GOVERNOR WENDELL R. ANDERSON

SPECIAL MESSAGE

RESPONSIVE HEALTH CARE FOR MINNESOTA'S PEOPLE

To the 67th Session of the Legislature of Minnesota

March 17, 1971

Mr. Speaker, Mr. President, Members of the 67th Session of the Minnesota Legislature, and fellow citizens of Minnesota:

Benjamin Disraeli, the great political statesman of the British Empire, said that "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

In my Inaugural Address, I committed this administration to realizing Floyd B. Olson's call for government to "function in the interests of the common happiness of the people." It is clear that health care must be a basic government concern if that function is to be realized.

The widely-publicized "Quality of Life" study of 1967 placed Minnesota first in the nation in the quality of its health and welfare. But in 1970 the Minnesota State Medical Association could identify 247 unfilled opportunities for medical practice in our state.

Our maternal death rate between 1965 and 1969 was less than half that of the United States as a whole. But a recent Minnesota poll shows that only 14 per cent of

Minnesotans regard their medical care as "excellent", and the percentage has dropped significantly from 33 per cent three years ago.

We have more physicians and nurses per 100,000 population in Minnesota than there are in most of our neighboring states and most other states in the nation. But a recent survey of group clinics estimated a need for 540 more physicians for that kind of practice in the next two years.

There is considerable agreement among our constituents, experts in the field, and our personal experiences that health care problems continue in Minnesota. They are problems of deficient organization and maldistribution of services, deficient manpower supplies, and high costs. They cannot be solved by the intervention of state government alone. But they are problems that state government can help to solve if we are willing to put our resources to work.

ORGANIZATION, MANPOWER, AND COST PROBLEMS

For some Minnesotans, health services are simply not available, especially if they live in rural areas or the disadvantaged neighborhoods of our major cities.

For many Minnesotans, available services are not accessible because of barriers of cost, geography, or time.

Long waits in offices and clinics, appointments that must be made months in advance, the inability to locate a physician when moving to a new community--these are all examples of the inaccessibility of the health care system.

For some Minnesotans, the available and accessible services are simply not acceptable, because the circumstances in which they are provided are impersonal or even degrading. Many who seek health care are treated as cases, rather than as persons.

For certain Minnesotans, social, economic, and cultural barriers in our present health system have produced a disenchantment or alienation that causes serious gaps in health services, even when they are available. Much of our present system has been designed for the convenience of those who provide the service, rather than for those who receive it and pay for it.

For nearly all Minnesotans, the system places emphasis on the sick, the injured, and the diseased. The maintenance of good health and the prevention of disease and injury have received inadequate emphasis to date. The result has been to force our citizens into a costly and

unresponsive institutional pattern for maintenance of health.

In part the inability to provide available, accessible, acceptable health care is a problem of organization. The health care system may be logical to some health providers, but it is not logical to me and other users of health services.

The components of the system are fragmented and uncoordinated. There is little help for the health service consumer in finding continuous and comprehensive care that includes prevention, treatment, rehabilitation, and long-term care. For the consumer, the system is both inefficient and ineffective. To make matters worse, numerous levels of government and myriads of private and public agencies are involved in providing or financing health services. And often where responsibility exists, accountability is regrettably absent.

Lack of access to the system and the inability of the system to meet consumer needs stem partly from shortage of health personnel: those individuals whose skills provide the services we demand. I have already suggested some examples of shortages in Minnesota; estimates of the

total shortage of physicians in this state range as high as 1,000. Only in recent months have the available positions for registered and licensed practical nurses in the larger cities of our state been filled. Our smaller communities especially reflect the unequal distribution of physicians, dentists, nurses, and other health practitioners.

Health manpower shortages are further aggravated by restrictive licensing laws that inhibit innovation and effective use of trained personnel. Until the supply, use, and distribution of health personnel are improved, we cannot respond to the expressed needs of the people of Minnesota for available, accessible, and acceptable health services.

Costs of care and patterns of payment are also problems for government and citizens alike. On a national scale, expenditures for health and medical care now account for seven per cent of the gross national product, or nearly $70 billion per year.

To some degree, these rising expenditures result from inflation, population growth, increased use of health services (especially by our growing population of elderly

citizens), and the expensive technology that saves lives through heart surgery, kidney transplants, intensive coronary care, and other new techniques.

But rising costs are also a result of inefficiencies, inappropriate uses of available health manpower and services, and failure to explore less expensive alternatives for providing health care. The variety of competing health insurance programs have contributed substantially to the undue emphasis on curative health care rather than prevention of disease or maintenance of health. The results are publicly evident today.

We overuse our hospitals and nursing homes--the most expensive elements in the health service spectrum. Construction or expansion of a hospital or nursing home may be a source of pride to a community, but it can be a source of pain as well if those expensive beds are not truly needed.

Fragmentation of services into small curative "pieces", each obtained by the consumer citizen from a different practitioner or agency, adds to the cost of health care and is inefficient for both the provider and

the seeker of services

It is not surprising, under these circumstances, that some observers refer to our non-system of health care.

RESOURCES AVAILABLE FOR A HEALTH CARE SYSTEM

The absence of systematic health care efforts in Minnesota does not result from a lack of resources in the state. By any known measure, Minnesota has many assets on which to build a fine health care system.

Studies of comparative health status often use statistics relating to the health and survival of mothers, and the survival of infants in the first year of life. Minnesota is a healthy state by all such measures.

Between 1965 and 1969 in Minnesota, the maternal death rate was 13.5 per 100,000 live births, or 53 per cent below the U.S. average of 28.6 deaths per 100,000 live births. The 1969 infant death rate of 16.8 per 1,000 live births was the lowest yet achieved in the state, and is one of the lowest anywhere in the world. It is approximately half the 1940 rate of 33.2 deaths per 1,000 live births, and is well below the U.S. average rate of approximately 22 deaths per 1,000 live births.

Other statistical indicators also confirm our relatively strong position compared to other states and to the United States as a whole. The "Quality of Life" study, for example, showed that Minnesotans live longer according to insurance statistics, and are healthier by most accepted indicators of health, than persons in most other states.

Our health professional training institutions are famous for their quality, both in faculty and in the product they produce--practitioners of medicine, dentistry, pharmacy, nursing, physical and occupational therapy, and many other related fields. Health and hospital administrators educated in Minnesota are demonstrating leadership for change at all levels in our nation. Our educational institutions have responded to the needs for allied health personnel who work with professionals, as well.

Minnesota has a higher proportion of physicians in group practice than any other state. Our hospitals and nursing homes are modern in design and competent in performance; there are now more beds available per capita in Minnesota than in the Upper Midwest states or the United

States as a whole.

The Mayo Institutions in Rochester and the University of Minnesota Health Sciences complex are training, research, and treatment facilities that set high standards for the rest of the state and the nation. Our network of Community Mental Health Centers, largely county and state supported, serves the state well, and I have already asked the Legislature to assign new responsibilities for innovative treatment of drug abusers to them.

State government in Minnesota has useful experience and power in maintaining and increasing the quality of health care, as well.

Our Comprehensive Health Planning Program in the State Planning Agency has worked since 1967 to formulate goals and priorities for health planning in Minnesota by seeking out and encouraging participation of all levels of government, health care service providers and consumers, and public and private health service agencies. It has helped to develop areawide planning councils throughout the state--structures where representatives of local government, interested citizens, and health professionals discuss the needs and desires of local populations and

develop plans to serve them. At the state level, the agency and its advisory council have developed recommendations and proposed policies and plans for Long-term Residential Care, Parent and Infant Health, and Constraining Health Care Costs. A new set of recommendations for Health Manpower Policy will soon be released.

The State of Minnesota also provides extensive regulatory control, through its license powers, over the various providers of health care--physicians and other health personnel, hospitals, nursing homes, and health insurers, for example.

The State of Minnesota works to safeguard the health of our citizens through enforcement of sanitation standards, public health regulations, and pollution control regulations; and I have already asked the Legislature to provide licensing of drug abuse programs in addition.

The State of Minnesota purchases health care services for patients in 13 state hospitals, for Medicaid and other health assistance programs, and for thousands of full-time employees and their families in state employee health benefit programs.

The State of Minnesota invests in the education

of physicians, nurses, dentists, pharmacists, public health workers, and other health manpower through appropriations to schools and other institutions, and provides additional dollars for miscellaneous health and health-related programs.

The resources available in Minnesota, including the state government's present participation in health care efforts, provide a sound basis for bringing state government to bear on the problem of developing a health care system in the state. Our health care assets and the leverage of our state involvements can be used to generate constructive change.

Perhaps most important, Minnesota has citizens who are energetic and concerned about health care--willing to accept change, seeking good change, and ready to work and become involved in planning and decision-making to use our assets for the benefit of our people. My recommendations to you today are intended to make the best use of all of these resources.

PROPOSALS FOR MORE RESPONSIVE HEALTH CARE

To bring all of the resources of the state to bear on the need to improve the health care system in

Minnesota, I recommend that the state take five important steps.

The first, which will likely be of greatest long-range benefit, will provide information and recommendations to the Governor and the 1973 Legislature for developing a better, more integrated, and more coordinated system of health services in the state, through state government leadership.

Two others are aimed at increasing the health manpower supply in the state, by providing more trained professionals and by bringing more allied health personnel into Minnesota's health care system through revising the regulations under which they work with health professionals.

Another is intended to reduce the cost of health care in the state by making sure that new facilities will be needed when they are built.

A final one deals with halting a severe threat to public health through an expanded program of communicable disease control.

Together, they make up a program which I believe will make Minnesota's health services more responsive to the needs of Minnesota's people.

1. Mobilizing State Resources for a Common Health Strategy

Extensive review of the role of the Federal government in the delivery of health care services is now under way, and the national role will almost certainly place an increasing responsibility on the various states.

A major redirection has also occurred in the delivery of health services in the states because of such Federal programs as the "Partnership for Health" legislation. This program and others such as Medicare, Medicaid, comprehensive health planning, and regional medical programs have done much to respond to the many gaps in health care delivery in the State of Minnesota. These programs have not, however, dissolved our major problem.

While our excellence of medical care has been high and our quality of life better than other states, the inability of our health structures to respond to the demands of health consumers has become increasingly evident. Diversification of method and effort has been one of the major contributors to quality and excellence in medicine. It has also been the single greatest deterrent in achieving

a truly efficient and effective health delivery system.

The "Partnership for Health" legislation did create a relationship between units within the health care system and the Federal government. Additionally, in some cases, it involved consumers of health services in decision-making relative to their own care. It did not, however, achieve adequate coordination or cooperation among the provider institutions, nor among the numerous health professionals within the system. Very serious gaps still remain, especially in rural areas and inner-city neighborhoods.

More money and new programs alone cannot solve our problem. Programs now anticipated at the Federal level cannot be expected to create a system that will assure each Minnesotan a potential for good health and high-quality health care. Nor for that matter, should we expect the Federal government to solve our problem for us, even though we recognize the impossibility of doing it without Federal assistance.

What has been missing has been the lack of a broadly-based catalyst to promote coordination and a joint pursuit of common goals. We need to bring together all of

our forces within the state which have health delivery capability. We need to enunciate and implement a common strategy for health care in our state. We need to create identifiable goals. We need to promote an attainable standard for health and health maintenance for Minnesota citizens.

I am therefore identifying a new role for our state government--a role which the crisis of health delivery requires and which I believe our state agencies are capable of fulfilling. It is a dual role--both as a catalyst for a common health strategy and as an advocate for citizens who do not have quality health care available to them.

Since our concern must not only be with direct personal health care--but with adequate nutrition, satisfactory housing, pollution-free air and water, and all of the factors that make up good health for our citizens--more responsibility for fulfilling the new dual role which I am projecting must be given to those who have best demonstrated their capability to perform in this area.

I have already described the distinctive work of the Comprehensive Health Planning Program over the past years in developing a statewide structure for planning

health care and involving lay citizens and professionals in the development of policy and plans in several health care areas. Through the work of this section, the State Planning Agency has taken significant steps to modify the traditional monopoly on health care planning by health professionals.

As state planning officer, relying on the effectiveness that has already been demonstrated by the Comprehensive Health Planning Program, I am today directing the State Planning Agency to mobilize state and local, public and private agencies, institutions, and individuals in a major effort to identify and promote a common health strategy and a coordinated system for delivering health care to all Minnesotans.

To fulfill this task, realistic goals and attainable objectives must be identified. Furthermore, the extensive efforts required of the State Planning Agency will require the assistance of other agencies. I am therefore directing all state departments and agencies to cooperate fully and to provide supportive personnel and services in accordance with Minnesota Statutes, Section 4.10, Subdivision 5.

I am further directing the State Planning Agency to request on my behalf cooperation and committed participation of the Northlands Regional Medical Program; the medical school, hospitals, School of Public Health, College of Pharmacy, and related departments of the Health Sciences Center at the University; the Institute of Interdisciplinary Studies; the Northern Association for Medical Education; the Mayo Clinic; and others now receiving participating state or Federal funds related to health care.

I further invite participation of the Minnesota Medical Association, the Minnesota Hospital Association, the Public Health Association, Blue Cross and Blue Shield, and all other associations for nursing homes, nursing, pharmacy, and the many other health-related interests. We will need their time, money, and effort where possible in this common mobilization.

While the matter of design for a common health strategy, with alternatives for delivery, will be the general responsibility of those participating with our State Planning Agency, some needs deserve special emphasis.

I am especially concerned that this effort involve the areawide health planning councils now in existence or soon to be formed, so that the forthcoming recommendations can reflect the needs of the consumer in the various geographic sections of the state.

I am concerned that those persons now estranged from the health system in pilot city areas and inner-city neighborhoods, as well as rural areas, be given adequate expression towards developing a health strategy to meet their needs.

I also encourage full attention to the issues under consideration nationally in the delivery of health care--the possible establishment of Health Maintenance Organizations as recommended by the President; implications of a national health insurance program for health care delivery in our state; and the possible effect that both Federal and state governments can have in influencing the nature and quality of care provided to government employees whose health insurance bills are paid by the government.

I ask that this study include possible incentives for medical, dental, and other health care practice in

shortage areas in our state, including scholarship or recruitment programs that might be useful in improving the accessibility of good health care to all of our citizens. I also expect the study to consider standing recommendations of the Northern Association for Medical Education, Northlands Regional Medical Program, interested groups, and the Inter-State Committee which has been examining possibilities for cooperation on a regional basis.

The major emphasis of this mobilization will be to redirect the pattern of health care delivery in order to promote comprehensive health care through preventive measures which assist in the maintenance of good personal and community health.

I also anticipate that this effort will consider out-patient care and home care and the need for state direction and funding. Data from St. Gabriel's Hospital in Little Falls, for example, accumulated in 1968-1969, indicates that home health care brought savings of $698,950 for delayed nursing home care and $8,032 for avoided or postponed hospital care. The feasibility of state subsidized home nursing and health care services

should be thoroughly examined.

I wish to direct specific attention to the quite apparent need for an integrated and coordinated statewide program for training health professionals for the health field. No system of health delivery can operate without appropriate and adequate manpower.

Elsewhere in this message I have detailed requests for expansion of training for doctors of medicine. Yet it seems obvious that simply training doctors will not solve the problem for Minnesota. Expanded numbers of all kinds of traditional health professionals are needed. But even more important, new types of health workers are needed in all sections of the state to assist medical doctors to deliver care more efficiently and more adequately.

I therefore ask those who join this common cause to develop specific recommendations to the Higher Education Coordination Commission for an inter-related program for training allied health professionals in Minnesota.

I believe the School of Public Health at the University of Minnesota should be a major contributor to allied health or paraprofessional training. I

encourage the expansion of their efforts to include planning and programming services to junior colleges, hospitals, vocational-technical schools, and others involved in such training.

This is a large effort. If it is to be successful, all of the health care interests in the state must cooperate and participate. As Governor, I call on them today to lend their skills, their resources, their manpower, and their goodwill for this effort.

In order to fulfill this charge, the State Planning Agency must become involved with both private and public agencies in ways previously uncharted for state government. This is a fitting and necessary assignment if we are to achieve coordination of the diverse and often competing elements of the health scene. As advocate for the long-range health needs of the public, no less than the best effort should be expected; no less than the best effort will be necessary.

I anticipate special conferences, countless committee meetings, selective planning and demonstration projects depicting alternative delivery methods, special

studies and reports, consultation services, expanded involvement with local areawide comprehensive health planning agencies, and new efforts to involve special needs groups in our state, and other yet unforeseen requirements.

I do not expect my words alone to inspire the public and the private sectors to respond with time, talent, and other resources. Therefore, I am requesting, as part of those funds designated in my budget message under the category of Medical Education, the sum of $425,000 be appropriated for this purpose to the State Planning Agency for the coming biennium.

2. Growth and Change in Medical Education

In my Budget Message, I made specific recommendations for state financial support of medical training programs which promise to increase the supply of health professionals and bring new emphasis on rural and family practice in the state.

I reiterate my support for full funding of the requests for:

--the Family Practice and Community Health Program in the University of Minnesota Medical School, to continue and expand a program that prepares doctors

specially trained to work on the health problems of families;

--undergraduate and graduate instruction in medicine with an emphasis on family practice at Hennepin County General Hospital and St. Paul Ramsey Hospital, under the Affiliated Hospitals program of the University of Minnesota;

--the Rural Health Physicians Associate Program recommended by the University of Minnesota Board of Regents, which attempts to provide study and practice in small towns or rural areas in order to increase the interest of medical students in outstate practice;

--the basic sciences program for medical training at the University of Minnesota--Duluth, to begin actual training of medical students as planned by the 1969 Legislature.

--the dental hygiene program at the University of Minnesota--Duluth.

--support of a new medical school at the Mayo Clinic in Rochester, to provide medical professionals to serve our state.

My January 27 budget recommendations provide for funding of all of these programs, for a total of

$8,446,943.

I am also recommending that the Legislature continue its support of the planning and development efforts of the Northern Association for Medical Education, whose proposals for the training of family physicians deserve further careful study. I further anticipate that N.A.M.E. will contribute substantially to the joint effort described in the previous section of this message. In order to carry out these efforts, I recommend an appropriation of $200,000 to the Northern Association for Medical Education for the biennium, from the funds identified for medical education in my Budget Message.

3. Expanding Productivity of Health Professionals

In order to improve the use of health care personnel, we must make it possible for our professionals to be more productive. There are three important steps in this direction which I wish to recommend. All three are inter-related, complement each other, and would extend considerably the capability of present professionals to extend their services without impairment of standards or quality of care. One is to grant physicians the statutory

right to delegate tasks to assistants who are, in their professional judgment, capable by formal or informal training of performing tasks under professional supervision and control. The second seeks to recognize the development of new careers in health by providing certification of workers in these careers, as well as in numerous existing but unlicensed specialties. A third encourages experimental programs which seek new ways of using existing personnel, and supports training programs for new types of health workers.

Bills have been introduced to the 1971 Session of the Legislature which will accomplish the right of a physician to delegate. Without such a right, the physician is compelled to perform many tasks and functions himself, which other personnel could properly and capably perform. Only the right to delegate is sought. The physician is still responsible for his assistants and their competence and their performance.

It has been estimated that an increase in physician productivity of 25 per cent might be achieved through the use of trained assistants, and this statutory effort is vital to the development of such productivity.

There must, however, be assurance of public accountability with respect to the level of competence of health workers to whom responsibilities are delegated.

In order to give assurance to the public and to the individual physician who delegates, a mechanism for certifying the level of competence of existing but unlicensed specialists and new experimental types of health workers must be provided. A provision for delegation would be less than responsible unless such a certification provision was provided.

During the past decade, there has been a huge increase in categories of technicians and assistants in health occupations. Some experts now identify 147 health occupations which could presently or in the foreseeable future seek statutorial licensing. Prior to this date, the licensed boards have dealt primarily with 16 statutorily defined health professional categories.

It would be undesirable to create a large number of licensing agencies to deal with these emerging occupations. Not only would they be difficult to administer, but they would also be costly to the taxpayer--both in dollars and in delaying the delivery of quality health care.

Both the American Medical Association and the American Hospital Association have called for a moratorium on licensing as a form of public accountability. These groups and other experts point out that licensing tends to restrict the duties which trained personnel are permitted to perform and also contributes to further fragmentation of health services.

Further development of new health occupations can be expected in the future. Federal and state programs are encouraging the 30,000 medical corpsmen and medical specialists discharged annually from military service to enter allied health professions. Universities and colleges, professional associations, and practicing physicians are cooperating in the planning of physicians' assistants training program in order to increase the availability of quality medical service to the public. A pediatric nurse practitioner program and an experimental dental assistant program are now under way at the University of Minnesota. These new types of health workers should and must be welcomed into the civilian health system. Their status and public assurance of their capability to perform need not be lost in the maze of

fragmentation.

These new occupational categories and the individuals who practice within them can and must be recognized. Their competence must be certified in order to protect the public. Their training and proficiency must be acknowledged by recognized authority. To do so will not only protect the public and give the physician who delegates an assurance of a level of competence, but will in addition assure job mobility and occupational advancement for those who wish to choose one of the developing allied health professions.

The time to act on provision of certification is now. Already the Higher Education Coordinating Commission reports that during 1970-71 it favorably reviewed 12 proposals for new educational programs in allied health occupations and that an additional ten proposals will seek preliminary consideration in the near future.

Bills have been introduced into this legislative session which accomplish delegatory right, certification of unlicensed health workers, and provisions for experimental use of new types of allied health professionals.

I therefore recommend that the Legislature provide for the right of physicians to delegate to assistants, at the same time that it creates a Health Manpower Coordinating Committee as an advisory body to the State Board of Health. The State Board of Health, through a new Health Manpower Coordinating Advisory Committee, should also be charged with the responsibility to foster experimental training of health personnel not now provided for by licensing authority under state statutes. Legislation currently before the Senate and the House should be combined to achieve the common objective of expanding productivity of health professionals in Minnesota.

I further recommend that the Legislature appropriate to the State Board of Health $125,000 for the coming biennium to establish this Health Manpower Coordinating Committee and provide staff for its operation.

4. Certification of Need for Health Facilities

The major portion of health expenditure in this and other states goes for institutions providing care, primarily hospitals and nursing homes. Fifty per cent of Medicaid expenditures in Minnesota are for nusing home care, and an additional 20 per cent in 1969 was for

in-patient hospital services. Minnesota now has the highest proportion of hospital beds for its population of any state in the nation.

There is a direct relationship between the supply of hospital and nursing home services and their use, and careful planning is necessary to keep the development of new and expanded services in line with real needs. It is imperative that a planning process for health facilities development be established on a statewide basis, and that all institutions be required to participate in such a process.

"Certification of need" legislation now before the Legislature provides for review of all expansion and construction plans by the areawide comprehensive health planning agencies, under general principles and guidelines to be developed by the State Planning Agency. Final certification, required before there can be new construction, expansion, or extensive modification, would be determined by the State Board of Health.

The process recommended in this legislation is comparable to that which is presently followed with Federal Housing Administration loans, Small Business

Administration loans, and the Hill-Burton funding program. I strongly recommend its passage, along with a $100,000 appropriation for the biennium to implement the program in the areawide health planning agencies and the Department of Health.

5. Emergency Funding for a Venereal Disease Control Program

Gonorrhea is presently the number one ranking reportable communicable disease in Minnesota. In the last eight years, reported cases have more than doubled from 1,967 in 1963 to 4,352 in 1970. The number of teenage cases, 895 in 1970, has increased threefold. It has been estimated that only 10 to 20 per cent of the cases actually treated are reported to health departments.

Failure to diagnose gonorrhea in females is a significant handicap in controlling the spread of disease. Female gonorrheal infections require laboratory culture techniques for diagnosis. Control efforts are also deterred by the general lack of accurate venereal disease information, or the abundance of misinformation, available to the public. Large numbers of people delay seeing a physician until they are financially able to receive care for gonorrhea.

I am therefore recommending a program to slow the alarming rate of gonorrheal infections. The objectives of this program will be fourfold: (1) to reduce the number of undiagnosed female patients; (2) to decrease the infectious period between development of symptoms and care; (3) to lessen the chances of immediate reinfection; (4) to relieve some of the financial burden for low-income patients.

In fulfillment of these objectives, certain measures need to be taken. Physicians in Minnesota must be aided in their efforts to diagnose infections by making the diagnostic culture services of the state laboratory available throughout the state. Training sessions must be conducted for junior and senior high school teachers throughout the state. Venereal disease information must be included as a routine step in training future teachers. Teaching aids and their availability must be increased, so that films, transparencies, and printed materials will assist in teaching vividly to students and others the character of this disease. Local communities must be assisted in control efforts by sharing the financial burden of medical care for low-income patients.

To further assist in this measure, I am recommending that the Legislature support the bills which have been introduced which provide for consent by minors to achieve treatment by medical practitioners.

I recommend an appropriation of $95,000 to the State Department of Health for the coming biennium to attack this threat to the public health.

EFFECTS OF THESE PROPOSALS ON RURAL HEALTH CARE IN MINNESOTA

There is no doubt that the rural areas of our state have suffered most from the problems surrounding the delivery of health care. Shortages of health personnel have been most acute in rural areas; the proportion of the elderly who require more health care is high in many rural counties.

A number of the programs recommended in this message will provide considerable assistance to the needs of rural communities, I believe:

--by increasing the number of physician graduates;

--by emphasizing family practice and the rural physician associate program at the University of Minnesota;

--by using allied health personnel to extend the physician's skills;

--by more effective use of existing health manpower as a result of experimental programs;

--by continued support of the planning and development efforts of the Northern Association for Medical Education;

--by providing comprehensive health planning through the areawide health planning councils with special emphasis on the mobilization of public and private efforts to provide a deeper knowledge of the problems and potential of each area of the state.

SUMMARY

In this special message I have recommended five specific proposals to improve the availability, accessibility, and acceptability of health care in Minnesota:

1. Assignment of responsibility to the State Planning Agency's Comprehensive Health Planning Program for a thorough mobilization to approach the organizational and finance needs of health care in cooperation with every

health care interest of the state at a cost of $425,000.

2. Support of medical and health training programs at the University of Minnesota, Hennepin General and St. Paul Ramsey Hospitals, the University of Minnesota--Duluth, the Mayo Clinic, and further activity of the Northern Association for Medical Education, in order to increase the supply of physicians and emphasize family health and rural practice, in the amount of $8,646,943.

3. Authorization of physicians to delegate authority to assistants under their supervision and control, in order to increase the productivity of medical practice; and certification of workers in new health careers by the State Board of Health with the advice of a Health Manpower Coordinating Committee, to assure the availability and competency of health personnel in new occupations developing in our state, at a cost of $125,000 for the biennium.

4. Certification of need for health facilities by areawide health planning councils and the Department of Health, in order to coordinate plans for new health facilities with demonstrated needs, at a cost of $100,000

for the biennium.

5. Emergency funding for expansion of a Venereal Disease Control Program at a cost of $95,000 for the biennium.

All of the appropriations recommended here fall within the support recommendations of my Budget Message.

If we undertake these efforts as a state, at a total cost of $9,391,943 for the biennium, I believe we will do much to alleviate Minnesota's health care crisis and provide the basis for more systematic provision of health care to all Minnesotans.