY.

AND MEDICAID PROVIDES SOME PROTECTION FOR 15 MILLION OF THE AGED POOR, THE BLIND, THE DISABLED, AND FAMILIES WITH CHILDREN.

YET LARGE NUMBERS OF OUR PEOPLE ARE EXCLUDED FROM FINANCIAL ACCESS TO HEALTH CARE. BENEFITS ARE OFTEN INADEQUATE. AND COSTS ARE UNNECESSARILY HIGH.

STILL ANOTHER PART OF THE HEALTH CARE CRISIS IS THE FINANCIAL CRISIS WHICH HAS BESET A LARGE NUMBER OF THE NATION'S MEDICAL ~~AND~~ DENTAL SCHOOLS, and nursing schools, THE INESCAPABLE FACT IS THAT THE PROFESSIONAL SCHOOLS ARE IN TROUBLE.

WE'VE TALKED ABOUT THE PROBLEM; NOW LET'S TALK ABOUT THE SOLUTION.

THERE IS LITTLE DOUBT THAT SOME TYPE OF NATIONAL HEALTH INSURANCE PLAN IS NEEDED TO BRING BETTER HEALTH CARE TO AMERICANS AND TO COPE WITH SOARING COSTS

OF MEDICAL AND HOSPITAL CARE.

THE PROBLEMS OF INCREASING MEDICAL AND HOSPITAL COSTS ARE NOT LIMITED TO THE POOR. THE PROBLEM IS NATIONWIDE, UNIVERSAL. IT NEEDS BROAD ATTENTION AND CORRECTION.

WE MUST RAISE THE HEALTH STANDARDS OF ALL AMERICANS. WE MUST DEAL WITH THE DEFECTS IN THE HEALTH CARE DELIVERY SYSTEM AS IT AFFECTS US ALL. THIS IS A CRISIS WHICH TOUCHES OUR CONSCIOUSNESS AND OUR CONSCIENCE. IT IS CENTRAL TO THE QUALITY OF LIFE IN AMERICA.

MANY PROPOSALS HAVE BEEN INTRODUCED IN THE CONGRESS. I PERSONALLY BELIEVE THE CHOICE IS PRIMARILY BETWEEN FEDERAL FINANCING OF A NATIONAL HEALTH PROGRAM AND THE ADMINISTRATION'S PLAN FOR A NATIONAL HEALTH INSURANCE PARTNERSHIP

BETWEEN THE FEDERAL GOVERNMENT AND THE HEALTH INSURANCE INDUSTRY. THE ADMINISTRATION'S PROPOSED NATIONAL HEALTH STRATEGY, OF COURSE, GOES FAR BEYOND JUST THE FINANCING OF HEALTH CARE. IT IS A REFORM PROPOSAL DIRECTED AT ALL OF THE PROBLEMS I HAVE OUTLINED.

AS FOR FEDERAL FINANCING OF A NATIONAL HEALTH PROGRAM, THE COST IS ESTIMATED AS HIGH AS $77 BILLION A YEAR.

FIRST OF ALL, I DO NOT BELIEVE JUST DOLLARS ALONE WILL RESOLVE OUR NATIONAL HEALTH CRISIS.

SECONDLY, IT IS DIFFICULT TO SAY JUST HOW MUCH MORE GOVERNMENTAL SOLICITUDE THE TAXPAYING PUBLIC CAN AFFORD. IF THE COST OF PROVIDING HEALTH CARE FOR EVERY MAN, WOMAN AND CHILD IN AMERICA WERE TO BE FEDERALLY FINANCED, THE COST WOULD BE

STAGGERING AND THE TAX LOAD WOULD BE VIRTUALLY UNBEARABLE. IF THE COST WERE TO BE PIGGY-BACKED ONTO OUR SOCIAL SECURITY TAXES, I THINK PAYROLL LEVIES WOULD SOON REACH THE BREAKING POINT. EVEN AT ITS PRESENT LEVELS, SOCIAL SECURITY TAXATION IS COSTING SOME FAMILIES AS MUCH AS THEY ARE PAYING IN FEDERAL INCOME TAXES.

I PERSONALLY FEEL IT WOULD BE BETTER FOR AMERICA TO PROVIDE BETTER HEALTH BY TAPPING THE PRIVATE ECONOMY THAN BY DIPPING INTO THE PUBLIC TILL.

THIS IS ONE REASON I HAVE CO-SPONSORED THE ADMINISTRATION'S NATIONAL HEALTH PARTNERSHIP ACT IN THE HOUSE OF REPRESENTATIVES. Furthermore ~~THE OTHER REASON IS THAT~~ THE ADMINISTRATION PLAN GOES DIRECTLY TO THE ROOT OF THE PROBLEMS WHICH ARE CAUSING OUR HEALTH CRISIS TODAY.

THE ADMINISTRATION PLAN EVOLVED OVER THE BETTER PART OF A YEAR. IT IS THE PRODUCT OF DEEP AND DETAILED STUDY -- A STUDY THAT CENTERED ON VARIOUS ALTERNATIVES.

THE END PRODUCT IS A PACKAGE THAT WOULD PLACE THE BULK OF THE COST OF BETTER HEALTH CARE SERVICES ON EMPLOYERS AND FOCUS ON PREVENTIVE MEDICINE RATHER THAN JUST GETTING THE SICK WELL.

THE ADMINISTRATION PLAN COVERS THE ENTIRE HEALTH CARE CRISIS -- FROM PREVENTION OF ILLNESS AND INJURY TO THE FINANCING OF HEALTH SERVICES, FROM INCENTIVES TO ENCOURAGE A BETTER DISTRIBUTION OF HEALTH SERVICES TO ASSISTANCE AND INCENTIVES FOR OUR PROFESSIONAL SCHOOLS.

ONE OF THE KEY PARTS OF THE ADMINISTRATION PLAN IS THE REQUIREMENT THAT

EMPLOYERS PAY 65 PER CENT OF THE COST OF HEALTH INSURANCE PREMIUMS AT THE START OF THE PROGRAM, JULY 1, 1973, AND 75 PER CENT AFTER 1976.

THE BENEFITS WOULD VARY, BUT IN GENERAL THEY WOULD BE FAR HIGHER THAN THOSE AVAILABLE TODAY. THE PLAN WOULD COVER MATERNITY CARE WITH NO DEDUCTIBLES. WELL-CHILD SERVICES, INCLUDING VACCINATIONS AND PERIODIC CHECKUPS BY A PEDIATRICIAN, WOULD BE COVERED.

ANOTHER KEY FEATURE IS THAT CATASTROPHIC ILLNESSES WOULD BE COVERED WITH TOTAL PAYMENTS AS HIGH AS $50,000 -- FAR ABOVE THOSE OF EXISTING POLICIES.

PREMIUMS WOULD VARY, DEPENDING ON CIRCUMSTANCES AND THE REGION.

THE PRIVATE HEALTH INSURANCE INDUSTRY, ~~INCLUDING BLUE CROSS AND BLUE SHIELD~~, IS CENTRAL TO THE PLAN. THEY ~~WOULD~~

UNDERWRITE BOTH THE INCREASED EMPLOYER INSURANCE AND THE FAMILY HEALTH INSURANCE PROGRAM.

FOR PERSONS ON WELFARE -- OR THOSE WHO EARN LESS THAN $5,000 A YEAR -- THE FEDERAL GOVERNMENT WOULD PAY MOST BASIC MEDICAL COSTS. RECIPIENTS WOULD PAY SOME PREMIUMS, HOWEVER, UNLESS THEIR INCOME WAS LESS THAN $3,000 A YEAR.

AT THE SAME TIME, "PART B" OF THE MEDICARE PROGRAM, WHICH COVERS PHYSICIANS FEES, WOULD BE COMBINED WITH THE FREE MANDATORY "PART A" HOSPITALIZATION WHICH IS PROVIDED PERSONS OVER 65. THIS WOULD ELIMINATE THE $5.30-A-MONTH PREMIUM NOW CHARGED RECIPIENTS FOR THE "PART B" PORTION.

ANOTHER KEY FEATURE OF THE PLAN IS THAT PRIVATE HEALTH INSURANCE COMPANIES WOULD BE BROUGHT UNDER FEDERAL REGULATION.

THIS IS NECESSARY IF EMPLOYERS ARE TO BE REQUIRED TO BUY POLICIES TO COVER THEIR EMPLOYES.

TO ME ONE OF THE OUTSTANDING FEATURES OF THE ADMINISTRATION PLAN IS ITS EMPHASIS ON HEALTH MAINTENANCE ORGANIZATIONS, OR HMO'S. HMO'S SIMULTANEOUSLY ATTACK MANY OF THE PROBLEMS COMPRISING THE HEALTH CARE CRISIS. THEY EMPHASIZE PREVENTION AND EARLY CARE. THEY PROVIDE INCENTIVES FOR HOLDING DOWN COSTS AND FOR INCREASING THE PRODUCTIVE USE OF RESOURCES. THEY PROVIDE A MEANS FOR IMPROVING THE GEOGRAPHIC DISTRIBUTION OF HEALTH CARE.

HMO'S, AS YOU KNOW, ARE ORGANIZED SYSTEMS OF HEALTH CARE WHICH PROVIDE COMPREHENSIVE SERVICES FOR ENROLLED MEMBERS FOR A FIXED, PREPARED ANNUAL FEE. THEY

PROVIDE A MIX OF OUTPATIENT AND HOSPITAL SERVICES THROUGH A SINGLE ORGANIZATION AND A SINGLE PAYMENT MECHANISM. PERHAPS THE BEST EXAMPLE IS THE KAISER FOUNDATION.

THIS IS ACTUALLY THE MOST IMPORTANT STEP THE FEDERAL GOVERNMENT CAN TAKE TO IMPROVE HEALTH CARE THROUGHOUT AMERICA -- TO ENCOURAGE THE GROWTH OF MORE EFFICIENT FORMS OF CARE SUCH AS THAT PROVIDED BY HMO'S. ALL OF THE STUDIES THAT HAVE BEEN MADE POINT TO THE SAME CONCLUSION -- THAT HMO'S LOWER THE TOTAL HEALTH-CARE COSTS OF FAMILIES AND INDIVIDUALS, AND THEIR PREMIUMS COVER A GREATER PERCENTAGE OF TOTAL COSTS.

THE ADMINISTRATION'S GOAL IS TO DEVELOP 450 HMO'S BY THE END OF FISCAL YEAR 1973. OF THESE, 100 WOULD SERVE AREAS WITH A SCARCITY OF HEALTH CARE RESOURCES.

THE PLAN CALLS FOR 1,700 HMO'S BY THE END OF 1976. THESE HMO'S WOULD HAVE A POTENTIAL FOR ENROLLING 40 MILLION PEOPLE, 10 MILLION OF WHOM WOULD BE IN FAMILIES WITH INCOMES OF UNDER $8,000 A YEAR. AND THE ULTIMATE GOAL WOULD BE TO ENROLL 90 PER CENT OF THE POPULATION IN HMO'S BY THE END OF THE DECADE.

THE ADMINISTRATION WILL USE VARIOUS EXISTING AUTHORITIES TO STIMULATE THE DEVELOPMENT OF HMO'S DURING FISCAL 1972 -- PARTNERSHIP FOR HEALTH, REGIONAL MEDICAL PROGRAMS, HEALTH SERVICES RESEARCH AND DEVELOPMENT, HILL-BURTON AND POSSIBLY OTHERS. BUT NEW LEGISLATIVE INITIATIVES WILL BE NEEDED TO BUILD UP HMO'S TO THE POINT ENVISIONED BY THE ADMINISTRATION.

THE ADMINISTRATION HAS PROPOSED A COMPREHENSIVE HEALTH MANPOWER STRATEGY

DESIGNED TO OVERCOME THE CRUCIAL PROBLEMS OF TODAY AND TO PREPARE FOR THE FUTURE. THE PRESIDENT'S FISCAL 1972 BUDGET CALLS FOR MORE THAN $1.1 BILLION FOR HEALTH MANPOWER EDUCATION AND TRAINING.

SIGNIFICANTLY, THE BUDGET PROVIDES $10 MILLION TO SEND DOCTORS, DENTISTS, NURSES AND OTHER HEALTH WORKERS INTO HEALTH PERSONNEL SCARCITY AREAS AT THE REQUEST OF PUBLIC OR NON-PROFIT HEALTH AGENCIES. THIS PROGRAM INVOLVES AN INITIAL 600 TO 1,000 HEALTH PERSONNEL.

AND TO ENCOURAGE PRIMARY CARE PHYSICIANS, DENTISTS AND NURSES TO PRACTICE IN MEDICALLY UNDERSERVED AREAS, THE ADMINISTRATION PROPOSES TO FORGIVE $5,000 IN LOANS, PLUS INTEREST, ON FUNDS BORROWED BY DOCTORS AND DENTISTS AS STUDENTS, AND 25 PER CENT OF NURSES' LOANS, FOR EACH YEAR

SERVED IN SUCH AREAS.

AS YOU ALL KNOW, WE HAVE A CRITICAL SHORTAGE OF NURSES IN AMERICA. THAT IS PART OF THE HEALTH CRISIS, AND THE ADMINISTRATION AND THE CONGRESS ARE ACTING TO REMEDY IT.

AT THE PRESENT TIME, THERE ARE 700,000 NURSES IN ACTIVE PRACTICE. AT LEAST 150,000 MORE ARE NEEDED NOW. BY 1980, 1,100,000 NURSES WILL BE NEEDED TO HELP MEET THE INCREASED DEMANDS FOR HEALTH SERVICES DUE TO THE GROWTH IN POPULATION, THE EXPANSION IN NURSES' DUTIES AND RESPONSIBILITIES, AND THE GROWTH IN THE COMPLEXITY OF HEALTH CARE.

THIS IS WHY THE HOUSE OF REPRESENTATIVES ~~LESS THAN TWO WEEKS AGO PASSED~~ next week will pass A THREE-YEAR EXTENSION OF THE NURSE TRAINING ACT, WITH A NUMBER OF AMENDMENTS

AND IMPROVEMENTS. THE NURSE TRAINING ACT OF 1971 CONTINUES NURSING SCHOOL CONSTRUCTION GRANTS AND ADDS NEW AUTHORITY FOR CONSTRUCTION LOANS AND INTEREST SUBSIDIES, OFFERS "START-UP" GRANTS FOR NEW SCHOOLS OF NURSING, INAUGURATES A PROGRAM OF CAPITATION GRANTS FOR NURSING SCHOOLS, INCREASES THE AMOUNT OF NURSING STUDENT LOANS TO $2,500 A YEAR, INCREASES NURSING STUDENT SCHOLARSHIPS TO A MAXIMUM OF $2,000 A YEAR, AND CONTINUES TRAINEESHIPS FOR PROFESSIONAL NURSES TO BECOME TEACHERS, SUPERVISORS AND CLINICAL SPECIALISTS.

MY GUESS IS THERE IS SPECIAL INTEREST AMONG YOU IN ADVANCED TRAINEESHIPS. THERE ARE ACUTE SHORTAGES OF NURSES PREPARED AS TEACHERS, EXPERT PRACTITIONERS AND ADMINISTRATORS.

AT PRESENT THERE ARE NOT ENOUGH

TEACHERS IN EXISTING SCHOOLS OF NURSING, NOR FOR THE MANY NEW AND DEVELOPING SCHOOLS.

IN THE SEVEN YEARS SINCE THE PASSAGE OF THE FIRST NURSE TRAINING ACT, THE NUMBER OF INITIAL PROGRAMS OF NURSING EDUCATION HAS INCREASED FROM 1,158 TO 1,355. THESE NEW PROGRAMS NEED TEACHERS, AS WILL THE OTHERS IF THEY ARE TO EXPAND ENROLLMENTS. THIS IS THE MOST CRITICAL SHORTAGE AREA IN NURSING.

THE PROFESSIONAL NURSE TRAINEESHIP PROGRAM WHICH IS INCLUDED IN THE NURSE TRAINING ACT OF 1971, PROVIDES ADVANCED TRAINING FOR NURSES TO TEACH IN THE VARIOUS FIELDS OF NURSE TRAINING, INCLUDING PRACTICAL NURSE TRAINING, OR TO SERVE IN ADMINISTRATIVE OR SUPERVISORY CAPACITIES, OR TO PREPARE NURSES TO SERVE IN OTHER PROFESSIONAL NURSING SPECIALTIES.

THERE IS A CRITICAL NEED FOR PREPARED FACULTY TO FILL POSITIONS IN EXISTING NURSING SCHOOLS AND IN NEW SCHOOLS NOW BEING ESTABLISHED.

AT THE SAME TIME, RAPID ADVANCES IN MEDICAL AND NURSING PRACTICE DICTATE THE NEED FOR EXPERT PRACTITIONERS TO GIVE HIGHLY SPECIALIZED CARE.

THE TRAINEESHIP PROGRAM ~~WAS ONE OF THE REASONS I STRONGLY SUPPORTED THE NURSE TRAINING ACT OF 1971. IT~~ IS VITAL TO THE RESOLUTION OF OUR HEALTH CARE CRISIS.

THE ADMINISTRATION AND THE CONGRESS ARE TAKING THESE AND OTHER STEPS TO IMPROVE HEALTH CARE IN AMERICA.

WHAT THE ADMINISTRATION HAS OFFERED CONGRESS WITH ITS NATIONAL HEALTH STRATEGY IS AN AGENDA FOR REFORM. REFORM IS CLOSELY AND INGENIOUSLY WOVEN

THROUGHOUT ALL OF THE ADMINISTRATION'S HEALTH CARE PROPOSALS. WHAT WE NEED NOW IS FOR THE CONGRESS TO ACT.

WHAT CAN YOU DO TO HELP? YOU CAN JOIN WITH OTHER AMERICANS IN DEMANDING FUNDAMENTAL CHANGES IN OUR HEALTH CARE SYSTEM. YOU CAN URGE THE CONGRESS TO RAISE OUR NATIONAL HEALTH CARE STANDARDS TO NEW HIGH LEVELS WHERE ALL OF OUR NEEDS CAN BE MET. YOU CAN INSIST THAT GOOD HEALTH CARE BE MADE AVAILABLE TO EVERY AMERICAN, REGARDLESS OF HIS MEANS.

IF YOU DO THIS WE CAN ALL GO FORWARD. WE CAN BUILD TOGETHER, BUILD A TRULY BETTER LIFE FOR ALL AMERICANS.

-- END --

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KEYNOTE SPEECH, REMARKS BY REP. GERALD R. FORD
AT THE OPENING SESSION OF THE DEPARTMENT OF SCHOOL
NURSES, NATIONAL EDUCATION ASSOCIATION, ANNUAL CONVENTION,
9:30 a.m. SATURDAY, JUNE 26, 1971, IN DETROIT, MICHIGAN.

Nursing is a noble profession. To care for the sick, to nurse the sick back to health, requires not only skill but the finest of human impulses and the tenderest of emotions.

In that connection, I quote Mr. Dooley, otherwise known as Finley Peter Dunne. Said Mr. Dooley: "I think that if th' Christian Scientists had some science an' th' doctors more Christianity, it wudden't make any diff'rence which ye called in--if ye had a good nurse."

Nor does it matter whether the nurse is good-looking. I once knew a nurse who was very pretty. She was so conceited that every time she took a man's pulse she subtracted about 10 beats to allow for the impact of her personality.

But that has no bearing on the keynote of this convention. And it is a keynote I am supposed to be sounding. Actually, that keynote is contained in the advice I received when I asked your convention planners what I should talk about.

Tell us, they said, what we can do to promote legislation that will bring about better health service for all school children and youth.

First of all, I don't think we should separate health service to school children from health service to all Americans. It is better family health service that we want--and the key to that is reform. Not a doubling of the dollars going into health care in America, but reform in the way that health care is delivered.

At the risk of sounding radical, I have to tell you that our health care delivery system isn't working right. Unlike the radicals, I am backing a plan, a constructive plan, which I think will give America good health care for all. And we can do it by building, not by tearing something down.

But before we talk about that plan, let's talk about what we have now and what's wrong with it. You know how it is when you're in a big building. They have floor maps around with an X that says, "Here is where you are." You have to know where you are in order to get where you want to go.

Where are we now in terms of health care? As health is measured, the United States is not doing as well as other advanced nations. We rank 13th, for instanee, in infant mortality. That is relatively poor. The United States should have the lowest infant death rate. There is no reason why we should not be able to achieve that rank.

(more)

Let me now immediately enter a disclaimer. While America is behind other western countries in many aspects of health care, it is far ahead of most in the overall quality of its medicine. The trouble is that the performance is spotty and uneven.

We have made a number of advances.

A child born today can expect to live 30 per cent longer on the average than a child born in 1920.

Nonwhite children, while lagging behind white children in total life expectancy, have made the greatest gains--a third more life for nonwhite men, and more than a 50 per cent increase in life span for nonwhite women.

Infant deaths have been on the decline for some time, and maternal death rates dropped by 66 per cent between 1950 and 1967.

So the gross measures of health status clearly indicate that our health has been improving, not worsening. Yet there is a crisis in health care today. What is the nature of that crisis? It is not to be found in the general status of health but in the uneven distribution of health care throughout America.

I speak of the fact that the poor and the racial minorities are being short-changed. Their lives are shorter. They have more chronic and debilitating diseases. Their infant and maternal death rates are higher. Their protection against infectious diseases, through immunization, is far lower. They have far less access to health services--and this is particularly true of the children among the poor and nonwhite minorities. Millions of these children receive little or no dental or pediatric care.

This is part of the health crisis.

Another part has to do with our rural population and our ghetto residents. The fact is that they are poorly served with medical care.

There are, for example, large geographic variations in the ratio of physicians to population. There are 82 active physicians per 100,000 people in Mississippi, 141 in Michigan, and 228 in New York. A study of 1,500 cities and towns in the Upper Midwest showed 1,000 of them without a physician, and 200 had only one. Large metropolitan areas average 185 physicians per 100,000 people, while non-metropolitan areas average 76. And the cities, particularly the ghettoes, fare far worse than the suburbs in the ratio of physicians to population.

Geographic location of doctors is not the only problem. The other is the shortage of primary care physicians--general practitioners, pediatricians, and

internists. The demand is for primary care physicians. Yet the relative ratio of primary care physicians to population has been declining. In 1931, roughly 117,00 physicians out of 156,000 were primary care physicians--75 per cent of the total. In 1967, there were roughly 115,000 primary care physicians out of 303,000 physicians, or only 39 per cent. From 94 primary care physicians per 100,000 people in 1931, the ratio has dropped to 73.

So we have the problem of geographic location of physicians and the problem of type of medical practice.

Still another problem is the improper management of our health care resources.

The Joint Council of National Pediatric Societies says that 75 per cent of the pediatric tasks performed by a physician could be done by a properly trained child health assistant. A significant amount of the work done by obstetricians could be performed by nurse-midwives. Ex-Medical corpsmen, or comparably trained individuals, with some additional training could assume a large number of the tasks now performed by general practitioners.

In every study of health care facilities, one finds varying percentages of patients who should be using more appropriate facilities.

The Health-Education-Welfare Department estimates that with just a 10 per cent improvement in the efficiency with which our health resources are used we could achieve a saving of more than $5 billion.

It is clear that the organization of our health care delivery system needs reforming.

What about financing? Expenditures on personal health care amounted to $58 billion in fiscal 1969. The largest part-almost 63 per cent--came from private sources, and the rest from public sources.

About 80 per cent of the population under 65 has some private health insurance, mainly for hospital and surgical coverage.

About 75 per cent of the working population is protected through employer-employe plans developed under collective bargaining agreements.

Medicare provides protection for more than 95 per cent of the elderly. And Medicaid provides some protection for 15 million of the aged poor, the blind, the disabled, and families with children.

Yet large numbers of our people are excluded from financial access to health care. Benefits are often inadequate. And costs are unnecessarily high.

(more)

Still another part of the health care crisis is the financial crisis which has beset a large number of the Nation's medical and dental schools. The inescapable fact is that the professional schools are in trouble.

We've talked about the problem; now let's talk about the solution.

There is little doubt that some type of national health insurance plan is needed to bring better health care to Americans and to cope with soaring costs of medical and hospital care.

The problems of increasing medical and hospital costs are not limited to the poor. The problem is nationwide, universal. It needs broad attention and correction.

We must raise the health standards of all Americans. We must deal with the defects in the health care delivery system as it affects us all. This is a crisis which touches our consciousness and our conscience. It is central to the quality of life in America.

Many proposals have been introduced in the Congress. I personally believe the choice is primarily between Federal financing of a national health program and the Administration's plan for a National Health Insurance Partnership between the Federal Government and the health insurance industry. The Administration's proposed national health strategy, of course, goes far beyond just the financing of health care. It is a reform proposal directed at all of the problems I have outlined.

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Secondly, it is difficult to say just how much more governmental solicitude the taxpaying public can afford. If the cost of providing health care for every man, woman and child in America were to be Federally financed, the cost would be staggering and the tax load would be virtually unbearable. If the cost were to be piggy-backed onto our Social Security taxes, I think payroll levies would soon reach the breaking point. Even at its present levels, Social Security taxation is costing some families as much as they are paying in Federal income taxes.

I personally feel it would be better for America to provide better health by tapping the private economy than by dipping into the public till.

This is one reason I have co-sponsored the Administration's National Health Partnership Act in the House of Representatives. The other reason is that the

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The end product is a package that would place the bulk of the cost of better health care services on employers and focus on preventive medicine rather than just getting the sick well.

The Administration plan covers the entire health care crisis--from prevention of illness and injury to the financing of health services, from incentives to encourage a better distribution of health services to assistance and incentives for our professional schools.

One of the key parts of the Administration plan is the requirement that employers pay 65 per cent of the cost of health insurance premiums at the start of the program, July 1, 1973, and 75 per cent after 1976.

The benefits would vary, but in general they would be far higher than those availabe today. The plan would cover maternity care with no deductibles. Well-child services, including vaccinations and periodic checkups by a pediatrician, would be covered.

Another key feature is that catastrophic illnesses would be covered with total payments as high as $50,000--far above those of existing policies.

Premiums would vary, depending on circumstances and the region.

The private health insurance industry, including Blue Cross and Blue Shield, is central to the plan. They would underwrite both the increased employer insurance and the family health insurance program.

For persons on welfare--or those who earn less than $5,000 a year----the Federal government would pay most basic medical costs. Recipients would pay some premiums, however, unless their income was less than $3,000 a year.

At the same time, "Part B" of the Medicare program, which covers physicians fees, would be combined with the free mandatory "Part A" hospitalization which is provided persons over 65. This would eliminate the $5.30-a-month premium now charged recipients for the "Part B" portion.

Another key feature of the plan is that private health insurance companies would be brought under Federal regulation. This is necessary if employers are to be required to buy policies to cover their employes.

To me one of the outstanding features of the Administration plan is its

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emphasis on Health Maintenance Organizations, or HMO's. HMO's simultaneously attack many of the problems comprising the health care crisis. They emphasize prevention and early care. They provide incentives for holding down costs and for increasing the productive use of resources. They provide a means for improving the geographic distribution of health care.

HMO's, as you know, are organized systems of health care which provide comprehensive services for enrolled members for a fixed, prepared annual fee. They provide a mix of outpatient and hospital services through a single organization and a single payment mechanism. Perhaps the best example is the Kaiser Foundation.

This is actually the most important step the Federal Government can take to improve health care throughout America--to encourage the growth of more efficient forms of care such as that provided by HMO's. All of the studies that have been made point to the same conclusion--that HMO's lower the total health-care costs of families and individuals, and their premiums cover a greater percentage of total costs.

The Administration's goal is to develop 450 HMO's by the end of fiscal year 1973. Of these, 100 would serve areas with a scarcity of health care resources.

The plan calls for 1,700 HMO's by the end of 1976. These HMO's would have a potential for enrolling 40 million people, 10 million of whom would be in families with incomes of under $8,000 a year. And the ultimate goal would be to enroll 90 per cent of the population in HMO's by the end of the decade.

The Administration will use various existing authorities to stimulate the development of HMO's during fiscal 1972--Partnership for Health, Regional Medical Programs, Health Services Research and Development, Hill-Burton and possibly others. But new legislative initiatives will be needed to build up HMO's to the point envisioned by the Administration.

The Administration has proposed a comprehensive health manpower strategy designed to overcome the crucial problems of today and to prepare for the future. The President's fiscal 1972 budget calls for more than $1.1 billion for health manpower education and training.

Significantly, the budget provides $10 million to send doctors, dentists, nurses and other health workers into health personnel scarcity areas at the request of public or non-profit health agencies. This program involves an initial 600 to 1,000 health personnel.

And to encourage primary care physicians, dentists and nurses to practice in medically underserved areas, the Administration proposes to forgive $5,000 in

loans, plus interest, on funds borrowed by doctors and dentists as students, and 25 per cent of nurses' loans, for each year served in such areas.

As you all know, we have a critical shortage of nurses in America. That is part of the health crisis, and the Administration and the Congress are acting to remedy it.

At the present time, there are 700,000 nurses in active practice; at least 150,000 more are needed now. By 1980, 1,100,000 nurses will be needed to help meet the increased demands for health services due to the growth in population, the expansion in nurses' duties and responsibilities, and the growth in the complexity of health care.

This is why the House of Representatives less than two weeks ago passed a three-year extension of the Nurse Training Act, with a number of amendments and improvements. The Nurse Training Act of 1971 continues nursing school construction grants and adds new authority for construction loans and interest subsidies, offers "start-up" grants for new schools of nursing, inaugurates a program of capitation grants for nursing schools, increases the amount of nursing student loans to $2,500 a year, increases nursing student scholarships to a maximum of $2,000 a year, and continues traineeships for professional nurses to become teachers, supervisors and clinical specialists.

My guess is there is special interest among you in advanced traineeships. There are acute shortages of nurses prepared as teachers, expert practitioners and administrators.

At present there are not enough teachers in existing schools of nursing, nor for the many new and developing schools.

In the seven years since the passage of the first Nurse Training Act, the number of initial programs of nursing education has increased from 1,158 to 1,355. These new programs need teachers, as will the others if they are to expand enrollments. This is the most critical shortage area in nursing.

The Professional Nurse Traineeship Program which is included in the Nurse Training Act of 1971, provides advanced training for nurses to teach in the various fields of nurse training, including practical nurse training, or to serve in administrative or supervisory capacities, or to prepare nurses to serve in other professional nursing specialties.

There is a critical need for prepared faculty to fill positions in existing nursing schools and in new schools now being established.

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At the same time, rapid advances in medical and nursing practice dictate the need for expert practitioners to give highly specialized care.

The traineeship program was one of the reasons I strongly supported the Nurse Training Act of 1971. It is vital to the resolution of our health care crisis.

The Administration and the Congress are taking these and other steps to improve health care in America.

What the Administration has offered Congress with its national health strategy is an agenda for reform. Reform is closely and ingeniously woven throughout all of the Administration's health care proposals. What we need now is for the Congress to act.

What can you do to help? You can join with other Americans in demanding fundamental changes in our health care system. You can urge the Congress to raise our national health care standards to new high levels where all of our needs can be met. You can insist that good health care be made available to every American, regardless of his means.

If you do this we can all go forward. We can build together, build a truly better life for all Americans.

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KEYNOTE SPEECH, REMARKS BY REP. GERALD R. FORD
AT THE OPENING SESSION OF THE DEPARTMENT OF SCHOOL
NURSES, NATIONAL EDUCATION ASSOCIATION, ANNUAL CONVENTION,
9:30 a.m. SATURDAY, JUNE 26, 1971, IN DETROIT, MICHIGAN.

Nursing is a noble profession. To care for the sick, to nurse the sick back to health, requires not only skill but the finest of human impulses and the tenderest of emotions.

In that connection, I quote Mr. Dooley, otherwise known as Finley Peter Dunne. Said Mr. Dooley: "I think that if th' Christian Scientists had some science an' th' doctors more Christianity, it wudden't make any diff'rence which ye called in--if ye had a good nurse."

Nor does it matter whether the nurse is good-looking. I once knew a nurse who was very pretty. She was so conceited that every time she took a man's pulse she subtracted about 10 beats to allow for the impact of her personality.

But that has no bearing on the keynote of this convention. And it is a keynote I am supposed to be sounding. Actually, that keynote is contained in the advice I received when I asked your convention planners what I should talk about.

Tell us, they said, what we can do to promote legislation that will bring about better health service for all school children and youth.

First of all, I don't think we should separate health service to school children from health service to all Americans. It is better family health service that we want--and the key to that is reform. Not a doubling of the dollars going into health care in America, but reform in the way that health care is delivered.

At the risk of sounding radical, I have to tell you that our health care delivery system isn't working right. Unlike the radicals, I am backing a plan, a constructive plan, which I think will give America good health care for all. And we can do it by building, not by tearing something down.

But before we talk about that plan, let's talk about what we have now and what's wrong with it. You know how it is when you're in a big building. They have floor maps around with an X that says, "Here is where you are." You have to know where you are in order to get where you want to go.

Where are we now in terms of health care? As health is measured, the United States is not doing as well as other advanced nations. We rank 13th, for instanee, in infant mortality. That is relatively poor. The United States should have the lowest infant death rate. There is no reason why we should not be able to achieve that rank.

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Let me now immediately enter a disclaimer. While America is behind other western countries in many aspects of health care, it is far ahead of most in the overall quality of its medicine. The trouble is that the performance is spotty and uneven.

We have made a number of advances.

A child born today can expect to live 30 per cent longer on the average than a child born in 1920.

Nonwhite children, while lagging behind white children in total life expectancy, have made the greatest gains--a third more life for nonwhite men, and more than a 50 per cent increase in life span for nonwhite women.

Infant deaths have been on the decline for some time, and maternal death rates dropped by 66 per cent between 1950 and 1967.

So the gross measures of health status clearly indicate that our health has been improving, not worsening. Yet there is a crisis in health care today. What is the nature of that crisis? It is not to be found in the general status of health but in the uneven distribution of health care throughout America.

I speak of the fact that the poor and the racial minorities are being short-changed. Their lives are shorter. They have more chronic and debilitating diseases. Their infant and maternal death rates are higher. Their protection against infectious diseases, through immunization, is far lower. They have far less access to health services--and this is particularly true of the children among the poor and nonwhite minorities. Millions of these children receive little or no dental or pediatric care.

This is part of the health crisis.

Another part has to do with our rural population and our ghetto residents. The fact is that they are poorly served with medical care.

There are, for example, large geographic variations in the ratio of physicians to population. There are 82 active physicians per 100,000 people in Mississippi, 141 in Michigan, and 228 in New York. A study of 1,500 cities and towns in the Upper Midwest showed 1,000 of them without a physician, and 200 had only one. Large metropolitan areas average 185 physicians per 100,000 people, while non-metropolitan areas average 76. And the cities, particularly the ghettoes, fare far worse than the suburbs in the ratio of physicians to population.

Geographic location of doctors is not the only problem. The other is the shortage of primary care physicians--general practitioners, pediatricians, and

internists. The demand is for primary care physicians. Yet the relative ratio of primary care physicians to population has been declining. In 1931, roughly 117,00 physicians out of 156,000 were primary care physicians--75 per cent of the total. In 1967, there were roughly 115,000 primary care physicians out of 303,000 physicians, or only 39 per cent. From 94 primary care physicians per 100,000 people in 1931, the ratio has dropped to 73.

So we have the problem of geographic location of physicians and the problem of type of medical practice.

Still another problem is the improper management of our health care resources.

The Joint Council of National Pediatric Societies says that 75 per cent of the pediatric tasks performed by a physician could be done by a properly trained child health assistant. A significant amount of the work done by obstetricians could be performed by nurse-midwives. Ex-Medical corpsmen, or comparably trained individuals, with some additional training could assume a large number of the tasks now performed by general practitioners.

In every study of health care facilities, one finds varying percentages of patients who should be using more appropriate facilities.

The Health-Education-Welfare Department estimates that with just a 10 per cent improvement in the efficiency with which our health resources are used we could achieve a saving of more than $5 billion.

It is clear that the organization of our health care delivery system needs reforming.

What about financing? Expenditures on personal health care amounted to $58 billion in fiscal 1969. The largest part-almost 63 per cent--came from private sources, and the rest from public sources.

About 80 per cent of the population under 65 has some private health insurance, mainly for hospital and surgical coverage.

About 75 per cent of the working population is protected through employer-employe plans developed under collective bargaining agreements.

Medicare provides protection for more than 95 per cent of the elderly. And Medicaid provides some protection for 15 million of the aged poor, the blind, the disabled, and families with children.

Yet large numbers of our people are excluded from financial access to health care. Benefits are often inadequate. And costs are unnecessarily high.

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